

A STUDY OF THE RELATIONSHIP BETWEEN
ANOMIE AND ALCOHOLISM

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PREFACE

The question of the relationship between the development of anomie and the development of alcoholism has attracted some interest, but not direct empirical research. The purpose of this study was to present some empirical research pertaining directly to the question in hopes of stimulating further investigation in this area.

The basic assumption underlying this study is that an answer to the question of the relationship between anomie and alcoholism will be more than just a solution to a theoretical problem, for it will also provide clinicians in the area of alcoholism with more knowledge about the psychological and social attitudes of the alcoholic patient.

It is with a deep sense of gratitude that I acknowledge the debt owed to the many people who have contributed to the completion of this study, particularly to the members of my thesis committee, Dr. Barry A. Kinsey, chairman; Dr. Benjamin Gorman and Dr. Solomon Sutker. Appreciation is also extended to Dr. Olivia Gironella, Mr. James A. S. Edwards, Miss Victoria Ross and the rest of the professional and clerical staff at the Division of Alcoholism, Edmonton, Alberta, Canada, for their extensive help in the testing of the subjects and the collection, tabulation and coding of the data. Indebtedness for statistical advice is acknowledged to Dr. David Bee of the Statistics Department of Oklahoma State University, and to Mr. Earl Westfall of the Computer Center, who ran the statistical analyses on the data. Much credit is due my wife Norma for her unending encouragement and for the typing

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CHAPTER I

NATURE OF THE PROBLEM

Introduction

The problem of alcoholism is one of the most serious social problems that faces society today. If the problem were limited only to the estimated four to five million alcoholics,¹ it would still constitute an area of grave concern; but when all who are directly affected by the alcoholic--family, friends, associates--are also taken into account, the problems that this disease produces are indeed gross. The alcoholic neither wishes nor tries to be a problem, but by the very nature of the alcoholic process he cannot help the outcome.

The alcoholic often appears or is regarded as an alienated person, either as a homeless skidder or as a lone drinker who is trying to shut himself off from the reality of his situation. This noticeable withdrawal from normal social relationships and activity has led some writers to propose the idea that alienation and rejection may play an important role in the addictive process.²

¹Marvin A. Block, Manual on Alcoholism (Chicago: American Medical Association, 1962), p. 77.

²See Ruth Bunzel, "The Role of Alcohol in Two Central American Cultures," Psychiatry, III (August 1966), pp. 361 ff. Donald Horton, "The Functions of Alcohol in Primitive Societies," Alcohol, Science, and Society (New Haven, Yale University Press), Lecture 13. Barry A. Kinsey, The Female Alcoholic: A Social Psychological Study (Springfield, Illinois: Charles C. Thomas, 1966), pp. 40-43.

This idea has been further extended by the inclusion of anomie as a variable which either is a predisposing factor or concomitantly develops along with the alcoholic process. Even though these two ideas are sometimes mistakenly placed together, they should not be handled as such, for they constitute two distinct points of view. The first, that anomie precedes alcoholism, gives the impression that anomie is wholly or at least partially the causation factor. As such there is no question as to the time relationship between the inception of alcoholism and the presence of anomie. Obviously, according to this approach, the state of anomie was present before the individual became an alcoholic.

The second approach, that the two phenomena developed concomitantly, does not present the idea that one state precedes the other. Rather, this approach states that as one of the conditions becomes more severe the other will also become more severe. The fact that there is no mention of the precedence of one condition does not necessarily eliminate the possibility of such from being included in this approach. However, the fact that this particular approach does not posit precedence but rather remains concerned with the concomitance of the two conditions makes this approach a more functional frame of reference through which to attack the problem.

The Problem

Specifically, the problem to which this study is directed is to present some empirical evidence that will show the relationship between the development of alcoholism and anomie. The study will concentrate on showing whether one condition precedes the other, whether there really is a concomitant development in severity, and whether the

relationship between these two conditions of anomie and alcoholism are directly affected by various socio-cultural factors.

Limitations

Due to the nature of the independent variable, alcoholism, it was necessary to procure the subjects from an alcoholism clinic. The problem with this technique is that it was impossible to acquire a random sample of the alcoholic population, as an alcoholism clinic attracts only those who have realized that they have a drinking problem. Thus, our sample is heavily weighted toward help-seeking, more severe alcoholics. The non-help-seeking and less severe alcoholics are therefore inadequately represented.

A second limitation of this study is the sample size (N=93). The research was conducted during the summer months, and this is the least desirable time as far as in-coming patients is concerned. The reason for this is that during the summer months casual work is very plentiful, and therefore the alcoholic can usually acquire enough money to support his drinking. Also, the lack of physical comforts which the alcoholic often must endure is more easily tolerated during the summer months. The winter months, on the other hand, present an entirely different picture. Jobs are not as plentiful and the physical discomforts of a Canadian winter are intolerable. Therefore, the number of in-coming patients is relatively higher during the winter months and lower during the summer months. Thus, only a small sample was available.

A third limitation which should be mentioned pertains to the location and some aspects of the population sample involved in the

study. The study was conducted in an urban area (Edmonton has a population of about 400,000), and therefore the rural area has been inadequately represented.

As to the population sample, it should be noted that Edmonton is predominantly inhabited by people with an English background, but there are a substantial number of Germans and Ukrainians scattered throughout the city. A check was made of the ethnic backgrounds of the subjects in the study, but this was not used as a socio-cultural factor since the results showed eighty-nine of the ninety-three subjects to be of English descent.

A final limitation to be noted is that there is no reference to the socio-economic background of the subjects. This was a problem that could not be avoided since income was not recorded and the occupational data were incomplete. Without data on these two factors, it would be very difficult to ascertain the socio-economic background of the subject.

In light of these limitations, it is felt that this study should more appropriately be viewed as a pilot study.

CHAPTER II

REVIEW OF THE LITERATURE

Development of the Major Concepts

Before attempting to present a review of the literature pertaining to the relationship between the concepts of anomie and alcoholism, it is felt that the development of the concepts themselves should be presented.

Anomie

The concept of anomie* was re-introduced to science by Emile Durkheim in The Division of Labor in Society published in 1893.¹ The concept was not unique with Durkheim, as it had been used in varying forms in the early writings of Aristotle and Plato and appeared again in the mid-seventeenth century in some theological writings.² But it is with Durkheim that most scholars begin when the concept is reviewed.

Initially Durkheim applied the concept of anomie to one of the abnormal forms of the division of labor which he found to exist in the

*There has been and still is some disagreement as to the correct spelling of the term anomie. For the rest of this paper I shall use the "anomie" spelling. Any other form will be in quotations.

¹Emile Durkheim, The Division of Labor in Society, George Simpson, trans. (New York: The Free Press of Glencoe, 1947).

²Sebastian De Grazia, The Political Community: A Study of Anomie. (Chicago: University of Chicago Press, 1948), p. 195.

