

Social Patterns of Substance-Use Among People With Dual Diagnoses

Hoyt Alverson,^{1,2,4} Marianne Alverson,² and Robert E. Drake^{2,3}

An ethnography, part of the larger New Hampshire Dual Diagnosis Study, discovered in a small subsample ($n = 16$) that clients participated in 1 (or sometimes 2) of 4 distinct and different social patterns of substance-use. These 4 patterns, (1) "the lone user," (2) "the small, closed social clique," (3) "the large, open user syndicate," and (4) the "entrepreneurial drug provider," manifest important social functions of such substance-use. These social functions need to be taken into account as case managers attempt to persuade clients to abstain from using substances, because changing one's substance-use immediately affects one's participation in these user networks. Case managers can understand the social pressures toward certain patterns of substance-use by attending to the social patterning of that use. Many social functions provided by these social patterns must be continued by other means if clients, once persuaded to attempt abstinence, are to be effectively supported in their sobriety.

KEY WORDS: treatment; dual diagnosis; social networks; substance abuse; substance consumption patterns; ethnography.

INTRODUCTION

Impairment in social functioning is a central feature of substance-use disorder. Diagnostic criteria specify that use of a substance becomes problematic when normal social activities are altered or reduced (American Psychiatric Association, 1994). For people with severe mental illness, several studies indicate that co-occurring substance disorder is associated with increased family problems and disruption in familial living arrangements (Blankertz & Cnaan, 1994; Dixon, McNary, & Lehman, 1995; Kashner *et al.*, 1991; McHugo, Paskus, & Drake, 1993; Test, Wallish, Allness, & Ripp, 1989; Westermeyer &

Walzer, 1975). Loss of familial support may be catastrophic for this population because they often live with marginal social, financial, and other resources. For example, studies suggest that loss of familial support may lead to homelessness or incarceration (Caton *et al.*, 1994; Clark, 1996).

At the same time, substance abuse and dependence often take place in social contexts, with peers facilitating and reinforcing use. For persons with severe mental illness, several studies show that substance-use is social and that patients report socializing as a primary motivator for use (Bergman & Harris, 1985; Dixon, Haas, Weiden, Sweeney, & Frances, 1991; Hekimian & Gershon, 1968; Mueser, Nishith, Tracy, DeGirolamo, & Molinaro, 1995; Test *et al.*, 1989; Warner *et al.*, 1994). For example, Warner *et al.* (1994) found that "activity with friends" was the most commonly reported reason for substance-use among outpatients with severe mental illness.

Clinicians commonly express concern that psychiatric patients are abandoning needed familial supports in favor of antisocial, drug-abusing peer groups that take advantage of these patients because of their

¹Department of Anthropology, Dartmouth College, Hanover, New Hampshire.

²New Hampshire-Dartmouth Psychiatric Research Center, Lebanon, New Hampshire.

³Dartmouth Medical School, Lebanon, New Hampshire.

⁴Correspondence should be directed to Hoyt Alverson, Department of Anthropology, Dartmouth College, 6047 Silsby Hall, Hanover, New Hampshire 03755-3570; e-mail: hoyt.alverson@Dartmouth.edu.

disability payments and hasten their slide into homelessness or incarceration. Despite these concerns, there have been few detailed studies of the social networks of individuals with dual diagnosis. Trumbetta, Mueser, Quimby, Bebout, and Teague (1999) examined network data on homeless dually diagnosed patients in Washington, DC, and found that having fewer addicts and more AA/NA members in one's social networks predicted recovery from substance-use disorder.

The purpose of this report is to present ethnographic data supplemented with certain of those obtained in formal surveys and interviews, which reveal important variations in features of study participants' social networks. More specifically, we attempt in this paper to suggest answers to the following questions. What is the social context of these individuals' substance-abusing behaviors? Are there distinctive social patterns of use? How do dually diagnosed individuals relate to peers, families, and mental health clinicians? What are the implications of the findings for clinical services?

ETHNOGRAPHIC METHOD

The etiology, prognosis, and treatment of mental illness have long been known to exhibit economic, social group, as well as (sub-) cultural effects. For this reason ethnographic research among the mentally ill has become an important and well-justified domain of research in the health sciences (Alverson, Alverson, Drake, & Becker, 1998; Alverson, Becker, & Drake, 1995; Estroff, 1981, 1991; Romanucci-Ross, Moerman, & Tancredi, 1997). Much of this work draws inspiration, method, and epistemology from the cross-cultural study of personality, cognition, and psychopathology (Berry, 1992; Cole, 1996; Dasen, 1988; Kleinman, 1980; Verma & Bagley, 1988).

Ethnography has been a favored method of inquiry where little is known of the cultural milieu and social group structure among people being investigated, or where there is a desire to document the ways in which people talk about, and bestow meaning upon, events in their lives. A subject's personal and socio-cultural situatedness or perspective is often accessible only by combining direct observation with discourse recorded in specific settings or contexts (Fetterman, 1989; Jorgensen, 1989; Spradley, 1980).

Unfortunately for much research, most people, most of the time behave or act in a state of half-conscious awareness of their behavior. The cognitive

and emotive meanings, the reasons for and purposes of behavior, usually "become clear" to any person in retrospect, when one thinks or tells about it. Such retrospective self-narration supplies characteristic "meaning" (reasons, justifications, motives, and goals) that may well have not been (consciously) operative at the time of the action. "Storied experience" (what people come to believe about their behavior as a function of how it is cast in verbal performances or self-reflection) is often at variance with contemporaneous cognizing of actual behavior. And yet, it is often such storied experience that later guides or informs actual subsequent thought or action. For these reasons, participation in, and observation of, ongoing lives and interviewing about past events together provide a potentially rich or "thick description" of one's lived-world and storied self-identity (Geertz, 1973; Kleinman, 1988; McAdams, 1993; Rosenwald & Ochberg, 1992; Sarbin, 1986).