France of his day. Society existed in "a state of nomia"³ as far as Durkheim could ascertain. This meant that society disciplined or constrained the individual through its solidarity and that, as long as the individual was acting in conjunction with the rules and regulations of society, the society would function in a controlled equilibrium or a state of nomia. But this state was not all-enduring; and, due to factors such as a lack of contact between the various parts of society or insufficient and unprolonged contact, an abnormal form of division of labor could emerge. This emergent form Durkheim entitled anomic.⁴

Durkheim did not really present a clear definition of what he meant by anomie in his initial work, but in his second major work, Suicide,⁵ he did present a basic definition of the concept; and it is this definition from which the social sciences originally drew the theoretical implications. The definition referred to anomie as a condition of relative normlessness that arises when the collective order is in a state of disruption such that man's aspirations are allowed to rise beyond all possibility of fulfillment. The ends to means are not defined and discipline is no longer imposed by society; in other words, the individual is in a position such that his activities are not restrained by regulated controls and he thus develops a lack of

³ Harry Alpert, Emile Durkheim and His Sociology (New York: Columbia University Press, 1939), p. 190.

⁴ Lewellyn Hendrix, "Durkheim's Abnormal Forms of the Division of Labor." (Unpublished Term Paper: Oklahoma State University, 1965).

⁵ Emile Durkheim, Suicide, John A. Spaulding and George Simpson, trans. (New York: The Free Press of Glencoe, 1951).

regulation of his basic nature.⁶

As Durkheim conceived it, anomie has three characteristics in the subjective sense: first, a painful uneasiness (or anxiety; second, a feeling of alienation from the group or an isolation from the standards of the group; and, third, a feeling of purposelessness or of nonexistence of real goals.⁷

Durkheim presented the concept of anomie in order to give some order or explanation to social disorganization. He conceived of anomie in terms of a sociological or group-oriented analysis, not in terms of an individual psychological analysis. The problem of anomie for Durkheim was societal, not individual. His re-opening and re-introduction of the concept has established the ground floor upon which others have been able to build or innovate.

The concept fell into disuse after Durkheim had defined it until Robert K. Merton picked it up and developed a particular elaboration of the idea of anomie. In an essay entitled "Social Structure and Anomie," which first appeared in 1938, was revised in 1949, and later was included in his book Social Theory and Social Structure,⁸ Merton presented his much discussed social and cultural explanation of deviant behavior based on the concept of anomie.

For Merton, as it had been for Durkheim, the explanation of deviant behavior had to be made in the light of the social order as a

⁶ Marshall B. Clinard, ed., Anomie and Deviant Behavior: A Discussion and Critique (New York: The Free Press of Glencoe, 1964), pp. 7-9.

⁷ De Grazia, p. 5.

⁸ Robert K. Merton, Social Theory and Social Structure, Rev. Ed. (Glencoe, Illinois: The Free Press, 1957), pp. 131-160.

whole and could not be explained by concentrating on the individual. He saw an arbitrary dichotomy between the desired cultural goals in society and the accepted institutionalized means of achieving these goals.⁹ The desired goals in society may change, and with these changes the means of securing the goals must also be changed; but the changed means must be according to socially prescribed measures, for society demands an acquiescent attitude commonly referred to as conformity from the acquirer.

If a man cannot obtain his desired goals through the prescribed means available, then he will choose a less acceptable pattern of action and a disequilibrium between the goals desired and socially acceptable means will be produced. This emphasis led Merton to define anomie as resulting from:

"A breakdown in the cultural norms and goals and the socially structured capacities of members of the group to act in accord with them. . . . When the cultural and social structure are malintegrated, the first calling for behavior and attitudes which the second precludes, there is a strain toward the breakdown of norms, toward normlessness."¹⁰

Merton and Durkheim were quite similar in their respective conceptions of anomie. Durkheim saw the situation in the sense that "social structures exert a definite pressure upon certain persons to engage in nonconforming rather than conforming conduct."¹¹ Merton, however, felt that, because of today's tremendous emphasis on the acquired goal of success without an equally strong emphasis upon

⁹ Clinard, pp. 11-12.

¹⁰ Merton, pp. 162-163.

¹¹ Merton, p. 152.

opportunities for individuals to use legitimate means in securing this goal, man is sometimes thrown into a position in which the appropriate normative restraints are no longer effective. The basic logic for both Durkheim and Merton is the same: the social condition produces the psychological state which, in turn, produces deviant behavior.¹² This deviant behavior is the eventual and inevitable outcome of a state of anomie. It may be in the form of suicide, as described by Durkheim, or more encompassing, as expressed by Merton, in the form of crime, delinquency, drug addiction, mental disorder, alcoholism, and many other phenomena.

Another writer who started with Durkheim's theory and extended it was Sebastian De Grazia. De Grazia found the concept of anomie to be even more encompassing than either Durkheim or Merton, as he could see anomie as accounting for nearly all of contemporary society's problems and maladjustments. Anomie for De Grazia was both a "social condition and a psychic state. . . sometimes referred to as a social and emotional void."¹³ He defined anomie as

"the disintegrated state of a society that possesses no body of common values or morals which effectively govern conduct. . . anomie is the ideological factors that weaken and destroy the bonds of allegiance which make the political community."¹⁴

¹²Herbert McClosky and John H. Schaar, "Psychological Dimensions of Anomy," American Sociological Review, XXX (February, 1965), 16.

¹³Elwin H. Powell, "Occupation, Status and Suicide: Toward a Redefinition of Anomie," American Sociological Review, XXIII, No. 2 (April, 1958), 132.

¹⁴De Grazia, pp. 12-19.

De Grazia's major contribution to the theoretical implications of the concept of anomie was his process of distinguishing between simple and acute anomie in society. The alienation of the worker from his work as evidenced by his reaction against impersonality and competition was designated as simple anomie. It was seen in contemporary literature and art through the moods and ideas which the authors and artists attempted to convey. The acute state of anomie was seen by the manifestations of mental disorder, suicide, and mass movements.¹⁵

From 1955 until the present, various writers have continued to redefine, modify, and add to both Durkheim's and Merton's theories. After the publication of Social Theory and Social Structure in 1957, Merton's theory, even more than Durkheim's, became the object of much controversy and analysis. Robert Dubin presented an article in which he started with Merton's views but proceeded to institute a number of modifications to the theory.¹⁶ He disagreed with Merton on the point that the deviant modes of adaptation which were presented in Merton's theory were always unfortunate or negative in the final outcome. Dubin insisted that the deviant modes of action are not necessarily dysfunctional to society and could in some cases actually be beneficial.¹⁷

Dubin, starting from the above assumption, proceeded to sub-divide Merton's four original typologies into fourteen forms of adaptation

¹⁵ Clinard, pp. 9-10.

¹⁶ Robert Dubin, "Deviant Behavior and Social Structure: Continuities in Social Theory," American Sociological Review, XXIV (April, 1959), 147-164.

¹⁷ Clinard, p. 25.

which he felt better explained the distinction between institutionalized norms and actual behavior. Twelve of the adaptations were new with Dubin and were outgrowths of Merton's innovation and ritualism forms of adaptation, while Merton's other two forms, retreatism and rebellion, were included unchanged in Dubin's new typology.¹⁸ In reality all Dubin did was to try to make Merton's theory broader, more inclusive, and more specific with regard to the types of deviant adaptation.

At the same time that Dubin published his work, Richard A. Cloward also presented a paper in an attempt to reformulate the Merton theory of anomie.¹⁹ Cloward pointed out that Merton's theory presents the idea that "deviant behavior is a product of patterned differentials in the access to goals of success, by the use of legitimate or sanctioned institutional means"²⁰ But Cloward felt that another variable needed to be added to the scheme, and that was the concept of differentials in access to success-goals by illegitimate means. The idea is that not only is access to the socially prescribed means subject to differential opportunity, but access to the illegitimate means is also subject to differential opportunity. Certain positions in the social, economic, and occupational hierarchy provide some individuals with more opportunity to capitalize on the use of deviant means or, because of the position held in the strata, deviant role performance is easier or may

¹⁸ Dubin, pp. 151-160.

¹⁹ Richard A. Cloward, "Illegitimate Means, Anomie, and Deviant Behavior," American Sociological Review, XXIV (April, 1959), 164-176.

²⁰ Clinard, p. 27.

be demanded by the subculture.

Merton expressed favorable comment on this addition to his theory, as he felt it to be a clarification and useful extension of the existing theory. He summed up Cloward's contribution by stating that he had

"assumed by default that access to deviant or illegitimate means for reaching a valued goal is uniformly available, irrespective of position in the social structure. . . . He [Cloward] corrects this unwitting and, it appears, untrue assumption by dealing with socially patterned differences of access to learning how to perform particular kinds of deviant roles and of access to learning how to perform particular kinds of deviant roles and of access to opportunity for carrying them out. . . . He [Cloward] thus generalizes the notion of social-structural differences in ease or difficulty of role-performance, to hold for both socially legitimate and illegitimate roles."²¹

Cloward's contribution was probably the last substantial one to the general theory of anomie and deviant behavior.

In recent years much of the controversy over the concept of anomie has centered on the academic problem of whether anomie denotes a psychological state or a social condition. The psychologists have claimed anomie in some cases to be part and parcel of the more generalized concept of alienation while many sociologists have held to the belief that anomie is a greater and more advanced form of alienation. This discussion has also been concerned with the synonyms used in reference to the concept and with the operational definitions presented.

If we again begin with Durkheim and Merton, we can see that their fundamental logic is similar: anomie is the social condition which produces the psychological state which in turn produces deviant

²¹Robert K. Merton, "Social Conformity, Deviation, and Opportunity-Structures: A Comment on the Contributions of Dubin and Cloward," American Sociological Review, XXIV (April, 1959), 188.

behavior.²²

Both Durkheim and Merton were concerned with the first and third aspects of the problem, the social condition and deviant behavior, and did not deal substantially with the second or middle aspect. Their orientation was obviously sociological and they did not directly concern themselves with the psychological dimension; it is with this point that the psychologically oriented writers take issue. One of the earliest writers to approach the concept from a psychological viewpoint was Robert M. MacIver. According to MacIver, "anomy" could be defined as

"the state of mind of one who has been pulled up by his moral roots. . . . The anomic man has become spiritually sterile, responsive only to himself, responsible to no one. He lives on the thin line of sensation between no future and no past. . . a state of mind in which the individual's sense of social cohesion--the mainspring of his morale--is broken or fatally weakened. . . . anomy is an extremer form of egoism. . . the fulfillment of the process of desocialization, the retreat of the individual into his own ego."²³

MacIver was obviously more concerned with the psychological state of mind of the individual than he was with the more general social factors involved in the process, and by presenting this picture he opened the floodgates for psychological interpretations and pronouncements on the subject.

In 1956 a series of articles written by Leo J. Srole appeared on

²² McClosky and Schaar, p. 16.

²³ Robert M. MacIver, The Ramparts We Guard (New York: Macmillan, 1950), pp. 76-85.

the subject of a psychological definition of anomie.²⁴ Srole presented anomie in the psychological terms by referring to it as a psychological state which refers to "the individual's generalized, pervasive sense of 'self-to-others distance' and 'self-to-others alienation' at the other pole of the continuum."²⁵ Srole agreed with the prevailing notion that anomie is dependent upon and in many respects determined by social and cultural factors with which the individual comes into contact. But he extended the theory to include the multifaceted effects of personality.²⁶ At this point Srole more or less (dropped the theoretical pursuit and concentrated on the development of a scale which he felt could test for the presence of anomie. Srole did not pursue his idea of the relation between anomie and personality any further than introducing this dimension and opening this aspect of the study for others to investigate.

The investigation of this approach was picked up by Elwin H. Powell, who presented a redefinition of anomie. The new definition was in the light of Durkheim's original analysis; that is, it was presented as a means of looking at the social problem of suicide as the end result of anomie. For Powell,

²⁴Leo J. Srole, "Anomie, Authoritarianism, and Prejudice," American Journal of Sociology, LXII (July, 1956), 63-67. See also "Social Integration and Certain Corollaries: An Exploratory Study," American Sociological Review, XXI (December, 1956), 709-716. See also "Interdisciplinary Conceptualization and Research in Social Psychiatry," (Unpublished paper read before the American Sociological Society, Detroit, 1956.)

²⁵Srole, "Social Integration and Certain Corollaries: An Exploratory Study," p. 711.

²⁶Srole, "Interdisciplinary Conceptualization and Research in Social Psychiatry," pp. 3-5.

"Anomie is both a social condition and a psychic state. . . . Characterized by a general loss of orientation and accompanied by feelings of 'emptiness' and apathy, anomie can be simply conceived of as meaninglessness."²⁷

Powell's ideas were challenged by Cary-Lundberg on the basis that anomie is a sociological concept denoting disruption in the social order and that it needs no common denominator and can by no stretch of the imagination be subsumed under the unitary term of meaninglessness.²⁸

Powell in a reply to Cary-Lundberg stated that Durkheim had presented his ideas in an anti-psychological manner and that this shackled the significance of the concept. He (Powell) was therefore re-defining the concept to include the psychological dimensions so that it would be of greater use in the study of social pathology.²⁹

The psychological cause was further enhanced by Melvin Seeman when he presented his five-fold alienation analysis. Alienation was categorized into (1) powerlessness, the inability to control one's own behavior; (2) meaninglessness, a lack of future orientation; (3) normlessness, the idea that deviant behavior will be required in order to achieve goals; (4) isolation, the belief that high esteem goals have a low reward value; and (5) self-estrangement, the control behavior due to anticipation of future rewards.³⁰

Seeman felt that anomie could be generally equated with his

²⁷ Powell, p. 132.

²⁸ Isabel Cary-Lundberg, "On Durkheim, Suicide and Anomie," American Sociological Review, XXIV (April, 1959), 250-252.

²⁹ Elwin H. Powell, "Rejoinder to Dr. Cary-Lundberg," American Sociological Review, XXIV (April, 1959), 252-253.

³⁰ Melvin Seeman, "On the Meaning of Alienation," American Sociological Review, XXIV (December, 1959), 783-791.

concept of normlessness and was therefore part and parcel of the old psychological concept of alienation. But this could be justified only by making normlessness a rather broad term; thus, he conceded that the

"idea of normlessness has been over-extended to include a wide variety of both social conditions and psychic states: personal disorganization, cultural breakdown, reciprocal distrust, and so on."³¹

One of the most recent attempts to give the concept of anomie some real psychological grounding was done by Herbert McClosky and John H. Schaar.³² After discounting previous attempts at the development of a theory of anomie in relation to psychological factors, McClosky and Schaar presented their ideas on

"the relations between anomy and various dimensions of personality. . . the contributions various psychic states may make to anomy independently of the person's social status . . . the thesis that certain objective social conditions cause anomy and that, conversely, individuals' anomic feelings may be taken as evidence that those objective social conditions exist."³³

More specifically, anomie is conceptualized by McClosky and Schaar as

"a state of mind, a cluster of attitudes, beliefs, and feelings in the minds of individuals. . . . it is the feeling that the world and oneself are adrift, wandering, lacking in clear rules and stable moorings. The anomic feels literally de-moralized; for him the norms governing behavior are weak, ambiguous and remote. . . the core of the concept is the feeling of moral emptiness."³⁴

³¹ Seeman, p. 787.