In the study reported here the principal field ethnographer, M. Alverson, established a welcome acceptance not only among study participants but also among numerous others—their families, friends, and associates. These others provided independent and valuable information from many and varied perspectives about study participants, thereby enriching, augmenting, qualifying, or contextualizing participants' own testimony and action. This kind of consensual validation of one's thoughts and actions are not obtainable by survey interviewing of randomly selected individuals from heterogeneous population aggregates. The ethnographer became a regular, intimate, but unobtrusive participant in their day-to-day lives following these clients and others on a regular basis for 2 years. She shared with them activities and experiences at many of their regular haunts engaging in observation, conversation, and informal interviewing in the many real-world contexts and settings in which their lives, including mental illness and substance abuse, are situated and expressed.

The willingness of these clients (and others) to participate in this ethnography, to part with valuable information, and to reveal intimate aspects of their lives, could only occur if two conditions were met: (1) a relationship of trust and mutual confidence between ethnographer and study participants were built, and (2) they came to feel a genuine equity in the valued outcomes exchanged between them and the ethnographer. The ethnographer met these conditions by participating in clients' daily lives primarily on terms and conditions of reciprocity negotiated with or set down by them (Denzin, 1989; Ferrell &

Hamm, 1998; Jorgensen, 1989; Judd, Smith, & Kidder, 1991).

THE NEW HAMPSHIRE DUAL DIAGNOSIS STUDY AND ETHNOGRAPHIC SUBSTUDY

The New Hampshire Dual Diagnosis Study, built upon a statewide treatment system put in place in 1988, was designed to assess, by randomized clinical trial, the clinical and cost effectiveness of two treatment regimes among dually diagnosed clients (Drake *et al.*, 1998). The clinical trial compared patient outcomes from two treatments: (1) integrated and coordinated mental health services delivered by “assertive community treatment” (ACT) and (2) standard case management. A total of 223 such persons (57 women, 166 men) from two cities and five small towns in New Hampshire were assigned randomly to one of the two treatments. The study participants were interviewed and evaluated regularly (every 6 months) by structured interview-questionnaire over the course of the next 3 years. Results of the clinical trial have been previously reported (Clark *et al.*, 1998; Drake *et al.*, 1998). Because of the small number of participants in the ethnographic substudy and because the ethnography was concluded 3 years before completion of the clinical trials, the ethnography did not attempt to evaluate outcome differences.

Data collection in the larger study—in addition to that obtained in the ethnography—consisted of baseline and semiannual follow-up administration of the following formal instruments and schedules: (Drake *et al.*, 1998)

- a. Structured Clinical Interview for *DSM-III-R* to establish severe mental illness and co-occurring substance-use disorder;
- b. Portions of the Uniform Client Data Inventory to obtain basic demographic information;
- c. The Time-Line Follow-Back to assess days of alcohol or drug-use or both over the 6 months prior to baseline;
- d. Sections of the Addiction Severity Index to assess abuse and dependency;
- e. A self-reported chronology of housing history and institutional stays supplemented with official records thereof;
- f. The Quality of Life Interview—a “subjective” and “objective” representation of perceived quality of life;
- g. The Expanded Brief Psychiatric Rating Scale to assess current symptom expression;

- h. Service Utilization Interview to assess utilization of health services.

Follow-up interviews utilized the same instruments except for (b) and sections of other instruments dealing with past life-history information. These instruments were supplemented by case managers’ assessments of clients, using the following rating scales: (a) the Alcohol Use Scale, (b) the Drug Use Scale, (c) the Substance Abuse Treatment Scale. Regular testing of urine for substance-use also took place.

Although these instruments elicited a great quantity of information with satisfactory reliability (some of which we report later), they did not reveal in detail or with contextual richness many important aspects of the social context and social functions of substance-use and many other activities of clients’ daily lives. By way of brief illustration, one client reported, in response to questions contained in a formal interview, that he had been employed by his brother during a portion of the study period. This response was coded in the database as “kin support” and “gaining employment.” Further the client reported not using drugs. The ethnographic study documented clearly that the brother in question was (is) one of the city’s known drug dealers, who was employing his SMI-SUD afflicted brother as a mule in the drug operation, and was paying him in part with drugs. The brother did have a lawn care business, which to some extent, was a front for the drug operation. The client stated that he was working for his brother in that business. In this case, as in many others, we see that a simple response to a seemingly straightforward interview question entails a seriously misleading implication or intentional deception about the nature and purpose of this reported “employment.”

More generally, the matrix of social relationships and social activities within which substance-use is couched is a complex structure of action. Clients do not typically carry around in their heads detailed or accurate characterizations of this structure as a whole or how its constituents fit together. Similarly, clients’ tacit knowledge of the social contexts of their substance-use is not readily accessible to introspection or propositional expression. Moreover, respondents often do not give full or candid answers to questions, even to those few, which they could in principle answer, when asked face-to-face to disclose information that may contain adverse personal or social demands.