³² McClosky and Schaar, pp. 14-40.

³³ McClosky and Schaar, p. 17.

³⁴ McClosky and Schaar, p. 19.

It is this last conception of anomie with which we will be concerned throughout the remainder of this paper.

Alcoholism

The concept of alcoholism or compulsive drinking of intoxicating beverages can be found in the literature as far back as one cares to investigate. Therefore, we do not feel that an extensive review of this concept is necessary. A detailed account of the phenomenon that is today classified as alcoholism would be more appropriate.

The best definition of this concept stems from the conclusions of the report on alcoholism presented by the World Health Organization committee. The definition they presented was as follows:

"Alcoholism is a progressive, chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of dietary and social uses of the community resulting in an increasing dependence upon alcohol and leading to physical, emotional and social disorders."³⁵

This definition has a number of advantages over most other definitions. First, it has been tested by at least two extensive research programs and was found in both cases to fit.³⁶ Second, it is a sociological definition and as such is directed toward the problem itself rather than at the etiological or causal aspect.³⁷ Third, this

³⁵M. Keller, "Alcoholism: Nature of the Problem," The Annals (January, 1958), pp. 2 ff.

³⁶D. Falkey, "Characteristics of Male Alcoholics Admitted to Medical Ward of a General Hospital," Quarterly Journal of Studies on Alcohol, XVIII, No. 1 (1957), 67-97. S. Schneyer, "A Short Form of the Weschler/Bellevue Scale, Form II, for Alcoholic Patients," Quarterly Journal of Studies on Alcohol, XVIII, No. 3 (1957), 382-387.

³⁷Barry A. Kinsey, The Female Alcoholic: A Social Psychological Study (Springfield, Illinois: Charles C. Thomas, 1966), p. 18.

definition is broad and encompassing and thus lends itself to sociological research and allows for the inclusion of all alcoholics regardless of differences in symptomatology and etiology.³⁸

As a sociological phenomenon, alcoholism can be described in terms of the specific behavior patterns of the alcoholic as these are differentiated from the behavior patterns of others. The condition could also be described in terms of the patterned and repetitive behaviors of significant others in their response to the alcoholic and his behavior patterns.³⁹ Both the actions of and the reactions to the alcoholic are necessary variables in the analysis of the alcoholic process.

Alcoholism is a complex concept in that it represents at least a mental condition, a physical condition, a series of behavior patterns, a chronic and progressive disease, and an addictive process. As such, it is difficult to definitely know what aspect of alcoholism one is referring to when the concept is used. For the purposes of this study the concept of alcoholism will basically refer to a chronic and progressive dependence upon alcohol, due to a physical and/or psychological addictive process. Alcoholism will be also regarded as a phenomenon that can be diagnosed and categorized into a three-stage classification: early, middle, and late.

With the explanation of the two major concepts now presented, we can proceed to a general review of the literature pertaining to the

³⁸Kinsey, p. 18.

³⁹Selden D. Bacon, "Social Settings Conducive to Alcoholism: A Sociological Approach to a Medical Problem," Manual on Alcoholism (Chicago: American Medical Association, 1962), p. 62.

relationship between the two conditions of anomie and alcoholism.

Previous Studies

With regard to the relationship between the progressive development of alcoholism and the existence of anomie, there does not appear to have been any specific research so far conducted. But some has been written about the interrelationship of the two phenomena and the general opinion on the problem has been summed up by Snyder in his statement that at both the inception and terminal stages of alcoholism, the alcoholic is an anomic person.⁴⁰ Evidence in support of this statement, which is suggestive rather than conclusive, was found in Park's study in which he concluded that the personality dispositions of incipient alcoholics show a marked inability to structure social roles in accordance with the social requirements of society.⁴¹

Connor's study of the self-concepts of alcoholics also produced some findings which would tend to support Snyder's contention that the alcoholic is anomic both before and during his alcoholism. Connor found a great deal of personal disorganization and an almost complete lack of favorable self-concepts in the alcoholic subjects which he

⁴⁰ Charles R. Snyder, "Inebriety, Alcoholism and Anomie," Anomie and Deviant Behavior, Marshall B. Clinard, ed. (New York: Free Press of Glencoe, 1964), p. 204.

⁴¹ Peter Park, "Problem Drinking and Role Deviation: A Study of Incipient Alcoholism," Society, Culture and Drinking Patterns, David J. Pittman and Charles R. Snyder, eds. (New York: John Wiley and Sons, 1962), pp. 431-455.

tested.⁴² It should be noted, however, that Connor's subjects had all been diagnosed as either middle- or late-stage alcoholics and his results have no bearing on the condition of the alcoholic in the early or inception phase of the alcoholic process.⁴³

Merton approached the subject of the relationship between anomie and alcoholism in his theory of deviant behavior.⁴⁴ He saw alcoholism as a mode of retreatism for the individual who could not gain access to the legitimate means for acquiring socially prescribed goals. The reaction of the retreatist was in the form of withdrawal from society or, as explained by Merton, the retreatist is ". . . strictly speaking in society but not of it. . . not sharing the common frame of values."⁴⁵

Merton definitely places anomie in the position of a predisposing factor to the advent of alcoholism and it is this contention more than any other which lends weight [to] the idea of anomie as a predisposing factor in alcoholism.

Cloward contributed to Merton's theory by adding the idea of differential access not only to legitimate means but also to illegitimate means to prescribed goals.⁴⁶ However, no attempt has been made to

⁴²Ralph G. Connor, "The Self-Concepts of Alcoholics," Society, Culture and Drinking Patterns, David J. Pittman and Charles R. Snyder, eds. (New York: John Wiley and Sons, 1962), pp. 455-468. Also see William McCord and Joan McCord, "A Longitudinal Study of the Personality of Alcoholics," Society, Culture and Drinking Patterns, David J. Pittman and Charles R. Snyder, eds. (New York: John Wiley and Sons, 1962), pp. 14-40. Barry Kinsey, pp. 53-55.

⁴³Connor, pp. 458-468.

⁴⁴Merton, pp. 131-160.

⁴⁵Merton, p. 153.

⁴⁶Cloward, pp. 164-176.

connect this theory specifically with the problem of alcoholism.

Another contention concerning possible relationships between anomie and alcoholism is that these two conditions develop concomitantly. Kinsey feels that the concomitant development may have important implications for the loss of control.⁴⁷ This idea, while not necessarily in agreement with Merton, is probably a more valid assumption in that it does not eliminate the possibility that alcoholism may be active before the anomic condition appears.

It is evident that research in this area is relatively sparse and that that which has been presented tends to adhere generally to the idea that anomie precedes alcoholism or is a predisposing factor in its development. The present study provides empirical data for testing this assumption and the following hypotheses are presented as a summary of the types of data which are to be used in this analysis.