Standardized instruments use prompting questions and answer codings that are decontextualized

and usually very general. Asking good, probative, nuanced, yet acceptable questions of someone about individual social relationships and activities requires, in addition to good rapport, detailed knowledge of social context and of biography. So, to augment and enrich the intertemporal method of the interviews and administration of formal instruments, an ethnographic study of a small subsample of this study population located in one city was planned and carried out over 2 years, 1990–92. During this time 19 clients of the 223 included in the larger study were selected by means of a combination of “accidental” and “purposive” sampling procedures (Judd, Smith & Kidder, 1991) to be participants in the ethnographic substudy. During the 2 years one died of substance abuse and three others dropped out. Of 15 client/informants officially still in the study at the end of the 2-year period, eleven are male, four female. Because of the sample size and the nature of the data collected we do not seek to generalize the findings to some larger population. Rather, we present the findings as data, which can validly motivate further study and sensitize clinicians to issues of clients’ social world that have so far not come to light in other research.

The ethnography collected considerable data that bear on and reveal important aspects of clients’ substance-use, including especially the sites and activities of their social networks in general and the composition and activities of their substance-use networks, in particular. The latter provided opportunities conducive to obtaining information on study participants’ proffered motivations for using addictive substances as well as their claimed abilities or inability to control or want to quit their use. The ethnography, in short, examined important *social functions* of substance-use.

SOCIAL PATTERNS OF SUBSTANCE-USE

Among the clients participating in the ethnography and among dozens of others informally observed, the social organization or patterning of an individual’s substance-use was found to fall into one (or sometimes two) of four distinct, different, and usually mutually exclusive types. Further, how clients perceived and responded to case managers’ entreaties to quit using or to clinical interventions in general were observed to differ with each social pattern of use, mainly because of the varying social resources associated with each pattern, which variably support, constrain, or discourage substance-use.

The discourse presented later is in clients’ own words extracted from conversations, some of which were held within, and some outside the settings of substance-use. None of the reported conversation was elicited in structured interviews. The quotes often composed portions or aspects of clients’ “life stories,” which typically “dribbled” out in informal chats, which took place over many months in many settings. Limitations of space preclude even sketching the larger life-stories from which the quoted material is taken. Likewise the ethnographer’s observations of clients’ and others’ behavior cannot be included in this brief report. All of these together—observation, dialog, life-stories—should and will in later publications be woven into an integrated description of clients’ life-worlds. Meanwhile we present the conversational data to indicate from the clients’ situation and perspective something about the social patterns of substance-use.

Pattern One

“The Solitary User,” comprises those whose addictive substance of choice is alcohol. These are loners who prefer to drink as their budget allows, rarely, if ever, sharing or reciprocating over time with other clients in the mental health center. Among the study participants these are the clients for whom social intercourse in general seems to be daunting or difficult.

People at the Mental Health Center don’t like me ‘cause I don’t bum anything off them. They’re always hitting me up for cigarettes. I try not to, but I give it to them anyway. I try not to bum off them, but they still come bumming to me!

Hoarding resources, these clients are more likely than are other users to refuse formal contact with the mental health center. Repeatedly they claim being misunderstood or not listened to by mental health professionals. They resent case managers who concentrate treatment solely or largely on sobriety because it does not address their “real problems.”

X (the case manager) is happy if I don’t drink, then he thinks everything is OK. He’s not concerned with the real issue, my depressions. They come whether I drink or not. There’s nothing I can do about it. The meds don’t help. X makes no attempt to understand me. He doesn’t listen to me. He only has one focus.

Avoiding case managers and group therapy, these clients do not deny the need for therapy, frequently wishing they could afford private care.

I don't like them (case managers) coming around. I don't like going to group. The others always talk. They're smarter than me. I'm a burnout. I'd rather have private therapy.

Although some of these clients may have experimented with drugs, they generally prefer alcohol, fearing the illegality of drug use and contacts with drug users.

There are too many drug users at AA meetings. I think that's a bad trend. There's a big difference between drink and drugs. Drugs are illegal. Drug users are criminals—dangerous. I don't want to be near them.

Typically, if these clients run out of funds for liquor before their next paycheck, they eat at soup kitchens and may in a few cases appeal to certain others (typically not fellow addicts) for extra cash. Without such extra support, however, use is usually heavier at the beginning of the month when they receive SSI/SSDI or other payments. Clients typically endure a dry spell at the end of the month, attending AA meetings, while waiting for the next monthly check. Many clients point to such a dry spell as proof of their ability to control use.

I bought a six pack and two quarts of wine. I'll go to AA when I'm out. [of liquor]

If there is regular family support, which includes cash or groceries, the client is more likely to be able to continue drinking throughout the month. With such extra financial resources, these clients confine themselves to their room, discontinue picking up their medication, and switch from beer to hard liquor. Because of their relative social isolation, they admit to putting themselves at greater risk of injury or even dying from intoxication.

If I don't get it (medication), I'm more likely to go on a vodka binge, and vodka is my undoing.

When such an escalation of liquor consumption occurs, these clients are unlikely to contact case managers for help, because they resent or fear sobriety-talk, which in their minds is about issues separate from what causes their binge drinking.

They have a one-track approach: sobriety first. Sobriety is defined as NO drinks. There is no difference between these two or three beers I'm drinking now and vodka. For me there IS a difference. Vodka is my undoing, not these few beers.

The only client to die from substance abuse during the 2-year study had no financial constraints and

drank alone. Locking herself up in her room with hard liquor, she refused all contacts with her case manager.

I feel suicidal when I drink. I don't want to be here. Nothing really makes a difference. I feel this way all the time.

Pattern Two

“The Street Corner Clique,” comprises those clients who are members of a small substance-use social network (outside the mental health center) based in the neighborhood, bar, or residential setting. This pattern is observed with regular alcohol use and occasionally marijuana. Clients share, in addition to addictive substances, numerous other material-items and social transactions with a small group of friends or acquaintances, who may or may not themselves be psychiatric patients. Substance-use is only one among many resources and activities that they enjoy together as a group.

Client: [speaking with ethnographer while sitting with friends in her local bar] *We play cards, tell stories. We take trips, go on picnics with the dues of members. In this club you have “Gemeinschaft” not just “Gesellschaft.”* [“Gemeinschaft” means “face-to-face group/community”; “Gesellschaft” means “anonymous social system.” Clearly this client is very well educated.]

Ethnographer: *Is this the only place you feel it?*

Client: *Yes. I have no family, and there certainly is none at mental health or the SRO [abstinence-oriented, mental health housing where she lives]. And T [her case manager] wouldn't come here. He hasn't even seen it, and he doesn't approve.*

Pointing to their small group's limited financial resources as proof, clients in this pattern refer to themselves as “in control.” In such a small network, one member's decision to try sobriety reduces the liquor funds for the group as a whole. Members have all had pressures to slow down or stop drinking, so they respect another member's abstinence efforts by not offering drinks, waiting for the urge for sobriety to pass. With the loss of a member, the individuals in a smaller group may feel more vulnerable or insecure in their habit, and may wrestle with questions of sobriety themselves. Those clients, who were observed to move from Pattern Two use to sobriety, easily apply their considerable interpersonal skills from their substance use group to their treatment sobriety groups. The following snippets of conversation take place variously between a client in Pattern One, called here, #1;

a client formerly in Pattern Two use, called here #2; and the ethnographer, M. Alverson. Notice client #2's considerable "discourse competence" (interaction management, information management, and subtle referential appositeness of contributions)

#2 [talking in the hallway with ethnographer minutes before treatment sobriety group, client interrupts the conversation to hug and greet group members as they come in.]

#2: [Turning to ethnographer] *Did you see the scratches on her arm?*

Ethnographer: *No.*

#2: *She's not suicidal but she tries to hurt herself. She has lousy self-esteem, like me. I'm trying to get her into CTT.*

Ethnographer: *Why?*

#2: *It's supposed to give more time, and she needs lots of support.*

#1 [Lone drinker after sobriety group session.] *I wanted to tell her that when you black out from drinking it means you drink too much and the more you drink, the more you're going to be in that situation. But I just couldn't speak up. I've always been shy. I was shy in school. I had a terrible stuttering problem when I was growing up, I know, though, I've got to learn to speak up.*

#2 [At the same group, #2 tried to persuade a member to drink less] *I've been able to use the money I used to drink up for things—like a TV.*

#1: *I don't like groups. They don't understand. I don't want to be around people that don't understand.*

#2 [Drawing out #1 in group.] *Remember when we were roommates at the hospital together? I didn't appreciate it then, but I sure do now—how good it was to room with you.*

No response

#2: *You were so nice. We did have good times, didn't we?*

#1: *Yeah, we made cocoa together.*

#2: *And remember when we used to talk about our children together?*

#1: *Yeah, when I held my little Sammy in my bed with me, all the bad feelings went away.*

Pattern Three

"The User Syndicate," comprises substance-users who are members of a large, thriving substance-use social network operating within and around the Mental Health Center itself. From there certain individuals go out occasionally to locate or secure resources (including information) to be shared with

members as a whole. Those in this pattern consume alcohol or drugs or both and may also, along with others in the network, abusively use their medications (hoarding, stockpiling, trading, or combining pharmaceuticals with street-drugs or alcohol). All of them—clients of the Mental Health Center—boast of steady, persistent, "controlled" substance-use with minor impairment and only occasional adverse consequences for their mental health. While asserting their "controlled use," they confidently point to "limits"—that unlike some others outside their "syndicate," they would not sell off personal belongings to support their substance-use.

Y drinks all the time—buys a case of beer, keeps half of it in his refrigerator and half of it in the bedroom. He just drinks through it, then buys another case. Y is always drinking. I would never go that far. I'd never sell my stuff. People who have to sell their stuff to use! I'm not like that.

I can stop. I don't use every day. I don't sell off my stuff like some of them do.

Clients in pattern three are circumspect regarding illegal activity, engaging in no more than low-risk crime (such as shoplifting) to support their habits. At or near the Mental Health Center, they daily seek and share with each other news of locations in the city where donations or surplus commodities are being distributed to the homeless. Together they go to line up for handout food or clothing to obtain living essentials without wasting precious cash needed for addictive substances.

Because every client in the group is expected to share cigarettes and trade portions of their monthly check for substance-use, those that generously include cash windfall or gifts, meds, meals, and sex in the barter are particularly highly regarded. Clients coming in new to the Mental Health Center are actively recruited to join. Giving things and other favors away is to store social obligations against possible personal shortfalls ahead. Unilateral social exchange in effect buys one insurance. This includes steady access to drugs and alcohol. Members are prevailed upon to share whatever they can as often as possible.

I get the cocaine, share it with T, then she gives me food.

I barter as much as possible. It's more common now 'cause most people don't have money... the more people you know, the better off you are in life.

If you don't have money, like me, you gotta know a lot of people.

These clients view their substance-use as leading a “normal” life.

Beer’s what everybody does. Look at the ads in football, it’s mainstream America.

I was just going along with my friend. Coke’s got nothing to do with my problems. Other people drink, go to cocktail parties and have a good time. The nurse at the hospital uses pot. I know doctors that drink. Dr. X. drinks cocktails. A lot of people enjoy themselves that way. That’s what I do with cocaine. I don’t see any difference. I could go cold turkey any time.