Hypotheses

In attempting to test empirically the assumptions mentioned above concerning the relationship between anomie and the development of alcoholism, we will be basically concerned with three questions or hypotheses. First, is anomie, as measured by a standardized test, positively correlated with alcoholism? Second, does this condition exist prior to or concomitant with the development of alcoholism? Third, if anomie does develop progressively along with alcoholism, is it due to some socio-cultural factor or factors other than the stages of alcoholism?

⁴⁷ See Kinsey, Chapter Three.

Operationally, these three general hypotheses can be stated in null form as two hypotheses and a third hypothesis with seven sub-hypotheses which identify specific socio-cultural factors to be used.

1. H_{01} : There is no significant association between stages of alcoholism and the degree of anomie.
2. H_{02} : Anomie will not be present to a significant degree in the response of early-stage alcoholics.
3. H_{03} : There is no significant difference between anomie scores of alcoholics from different socio-cultural groupings, holding constant the degree or stage of alcoholism.

The third hypothesis deals with a variety of socio-cultural factors which can be further broken down into seven sub-hypotheses. After controlling for the stage of alcoholism, it is hypothesized that:

1. There are no significant differences in anomie scores of males and females.
2. There are no significant differences in anomie scores of Catholics and Protestants.
3. There is no significant correlation in the anomie scores of respondents and the degree of liberalism-conservatism associated with their religious affiliations.
4. There are no significant differences in anomie scores of respondents in various age groupings.
5. There are no significant differences in anomie scores of respondents with different marital statuses.
6. There are no significant differences in anomie scores of respondents in various categories of "years of drinking."
7. There are no significant differences in anomie scores of respondents in various categories of "years drinking has been a problem."

Definitions

The two major variables, anomie and alcoholism, were previously defined above. However, some of the other concepts and variables need

further clarification at this point.

Stages of alcoholism refers to the three-fold classification of alcoholics into early, middle and late stages as measured by the Phillips Phases of Alcoholism Scale.⁴⁸

Stages of anomie refers to the classification of anomie into the three stages of non-anomic, moderately anomic and severely anomic as measured by the McClosky-Schaar Anomy Scale.⁴⁹

The degree of religious liberalism-conservatism refers to the position on a liberal-conservative continuum that each of the subjects' religion or denomination would occupy, based upon the theological approach and practical position to which the religion or denomination adheres. The religious groups were ranked by three judges who were well versed in the theology and practice of the groups.

The years drinking category refers to the total number of years that the subject has been drinking alcoholic beverages. This category differs from the years drinking has been a problem category in that the latter category includes only the total number of years that the subject feels his drinking has been causing him physical, emotional or social problems.

⁴⁸ See Chapter III.

⁴⁹ See Chapter III.

CHAPTER III

METHODOLOGY

The Sample

The sample used in this study consisted of ninety-three new or old-returning patients to the Division of Alcoholism, Department of Public Health, Edmonton, Alberta, Canada. The selection of only new or old-returning patients was made to insure that the subjects had not been affected by the treatment program. This represented an attempt to use subjects who would most closely approximate the typical alcoholic.

Another criterion which the subject was required to possess was that he had been recently drinking. That is, the subject was still an active alcoholic as opposed to a sober or recovered alcoholic. If the subject had had sobriety for a relatively lengthy period, the scale scores would probably be invalid; therefore, only those subjects who were still classified as active were used.

It should be noted that all of the information from the subjects was acquired during the first week of counselling. Since some subjects were incapable of completing the scales and file folder during the first or second interview while others were capable, there is a slight discrepancy between date of contact and date of completion of the data collection.

The subjects were presented the following as a part of the normal clinic procedure.

Research Instruments

In order to determine whether the subjects were alcoholic and/or anomic, it was necessary to use two different scales.* The socio-cultural data used was obtained from a file folder that is completed on every patient who enters the alcoholism clinic. Only professional alcoholism counsellors were used for the administering of these instruments. (The following is an explanation of the scales and the file folder.)

The McClosky-Schaar Anomy Scale¹

McClosky and Schaar developed a scale to be used as a measurement of anomic feelings, based on the assumptions that anomic feelings are the result of improper socialization and failure to conform to the normative structure of society.² In pre-testing their Anomy Scale, McClosky and Schaar compared the results of their anomy scale with the results from other scales measuring pessimism, alienation, hostility, bewilderment, anxiety, and a sense of political futility. They found a high correlation between the anomy scale scores and the scores from

* It should be noted that there may be some question as to the applicability of the term "scale" in the strictest sense in connection with the two instruments used in this study.

¹ See Appendix A.

² Herbert McClosky and John H. Schaar, "Psychological Dimensions of Anomy," American Sociological Review, XXX (February, 1965), 14-40.

these other instruments.³

The McClosky-Schaar Anomy Scale is a nine-item questionnaire, composed of close-ended questions and mutually exclusive answer choices. Based on a numerical count of the number of "agree" answers given, a scorer can readily assess the severity of the individual's anomic feelings. Three levels or degrees of anomie are identified: non- or only slightly anomic (0-2), moderately anomic (3-5), and severely anomic (6-9). The scale is designed so that each respondent falls into one of the three named categories.⁴

The Phillips Phases of Alcoholism Scale⁵

The Phillips Phases of Alcoholism Scale was designed by this author with assistance from the treatment staff of the Division of Alcoholism, Edmonton, Alberta, Canada.

The scale was composed of selected items from "A Profile of the Problem Drinker"⁶ and "The Phases of Alcoholism Chart."⁷ The initial scale was presented to the entire clinical staff for revision and comments. It was then reconstructed and pre-tested for reliability and validity on 20 known alcoholics. The scale scores were compared with each counsellor's evaluation of the respondent's actual stage of

³McClosky and Schaar, pp. 25-38.

⁴McClosky and Schaar, pp. 23-25.

⁵See Appendix B.

⁶"A Profile of the Problem Drinker," Reprint from Proceedings of the 1954 Alberta Conference on Alcoholic Studies.

⁷"The Phases of Alcoholism Chart," Reprint from Alcoholism: Definition, Etiology, Classification and Clinical Picture (Unpublished Alcoholism Foundation of Alberta counsellor's handbook).

alcoholism, and in all cases the scale score and the counsellor's analysis were in agreement. Because of this agreement further tests of the scale's reliability and validity were not instituted. It was felt that since the scale was accurately measuring the phenomenon it was designed to measure, according to expert judges, and since there was no other scale available with which to compare the results, the scale was accepted as being both reliable and valid.

The Phillips Phases of Alcoholism Scale is composed of sixteen close-ended questions with mutually exclusive answers. The questions were randomly arranged so that the respondent would not detect a natural progression in the severity of the items.

File Folder⁸

The file folder from which the socio-cultural data were procured is a standard clinical recording device. It is so structured that most of the seventy-nine questions are close-ended and coded, which permits the counsellor to collect and record the information rapidly.

The information received covers a wide range of subjects, which presents the counsellor with a quick but quite comprehensive background sketch of the patient.

The file folder is coded in order that the information can be readily transferred to punch cards and fed to a computer for research purposes.

⁸ See Appendix C.