Although they themselves do not engage in high crimes to support their substance-use, they do buy small, regular amounts from those clients who, acting as couriers, bring in drugs obtained from outside dealers to the Mental Health Center. As long as these client-couriers provide drugs to the group on a regular and discrete basis, the group conceals their identity from inquiring officials and provides a hideout for those escaping the law. If, however, the client-courier escalates personal use to the point that mental illness symptoms and drug-use appear out of control, members of the group will inform on him/her to mental health personnel. This “ratting” has the effect of getting help for an out-of-control member and protecting the group from a crack-down that conspicuous behavior might invite.

Participants in this substance-use pattern have striven for sobriety for short spells. Word of this gets around fast. Because the group has multiple sources of funding, any one member’s defection does not affect the group as a whole. Although a member seeking sobriety is not pressured or propositioned to join in substance-use, such a client will often be left to sit alone at a table, cut off from usual reciprocities such as cigarette swaps. In this situation a “shunned” client will spend more time at the sobriety club in the Mental Health Center where “substance abuse” is not a topic and where directed activities provide some diversion. Isolation from the usual, larger group of support and reciprocities, even if one is engaged in treatment, usually insures that such effort at sobriety is short-lived.

By avoiding detection (abetted by staying away from conspicuously illegal behavior), clients in Pattern Three have little experience with long-term periods of sobriety. Substance-use, no more and no less than picking up meds or swapping cigarettes, is how members identify the Mental Health Center. It’s the place to hang out to do and get what one wants. Suffering from symptoms or stigma of mental illness, these clients feel an important connection to the Mental

Health Center and the reciprocities thriving within it to satisfy their needs for acceptance in an otherwise hostile world.

People who have mental illness tend to be more friendly. The outside world is cold. . . . You know, it makes you feel good to feel the support among the mental health clients. They show concern for each other. We all know each other. We’ve all been there before. I’m an alumni going into a neutral territory, a safe zone.

Pattern Four

“Entrepreneurial Substance Providers,” includes those clients who take on the role of creating and maintaining the flow of alcohol and drugs for themselves and to the Pattern Three syndicate. They are actively engaged in arranging reciprocities and procuring supplies from outside and delivering alcohol and drugs to other clients. They command considerable social skills and can describe contacts they artfully make outside the Mental Health Center and the circle of those in the “mental health system” in bars, on streets, in jail. They act as liaison between mental health client users and distributors in the city.

You have to plan it out and have some kind of strategy and that gives you something to do. It’s something to keep you from getting bored, and it takes some intelligence.

You get more friends on the outside because you have to talk to people to find it, to get it. You meet people.

Just like their case managers, these clients believe they are providing a useful service to clients, and upon occasion they boast of such accomplishments to one another and the ethnographer.

Client [describing reasons for distributing cocaine to fellow clients]: *They oughta make it legal. What we got here is pure, powdery drugs, so it’s more potent, and that’s why we feel better.*

Ethnographer: *What did your case manager say when you told her you were using and selling cocaine?*

Client: *I don’t know. Nothin’ much. That’s why she wants to see me today, but I don’t feel like getting preached at. What does she know? She don’t help me find a job or nothin’. There’s nothin’ for me to do. I got a good mind. I gotta have somethin’ to do.*

These clients describe themselves as being on a “roller-coaster” existence. Persistent, escalating use leads to selling off personal belongings.

I got high off cocaine, and I wanted more, so I sold my amplifier, and then I sold my leather jacket. Now all I got left is the radio.

It also leads to multiple criminal activities, to homelessness, and eventually to hospitalization or incarceration. These clients are risk-takers and appear to be “higher functioning.” They exhibit fewer side effects from medication. If they survive “hitting bottom” with drug-related violence, hospitalizations, arrests, and other traumatic experiences, they may grow weary of their roller-coaster life and risk continuing the sobriety that was forced upon them in hospital, jail, or on probation, to change their life.

I just don't want to go to prison or to hospital anymore, and the only way that'll happen is if I stop using.

Each time the ethnographer accompanied a client returning “home” from hospital or jail with determination to remain sober and “get a life,” the same outcome was observed. The client received little or no support for sobriety and within days returned to the expected procuring of drugs and sharing, increasing use and dependency, until the next institutionalization.

SOCIAL PATTERNS OF USE AND REPORTED “QUALITY OF LIFE”

In Table 1, 16 client participants of the ethnographic study are listed along with the sites where their social networks are situated, the social pattern of their substance-use, and the relationship of the client to his/her case manager in the client's expressed opinions. (Client “0” died before the study was completed.)

As the table illustrates, there is—in this small sample anyway—a positive association between social patterning of drug use and the size and variety in the client's social networks generally. Those in Patterns Three and Four tend to belong to larger, functionally and geographically more varied social groupings than do those in substance-use Patterns One or Two. The latter have fewer and smaller social networks generally and are on the whole less gregarious and, in some cases, less socially skilled than those in Patterns Three and Four. On the other hand, the variation in the observed and self-reported quality of clients' relationships to their case managers seems to be unrelated to differences in the social pattern of substance-use. This is not surprising because case

Table 1. Clients' Social Networks

Client	Site/SN ^a	SUSN ^b	Case manager ^c
#0	7,4	1	0
#1	7,4,1	1	1
#2	7,3,4	1	3
#3	6,3	1,2	1
#4	7,3	2	2
#12	6,3,4	2	1
#5	6,1,3,2,4	3	2
#11	2,3,4,1	3	0
#13	2,3,6,4	3	0
#14	3,4,1,7	3	3
#15	2,6,4,3,1	3	0
#9	3,5,1	3,4	4
#10	2,3	3,4	4
#6	2,6,1,4,3	4	0
#7	2,3,4,1	4	2
#8	5,3,7,1	4	4

^aSite/SN shows site of social networks, listed in order of client's observed interaction propensities: 1 = In around mental health center or other hang-outs of mentally ill in town; 2 = Substance-use hang-outs in city; 3 = Neighborhood; 4 = Site of family, spouse, children, friends; 5 = Case manager's personal world; 6 = In partner's place; 7 = In own dwelling.