Research Procedures

The procedure used for obtaining the data was as follows. First, each subject was required to help fill in the file folder, which has been a common practice in the clinic since the therapy program began. In the process of filling in the file folder, counsellors were able to develop an early diagnostic assessment of the respondents. Second, in most cases the counsellor immediately presented the two scales to the subject and asked him to answer the questions. In none of the ninety-three cases was the request of the counsellor refused. However, in five cases the counsellor felt that, because of the subject's severe withdrawal symptoms, the scale scores might not be valid. In these cases, the scales were not administered until later in the week.

The Phillips Phases of Alcoholism Scale was administered first and, unless the counsellor felt that the subject was not being truthful (in which case the data were not used), the McClosky-Schaar Anomy Scale was administered immediately afterward. Again, there were no cases in which the counsellor's first impression of the stage of alcoholism and the scale scores did not coincide. As a further check of reliability, the counsellors retained the alcoholism scale scores until the patients had been more thoroughly diagnosed, usually about one week. At this time they compared the scale score with their professional judgment of the patient's condition and recommended whether or not to accept the scale results. A total of four scale scores were disqualified: three because respondents had underemphasized their drinking problem and one because the drinking problem had been overemphasized. It should be noted that there is a progressive nature to the development of alcoholism as measured by the scale, and certain

items necessarily precede others. This means that, if a subject has developed some of the symptoms, he must also have developed certain others. It was on this basis that relatively obvious errors could be identified.

The data from the two scales were given directly to the author, while the data from the file folder were sent to the research department of the Division of Alcoholism to be coded and put on computer code sheets. The code sheets were then mailed to this researcher as they became available. All the data were then coded and put on computer punch cards for use in statistical analyses.

Statistical Procedures

Due to the varied types of questions being asked in the proposed hypotheses, it was necessary to use a number of different statistical tests. Each test chosen was selected on the basis of being the most suitable, reliable and functional test that could be used with the particular data available. The decisions as to which statistical tests to use were arrived at through consultation with two statisticians. It was decided that, due to the type of data that were available, it would be necessary to use only non-parametric statistics since certain assumptions about the data which would have allowed the use of parametric statistics could not be met.

The first hypothesis was tested by use of the Spearman Rank Correlation Coefficient.⁹ This statistic is a measure of association

⁹Sidney Siegel, Non-Parametric Statistics for the Behavioral Sciences (McGraw-Hill Book Company, Inc., 1956), pp. 202-213.

between two ordered series. It shows whether any correlation exists between the two phenomena being tested.

The second hypothesis was tested by use of the Binomial test.¹⁰ This test is used to discover the probability that the observed values were obtained by chance. It was used with this hypothesis because of its applicability with small samples and because the primary goal of this hypothesis was just to show whether or not anomie was significantly present in the early stage of alcoholism.

The seven sub-hypotheses of the third hypothesis were tested by the use of three different statistics. The following is an explanation of those statistical tests.

The Mann-Whitney U Test¹¹ was used on the first two sub-hypotheses, those dealing with Catholics versus Protestants and males versus females. This test is used to show whether two independent groups have been drawn from the same population. If there is a significant difference between the two groups, then it will be evident that one of the factors may account for the action of the dependent variable, in this case anomie.

The third sub-hypothesis, that dealing with the liberalism-conservatism of the respondent's religious affiliation, was also tested by the Spearman Rank Order Correlation Coefficient.¹² Again, this test was used to determine whether any correlation existed between the two groups of data.

¹⁰Siegel, pp. 36-42.

¹¹Siegel, pp. 116-127.

¹²Siegel, pp. 202-212.

The last four sub-hypotheses, those dealing with age groupings, marital status, years drinking, and years a problem, were all tested with the use of the Kruskal-Wallis One-Way Analysis of Variance by Ranks Test.¹³ This test shows whether the differences among the samples tested are genuine differences or if the differences are due to nothing more than chance. Differences are to be expected, but the significance of these differences could help to determine whether or not some factor had an effect upon the dependent variable, the anomie scores.

After deciding upon the statistical tests to be used, the problems were programmed for the computer and the runs were conducted. The results were tabulated and analyzed and the findings presented.

¹³ Siegel, pp. 184-193.

CHAPTER IV

SUMMARY OF THE FINDINGS

The following is a summary and interpretation of the findings of the study. In order to reduce ambiguity and confusion, the results have been grouped together on the basis of the statistical test used to evaluate the data.

The first hypothesis, designed to determine the significance of the correlation between scores on the Phases of Alcoholism Scale and the McGlosky-Schaar Anomy Scale, was tested with the use of the Spearman Rank Correlation Coefficient.¹ Scores on the Phases of Alcoholism Scale were ranked into three categories representing early, middle, and late stages of alcoholism. These scores were then correlated with stages of anomie and the results are presented in the following Table I.

TABLE I

RELATIONSHIP BETWEEN ANOMIE SCORES OF RESPONDENTS AND PROGRESSIVE DEVELOPMENT OF ALCOHOLISM AS MEASURED BY THE PHASES OF ALCOHOLISM SCALE

Test Used	N	Rho	t	df	Level of Significance
Spearman Rank Correlation Coefficient	93	.544	6.186	2	.05

¹Sidney Siegel, Non-Parametric Statistics for the Behavioral Sciences (McGraw-Hill Book Company, Inc., 1956), pp. 202-212.

As the data in this table indicate, the null hypothesis is rejected as the anomie scores do increase as the respondents progress from one stage of alcoholism to another.

The second hypothesis stated that anomie would not be present in early stage alcoholism. In order to test this hypothesis, a binomial test was used to determine the relationship between early stage alcoholism and the presence of anomie.² The results (Table II) support the hypothesis that early stage alcoholics do not have high anomie scores; however, because of the small number in the sample, these findings must be considered as tentative.

TABLE II

BINOMIAL TEST OF RELATIONSHIP BETWEEN EARLY STAGE
ALCOHOLICS AND THE PRESENCE OF ANOMIE

	<u>STAGES OF ANOMIE</u>			
	None	Moderate	Severe	Total
Frequency	9	1	0	10

Up to this point, data related to the first two hypotheses have provided evidence that (1) anomie scores are positively correlated with progressive development of alcoholism and (2) anomie is not present to any significant extent in the responses of early stage alcoholics. These results tend to support the view that anomie is not a predisposing factor but emerges after alcoholism has begun its progressive development.

It is not possible, however, to say at this point whether the

²Siegel, pp. 36-42.

development of anomie in conjunction with alcoholism is due to increased dependency upon alcohol or to other socio-cultural factors such as age, sex, years of drinking, and so forth. The third hypothesis (seven sub-hypotheses) was designed to determine whether or not these socio-cultural factors were able to account for the development of anomie after controlling for the stages of alcoholism.

TABLE III

MANN-WHITNEY TEST OF THE DIFFERENCE IN ANOMIE SCORES OF CATHOLICS AND PROTESTANTS AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	N		U	U-Prime	Z	Level of Significance
	Catholic	Protestant				
Early	3	1	1.5	1.5	--	n.s.
Middle	7	12	55.5	28.5	1.14	n.s.
Late	17	28	190.5	285.5	1.375	n.s.

The possible influence of sex and religious affiliation (sub-hypotheses 1 and 2) were measured through the use of the Mann-Whitney U test for two independent groups.³ As the results in Tables III and IV indicate, there were no significant differences in anomie scores of males and females or in Catholics and Protestants at different stages of alcoholism.⁴

³Siegel, pp. 116-127.