^bSUSN shows substance-use social network, given according to pattern number discussed earlier.

^cCase Manager shows quality of client's relationship with the case manager: 0 = not engaged with case manager; 1 = reluctantly engaged; 2 = neutrally engaged; 3 = willingly engaged; 4 = closely, personally engaged.

managers used the same kinds of interventions and treatments with all study clients, irrespective of their social patterns of substance-use.

The sample size here is too small to establish definitively whether there are important correlations among use networks, social networks, current or past familial ties, and satisfaction with social relationships and activities. There are however some interesting suggestive connections contained in data obtained from administration of the Quality of Life Interview (QOLI) administered as part of the larger clinical trial. Sections G and H of that schedule deal with reported family and other social interactions in terms of frequency and emotional quality. By examining client responses to questions on QOLI according to their social pattern of substance-use we may obtain information that neither method alone disclosed. We note the following suggestive trends and regularities. (Small sample size makes impossible the estimation of statistical significance.)

Among the ethnographic subsample, Pattern Four users consistently report in the QOLI interviews the least contact with family members in person or by phone, and the relatively lowest level of satisfaction

with activities or relationships that they do have with family members.

Pattern One and Pattern Two users report the fewest phone calls or visits with anyone outside their own dwelling, but report the highest frequency of activity that is planned ahead of time or takes place with some one special friend (partner, lover). Pattern One users most often report having no close friends outside their home or the treatment center, and report having no friends anywhere that are *not* users. Pattern One and Two users report somewhat lower numbers of opportunities to get to know new people. But rather unexpectedly (and for reasons suggested below) clients from Pattern One claim about the same degree of overall satisfaction with the amount of friendship they enjoy in their life as do those found in the other use-patterns.

Pattern Two and Pattern Three users report the highest degree of satisfaction with how they “get along” with people in general.

Pattern Four users report having the most contact with nonusers.

But all clients report on average a similar, moderately high, degree of satisfaction with the activities they engage in with other people.

With one notable exception, there is nothing unexpected or counter-intuitive in these findings. The exception lies with those in Pattern One, who claim about the same degree of satisfaction with their social relationships and activities as do those in the other patterns. In fact the Pattern One clients in the ethnographic subsample surveyed in the QOLI interview were quite isolated. Very likely the “satisfaction” they expressed on the QOLI was based on their lack of any expectation for establishing positive social relationships. Indeed study clients and others in this use-pattern confided to the ethnographer that they despaired of making friends and having a “social life.” They had no expectations of meeting and carrying on positive relations with other people. They were resigned at times to their lot, but they weren’t satisfied with it. Indeed their drinking—invariably alone and to great excess—is bound up with their general expectation that they were consigned to unremitting isolation.

This information illustrates how valuable it can be to move back and forth between survey-opinion data and ethnographic observation to enable the one to contextualize and interpret the other. The meaning of the responses in this case offered by those in Pattern One can be seen in a light that would not be apparent from the survey data alone. Of course the statistical

distribution of these facts would require much further study.

PATTERNS OF USE AND IMPLICATIONS FOR TREATMENT

Obviously case managers should know what important social consequences a client will face if she/he is persuaded to stop using addictive substances, for, as noted at the outset, to start using is to change one’s life and to stop using is to change one’s life. Some clients reckon they are never free, always trapped no matter what.

Whether, like me, you don’t stop or whether, like P. you do stop, it’s a great monolith. You can’t get around it. You are either addicted, craving it, letting it rule your life OR your life purpose is to avoid it, going to meetings, collecting chips.

If sobriety is a necessary goal to treat mental illness what assurance do I have that attaining sobriety won’t lead to another dead-end. You’ve got to see a way out.

The ethnography discovered that, in general, the mental health service professionals at this Center did not take cognizance of the social matrix of clients’ substance-use, despite the fact that for clients themselves, drug or alcohol use for those in Patterns Two, Three, and Four is experienced not simply as a relationship between oneself and an addictive substance but equally as a set of relations to other people via the consumption and sharing of these substances.

I can’t give up friends to be sober. They’re talking about my family, my friends, hey, that’s everybody I know.

Cocaine is our way to have a fun time. It’s our leisure time.

I paid for the cocaine with my Friday check, and we had cocaine on the bus to Boston and again on the bus comin’ home. We ate out. It was a beautiful day. We had a good time.

Early in the New Hampshire study, though the ethnography was underway, case managers employed a rigid, 12-step approach to substance abuse treatment that neglected social relationships and consequently failed to engage many clients (Noordsy, Schwab, Fox, & Drake, 1996). Only later did case managers shift to a more motivational approach, which takes more specific account of each client’s personal resources, social circumstances, and goals (Miller & Rollnick, 1991). The patterns of substance-use identified in this study have several important and fairly obvious

consequences for such motivational approaches to treatment.