⁴The importance of sex as a factor in anomie has been suggested by several writers who emphasize the importance of "telescoped development" in women because of greater moral condemnation of female alcoholics. See, World Health Organization Expert Committee on Mental Health, Alcoholism Subcommittee 2nd Report, Technical Report Series, Vol. XLVIII, 1952.

TABLE IV

MANN-WHITNEY TEST OF THE DIFFERENCES IN ANOMIE SCORES
OF MALES AND FEMALES AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	N		U	U-Prime	Z	Level of Signifi- cance
	Male	Female				
Early*	--	-	--	---	-	--
Middle	19	6	46	68.0	-	n.s.
Late	52	6	144	169.0	.3584	n.s.

*No females at early age

In order to obtain a more precise indication of the possible influence of religious affiliation, different religious groups were ranked on a scale from most liberal to most conservative.⁵ Spearman Rank Order Correlation Coefficient (Rho)⁶ was used to determine the degree of association between religious conservatism and anomie scores. The absence of a significant correlation (Table V) provides additional evidence that religious affiliation does not account for the progressive development of anomie among alcoholics.

TABLE V

SPEARMAN'S RANK CORRELATION OF THE RELATIONSHIP BETWEEN THE DEGREE OF
LIBERALISM-CONSERVATISM OF RESPONDENTS' RELIGIOUS AFFILIATIONS AND
ANOMIE SCORES AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	N	Rho	t	Level of Significance
Early	5	0.000	---	n.s.
Middle	19	.170	.713	n.s.
Late	46	.137	.921	n.s.

The remaining hypotheses concerning the influence of socio-cultural

⁵ Rankings were made independently by two experts thoroughly familiar with Canadian religious beliefs and traditions. Also, the rankings by the raters were in complete agreement.

⁶ Siegel, pp. 202-213.

factors upon anomie scores of the respondents were tested with the use of the Kruskal-Wallis One-Way Analysis of Variance by Ranks. This technique tests the null hypotheses that the k samples come from the same population or identical populations with respect to averages.⁷ The results are presented in Tables VI - IX. Since no significant differences were found for any of the groups, the data may be summarized as follows:

1. No significant differences were found in anomie scores of respondents in different age groupings.
2. No significant differences were found in anomie scores of respondents with different marital status (married, single, divorced, separated or widowed).
3. No significant differences were found in anomie scores of respondents in different categories of "years of drinking."
4. No significant differences were found in anomie scores of respondents in different categories of "years drinking has been a problem."

TABLE VI

KRUSKAL-WALLIS TEST OF THE DIFFERENCE IN ANOMIE SCORES
OF DIFFERENT AGE GROUPINGS AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	Number of Observations	H Value	Degrees of Freedom	Level of Significance
Early Stage	10	1.500	4	n.s.
Middle Stage	24	4.255	4	n.s.
Late Stage	58	3.241	5	n.s.

⁷ Siegel, pp. 184-194.

TABLE VII

KRUSKAL-WALLIS TEST OF THE DIFFERENCES IN ANOMIE SCORES
OF MARRIED, SINGLE, DIVORCED, SEPARATED, AND WIDOWED RESPONDENTS
AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	Number of Observations	H Value	Degrees of Freedom	Level of Significance
Early Stage	10	0.429	2	n.s.
Middle Stage	25	6.458	4	n.s.
Late Stage	58	5.185	5	n.s.

TABLE VIII

KRUSKAL-WALLIS TEST OF THE DIFFERENCES IN ANOMIE SCORES
OF RESPONDENTS IN DIFFERENT CATEGORIES OF "YEARS OF DRINKING"
AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	Number of Observations	H Value	Degrees of Freedom	Level of Significance
Early Stage	10	4.000	5	n.s.
Middle Stage	25	3.318	5	n.s.
Late Stage	55	3.628	6	n.s.

TABLE IX

KRUSKAL-WALLIS TEST OF THE DIFFERENCES IN ANOMIE SCORES
OF RESPONDENTS IN DIFFERENT CATEGORIES OF "YEARS DRINKING
HAS BEEN PROBLEM" AT VARIOUS STAGES OF ALCOHOLISM

Stages of Alcoholism	Observations	H Value	Degrees of Freedom	Level of Significance
Early Stage	10	4.000	5	n.s.
Middle Stage	24	7.925	6	n.s.
Late Stage	54	6.505	8	n.s.

The findings have quite conclusively shown that many of the assumptions about the association between anomie and alcoholism are at least questionable. Furthermore, the findings present a number of questions which can be readily utilized for further research. The

following chapter presents a general summary of the problem and the final conclusions that this writer has made based on the above findings.

CHAPTER V

SUMMARY AND CONCLUSIONS

The primary purpose of this study is to present some empirical evidence as to the relationship between the development of alcoholism and the development of anomie. The problem is derived from the fact that a number of writers have made assumptions about this relationship even though very little direct empirical research has been conducted on the subject. This study will act as a pilot study for further investigation of the relationship between anomie and alcoholism.

The sample was composed of ninety-three subjects from the outpatient clinic of the Division of Alcoholism in Edmonton, Alberta, Canada. Each subject in the sample was given two scales, one to determine the stage of alcoholism of the subject, the second to evaluate the degree of anomie reflected in the respondent's answers to specific scale questions. In addition to these scales, a comprehensive personal history of the subject was obtained.

The data from the three sources were compiled, coded, analyzed and subjected to appropriate statistical tests.

The results as interpreted by this writer support the following conclusions.

Conclusions and Interpretation

First, the assumption that alcoholics are anomic individuals at inception is not justified; and actually, based upon the findings, the early stage alcoholic is more likely to be non-anomic. This can be explained in that in the case of early stage alcoholism, while the alcoholism has appeared, it is not of significant notice to the society in general and thus has not had serious effects upon the alcoholic's general social relationships. This could account for the presence of alcoholism without the accompanying presence of anomie.

Second, the assumption that alcoholism and anomie develop concomitantly appears to be a valid one. Based upon the findings in this study, it appears that there is a positive association between the anomic and alcoholic progression. As the alcoholic becomes more deeply mired in the disease and is affected by the results of increased alcoholism, such as loss of job, family and friends and increased alienation from these groups, the condition of anomie could easily develop. The process can probably be regarded as circular in that as alcoholism increases anomie increases, which in turn drives the individual more toward his defense mechanism, alcohol. This leads to more severe anomie, and the vicious circle continues.

In this study, evaluation of this aspect of the association between anomie and alcoholism was hampered in that the scales used were not the most precise, and it was not possible to compare the development of the two phenomena on any level other than the three-fold stages. However, based on the three stages of both alcoholism and anomie used in this analysis, it was evident that after the early stage of alcoholism the two phenomena progressed together.

The final conclusion is that it does not appear that selected socio-cultural factors such as sex, age, religiosity, marital status, years drinking, and years a problem have any effect upon the association between anomie and alcoholism. According to the data reported in the previous chapter, none of the above-named factors were able to account for this relationship. However, this does not eliminate the possibility that other socio-cultural factors not identified in this analysis may have had some effect upon the association.

This study, while considered primarily as a pilot project, has produced some interesting results which bear further investigation. The fact that the early stage alcoholics were almost all non-anomic presents a large question regarding the previous literature presented in Chapter II on this subject. Also, the fact that this writer found no connection between certain socio-cultural factors and the association between anomie and alcoholism indicates that much more research in this area is needed. The seven factors used in this study represent only a few of the possibilities for research on the subject. It is hoped that this study will act as a stimulus to further investigation on the subject.

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APPENDIXES

Appendix A

THE PHILLIPS PHASES OF ALCOHOLISM SCALE

INSTRUCTIONS: Please answer EACH question "YES" or "NO".

1. Do you feel that you always must have alcohol on hand? _____
2. Have you begun to feel that religion may have the answer to your problems? _____
3. Do you find your family or friends are questioning your drinking behavior? _____
4. Have you found your work, family or finance relations seriously affected, due to your drinking? _____
5. Do you consider a morning drink to be usually necessary? _____
6. Do you become drunk during the daytime? _____
7. Have you experienced prolonged benders (over one day)? _____
8. Have you tried complete abstinence for periods of time? _____
9. Do you feel uncomfortable when your supply of alcohol is "cut off"? _____
10. When you begin to drink, can you stop at only one drink? _____
11. Do you drink non-beverage alcohol (rubbing alcohol, vanilla extract, shaving lotion, etc.)? _____
12. Do you feel that you have to find reasons to explain your drinking? _____
13. Have you ever experienced D.T.'s? _____
14. Have you been sleeping and eating regularly? _____
15. Do you occasionally drink more than you intend? _____
16. Has your ability to consume alcohol decreased? _____

Name _____

Case No. _____

Appendix B

THE MCCLOSKY-SCHAAR ANOMY SCALE

INSTRUCTIONS: If you agree with the statement, put a check (✓) under the "AGREE" column. If you disagree with the statement, put a check (✓) under the "DISAGREE" column.

STATEMENT	<u>AGREE</u>	<u>DISAGREE</u>
1. With everything so uncertain these days it seems as though anything could happen.	_____	_____
2. What is lacking in the world today is the old kind of friendship that lasted for a lifetime.	_____	_____
3. With everything in such a state of disorder, it's hard for a person to know where he stands from one day to the next.	_____	_____
4. Everything changes so quickly these days that I often have trouble deciding which are the right rules to follow.	_____	_____
5. I often feel that many things our parents stood for are just going to ruin before our very eyes.	_____	_____
6. The trouble with the world today is that most people really don't believe in anything.	_____	_____
7. I often feel awkward and out of place.	_____	_____
8. People Were better off in the old days when everyone knew just how he was expected to act.	_____	_____
9. It seems to me that other people find it easier to decide what is right than I do.	_____	_____

Appendix C

ABBREVIATIONS

P = Patient
S = Spouse
N/A = Not Applicable
UNK = Unknown

DIVISION OF ALCOHOLISM
DEPARTMENT OF PUBLIC HEALTH

(6) CURRENT TREATMENT CENTRE

0 Edmonton
1 Calgary
2 Red Deer
3 Other

PERSONAL DATA:

AGE P(yrs.) _____ S(yrs.) _____		BIRTH PLACE P _____ S _____		(13)SEX 0 Male 1 Female	NOTES:
(9)P (10)S	(11)P (12)S				
0 0 19 & under	0 0 Alberta				
1 1 20 - 24	1 1 Other province				
2 2 25 - 34	2 2 U. S. A.				
3 3 35 - 44	3 3 Europe				
4 4 45 - 54	4 4 Other				
5 5 55 - 64	8 8 N/A				
6 6 65 - 69	9 9 UNK				
7 7 70 & over	DATE OF BIRTH _____				
8 8 N/A	Month _____ Day _____ Year _____				
9 9 UNK					

PARENTAL BACKGROUND:

ETHNICITY (14)Father (15)Mother		RACE (16)P (17)S		(18)FATHER (19)MOTHER BORN IN CANADA	
0 0	English, Scottish, Irish, Welsh	0 0	White	0 0	Yes
1 1	French, French-Canadian	1 1	Indian	1 1	No
2 2	German, Austrian	2 2	Mixed Indian-White	9 9	UNK
3 3	Ukrainian	3 3	Oriental	NOTES:	
4 4	Scandinavian	4 4	Mixed Oriental-White		
5 5	Russian, Polish, Slavic	5 5	Negro		
6 6	Other European	6 6	Mixed Negro-White		
7 7	Indian	7 7	Other		
8 8	Other	8 8	N/A		
9 9	UNK	9 9	UNK		

MARITAL SITUATION:

(20)MARITAL STATUS		TIMES MARRIED (21)P (22)S		NUMBER OF CHILDREN (23)Total (24)At Home		(25)LEGAL DEPENDENTS		NOTES:
0 Single	0 0 None	0 0	None	0 None				
1 Married	1 1 One	1 1	One	1 One				
2 Divorced	2 2 Two	2 2	Two	2 Two				
3 Separated	3 3 Three	3 3	Three	3 Three				
4 Legal Separation	4 4 Four	4 4	Four	4 Four				
5 Judicial Separation	5 5 Five & over	5 5	Five	5 Five				
6 Widowed	9 9 UNK	6 6	Six	6 Six				
7 Common Law		7 7	Seven & over	7 Seven				
9 UNK		8 8	N/A	8 Eight & over				
AGE AND SEX OF CHILDREN		9 9	UNK	9 UNK				

RESIDENCE DATA:

(26-27)PLACE OF RESIDENCE AT TIME OF CONTACT 00 Edmonton City 01 Red Deer City 02 Calgary City 03 Alberta East Central 04 Athabasca 05 Banff 06 Barons-Eureka 07 Big Country 08 Chinook 09 Lethbridge 10 Drumheller 11 Edson 12 Foothills 13 Grande Prairie 14 Jasper 15 Leduc-Strathcona 16 Medicine Hat 17 Minburn-Vermilion 18 Mount View 19 North Eastern Alberta 20 Peace River 21 Red Deer (Health Unit) 22 Stony Plain - Loc Ste. Anne 23 Sturgeon 24 Vegreville 25 Wetoka 26 Other 99 UNK	PATIENT: Address: _____ Date: _____ Phone: _____		SPOUSE: (Name: _____) Address: _____ Date: _____ Phone: _____		
	TENANCY (29)New (30)Regular 0 0 Owner 1 1 Rents 2 2 Gratuitous 3 3 Other 9 9 UNK		(31)YEARS RESIDENCE IN CANADA 0 Entire life or 1 Less than one 2 One to two 3 Three to four 4 Five to six 5 Seven to ten 6 Eleven to fifteen 7 Sixteen to twenty 8 Over twenty 9 UNK		(32)NUMBER IN HOUSEHOLD 0 One 1 Two 2 Three 3 Four 4 Five 5 Six 6 Seven 7 Eight & over 8 Group residence 9 UNK
	(28)LEGAL RESIDENCE 0 Municipality 1 Transient 2 Other Province/country 9 UNK				
	NOTES:				

VITA

Lorne Archer Phillips

Candidate for the Degree of

Master of Science

Thesis: A STUDY OF THE RELATIONSHIP BETWEEN ANOMIE AND ALCOHOLISM

Major Field: Sociology

Biographical:

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