First, clients in Pattern One are most often solitary in their substance-use and are ill-at-ease in most kinds of social activity, especially if it is forced or contrived. If they have financial means, even episodically, they are at great risk for unobserved, uncontrolled binge drinking that can or will cause serious organic damage and even death. Their aloneness, dejection or depression, difficulty to locate and to engage in therapy—particularly “group therapy”—all put them very much at risk from their substance-use. No one knows what’s going on in their lives. The only ethnographic study participant to die during the study was a Pattern One user. She died, alone, drinking. Case managers who believe a client is a Pattern One user must make great efforts to monitor the client’s behavior, assertively reach out to gain the client’s trust and employ a one-on-one relationship to persuade and support the client in efforts to get sober.

Second, clients in Pattern Two seem to respond relatively well to group therapy. They may seek out and enjoy supportive, patterned social interaction, even that with mental health professionals. They are most at home in small groups and are often good listeners and speakers. It may be that “milieu therapy” approaches, which seek to treat people in the context of natural, already existing groups, would be most effective with those in use-Pattern Two.

Third, Pattern Three users have the most social and economic support for their substance-use and lifestyles in general. The large flexible, multifunctional, permeable network of sometime and full-time substance users permits wide and varied sharing of resources. Pattern Three networks support people who crash and help them get on their feet so they can start using again. Pattern Three networks encapsulate the client, insulating or buffering him or her from case manager’s efforts to intervene and help with an addiction problem. Members provide an ideological rationalization for being a user in a using group. Clients in this pattern of use are probably on average the hardest to treat, either individually or in small groups. For one thing they are adept at conning, gaming and denying, all with social support. Many AA and NA groups will have cynical Pattern Three users in their midst who can ruin the experience for those individuals sincerely trying to kick and stay off drugs or booze. The only Pattern Three users observed to have attained sobriety moved far away from the area where their using network was located.

Pattern Four users are on average—in the short run at least—the most socially adept and street-smart, the biggest social risk takers, those with the most get-up-and-go energy. They are, however, the most likely to get caught using, running or procuring, and be hospitalized or jailed. Incarceration forces them into periods of sobriety and even at times into a penitent frame of mind. On these occasions they may decide that they really do not want to go back to their old bad habits or haunts. Intervention by case managers when Pattern Four users are discharged, or for other reasons hit bottom and see the light, can be key to supporting them in their vows to go straight, stay clean, or move to a new place to avoid the moral hazard of old user networks. The only participants in the ethnographic study to attain durable sobriety were former Pattern Four users, who had been forced into sobriety, moved away from their old substance-use cliques, were helped to establish themselves in a new community, and were supported in their abstinence from drugs.

CONCLUSIONS

To ask what “motivates” or “causes” an individual, whether mentally ill or not, to use or continue using drugs, or contrariwise, to stop and get a stable, abstinent life, is to ask extremely complicated questions about a person’s life as a whole. This ethnography has shown that change in substance-use entails a host of emotion-laden anticipations as well as probable consequences for the material, social conditions of clients’ lives. This is in addition to their perceptions of consequent psychological detriment or purely personal well-being such change might bring about.

Effective intervention by case managers to deal with clients’ addiction presupposes and necessitates that the social effects and consequences of what case managers entreat clients to do be seen as integral to the process of treatment (Mueser, Drake, & Noordsy, 1998). The four social patterns of use described here are key to different clients’ access to alcohol or drugs and reveal clients’ predilections for social engagement, which must be satisfied in the sober state. Each pattern entails its own risks and burdens as well as important resources and opportunities for the client and for the case manager in attempting different kinds of substance abuse treatment interventions.

Finally, each social pattern of use appears to be an effective field for finding “how-to” clues on motivating and supporting sobriety. Yet, pattern of use by

itself is not predictive of responsiveness to treatment or of sobriety. Although clients in Patterns Two or Four talk of sobriety more often than those in Patterns One or Three, whether they actually become abstinent or sober was observed to depend on other factors having to do with the material and emotional quality of life, which are described in a companion paper (Alverson, Alverson, & Drake, 2000).

ACKNOWLEDGMENTS

This work was supported by U.S. Public Health Service Grants MH-00839, MH-46072, and MH-47567 from the National Institute of Mental Health; by Grant AA-08341 from the National Institutes on Alcohol Abuse and Alcoholism; and also grants from the New Hampshire Division of Behavioral Health and the Mental Health Center of Greater Manchester.

REFERENCES

- Alverson, H., Alverson, M., Drake, R. E., & Becker, D. R. (1998). Social correlates of competitive employment among people with severe mental illness. *Psychiatric Rehabilitation Journal*, 22(1), 34–40.
- Alverson, M., Becker, D. R., & Drake, R. E. (1995). An ethnographic study of coping strategies used by persons with severe mental illness participating in supported employment. *Psychosocial Rehabilitation Journal*, 18, 115–128.
- Alverson, H., Alverson, M., & Drake, R. E. (2000). An ethnographic study of the longitudinal course of substance abuse among people with severe mental illness. *Community Mental Health Journal*, 36(6), 557–569.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*. (4th ed.). Washington, DC: Author.
- Bergman, H., & Harris, M. (1985). Substance abuse among young adult chronic patients. *Psychosocial Rehabilitation Journal*, 9(1), 49–54.
- Berry, J. (1992). *Cross-cultural psychology: Research and applications*. New York: Cambridge University Press.
- Blankertz, L. E., & Cnaan, R. A. (1994). Assessing the impact of two residential programs for dually diagnosed homeless individuals. *Social Service Review*, 68, 536–560.
- Caton, C., Shrout, P., Eagle, P., Opler, L., Felix, A., & Dominguez, B. (1994). Risk factors for homelessness among schizophrenic men: A case-control study. *American Journal of Public Health*, 84(2), 265–270.
- Clark, R. E. (1996). Family support for persons with dual disorders. In R. E. Drake & K. T. Mueser (eds.), *Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder II: Recent Research and Clinical Implications. New Directions for Mental Health Services* (Vol. 70, pp. 65–77). San Francisco: Jossey-Bass.
- Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., Drake, R. E., McHugo, G. J., Keller, A. M., & Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Services Research*, 33(5), 1285–1308.
- Cole, M. (1996). *Cultural psychology*. Cambridge: Belknap Press.
- Dasen, P. R. (ed.). (1988). *Health & cross-cultural psychology*. Newbury Park: Sage.
- Denzin, N. (1989). *Interpretive interactionism*. Beverly Hills: Sage Press.
- Dixon, L., Haas, G., Weiden, P. J., Sweeney, J., & Frances, A. J. (1991). Drug abuse in schizophrenic patients: Clinical correlates and reasons for use. *American Journal of Psychiatry*, 143, 224–230.
- Dixon, L., McNary, S., & Lehman, A. (1995). Substance abuse and family relationships of persons with severe mental illness. *American Journal of Psychiatry*, 152, 456–458.
- Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., & Ackerson, T. H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry*, 68(2), 201–215.
- Estroff, S. (1981). *Making it crazy: An ethnography of psychiatric clients in an American community*. Berkeley: University of California Press.
- Estroff, S. (1991). Everybody's got a little mental illness: Accounts of illness and self among people with severe, persistent mental illnesses. *Medical Anthropology Quarterly*, 5(4), 331–369.
- Ferrell, J., & Hamm, M. S. (Eds.). (1998). *Ethnography at the edge: Crime, deviance, and field research*. Boston: Northeastern University Press.
- Fetterman, D. (1989). *Ethnography step by step*. Newberry Park: Sage Press.
- Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In C. Geertz (ed.), *The Interpretation of cultures* (pp. 3–32). New York City: Basic Books.
- Hekimian, L. J., & Gershon, S. (1968). Characteristics of drug abusers admitted to a psychiatric hospital. *Journal of the American Medical Association*, 205, 125–130.
- Jorgensen, D. (1989). *Participant observation*. Beverly Hills: Sage Press.
- Judd, C. M., Smith, E. R., & Kidder, L. H. (1991). *Research methods in social relations* (6th ed.). Orlando: Harcourt, Brace, Jovanovich.
- Kashner, M., Rader, L., Rodell, D., Beck, C., Rodell, L., & Muller, K. (1991). Family characteristics, substance abuse, and hospitalization patterns of patients with schizophrenia. *Hospital and Community Psychiatry*, 42(2), 195–197.
- Kleinman, A. (1980). Major conceptual and research issues for cultural psychiatry. *Culture, Medicine, and Psychiatry*, 4(1), 3–13.
- Kleinman, A. (1988). *The illness narratives*. New York City: Basic Books.
- McAdams, D. P. (1993). *Personal myths and the making of the self*. New York: Guilford Press.
- McHugo, G. J., Paskus, T. S., & Drake, R. E. (1993). Detection of alcoholism in schizophrenia using the MAST. *Alcoholism: Clinical and Experimental Research*, 17(1), 187–191.
- Miller, W., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.
- Mueser, K. T., Nishith, P., Tracy, J. I., DeGirolamo, J., & Molinaro, M. (1995). Expectations and motives for substance use in schizophrenia. *Schizophrenia Bulletin*, 21(3), 367–378.
- Mueser, K. T., Drake, R. E., & Noordsy, D. L. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. *Journal of Practical Psychiatry and Behavioral Health*, 4(3), 129–139.
- Noordsy, D. L., Schwab, B., Fox, L., & Drake, R. E. (1996). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. *Community Mental Health Journal*, 32, 71–81.

- Romanucci-Ross, L., Moerman, D. E., & Tancredi, L. R. (1997). *The anthropology of medicine: From culture to method* (3rd ed.). Westport, CT: Bergin & Garvey.
- Rosenwald, G. G., & Ochberg, R. L. (eds.). (1992). *Storied lives: The cultural politics of self-understanding*. New Haven: Yale University Press.
- Sarbin, T. R. (ed.). (1986). *Narrative psychology*. New York City: Praeger.
- Spradley, J. K. (1980). *Participant observation*. New York City: Holt-Rinehart.
- Test, M. A., Wallish, L. S., Allness, D. G., & Ripp, K. (1989). Substance use in young adults with schizophrenic disorders. *Schizophrenia Bulletin*, *15*(3), 465–476.
- Trumbetta, S. L., Mueser, K., Quimby, E., Bebout, R., & Teague, G. B. (1999). Social networks and clinical outcomes of dually diagnosed homeless persons. *Behavior Therapy*, *30*, 407–430.
- Verma, G., & Bagley, C. (1988). *Cross-cultural studies of personality*. New York: St. Martins Press.
- Warner, R., Taylor, D., Wright, J., Sloat, A., Springett, G., Arnold, S., & Weinberg, H. (1994). Substance use among the mentally ill: Prevalence, reasons for use and effects on illness. *American Journal of Orthopsychiatry*, *64*(1), 30–39.
- Westermeyer, J., & Walzer, V. (1975). Sociopathy and drug use in a young psychiatric population. *Disease of the Nervous System*, *36*, 673–677.