A role for nursing in teaching and counseling wives of alcoholics: a comparison of two group approaches.

Nancy Bartot Fisk

University of Massachusetts Amherst
A ROLE FOR NURSING IN TEACHING AND COUNSELING
WIVES OF ALCOHOLICS:
A COMPARISON OF TWO GROUP APPROACHES

A Dissertation Presented
by
NANCY BARTOT FISK

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

September 1989

School of Education
A ROLE FOR NURSING IN TEACHING AND COUNSELING
WIVES OF ALCOHOLICS:
A COMPARISON OF TWO GROUP APPROACHES

A Dissertation Presented
by
NANCY BARTOT FISK

Approved as to style and content by:

Janine Roberts, Chairperson of Committee
Carlene Riccelli, Member
Mary Anne Bright, Member

Marilyn Haring-Hidore, Dean
School of Education
DEDICATION

This work is dedicated to the 12 women whose experiences in living with and caring about alcoholic husbands were shared so openly in the two research groups. I am deeply indebted to them for their courage and willingness to participate in the project and truly humbled by their trust in me and caring about each other. This is also dedicated to the larger community of women who have lived in similar situations where alcoholism has altered family process; those who have chosen to stay in the relationship as well as those who have chosen to leave it.
ACKNOWLEDGEMENTS

Many persons have contributed to the development of the ideas and activities which comprise this research. It is not possible to adequately thank all the many direct and indirect sources of help in this process. I will attempt to at least highlight the major direct contributors:

Brainstorming sessions with present and former School of Nursing faculty colleagues Josephine Ryan, Sally Tripp, Brenda Millette, Patricia Hanrahan, and M. Christine King helped both in the initial process and in the analysis and implications of the study. Other nurse colleagues, Gail Higgins and Gerri Templeton also helped at an early stage of the project. The assistance of both of these groups was greatly appreciated.

The Research and Evaluation Methods Program of the School of Education was an extremely valuable resource. I wish to thank especially graduate assistant Kathy Mazor and Dr. Ron Hambleton for their input at various stages of the research.

I am deeply grateful also to Linda Johnson and Tom Zink, the other two members of a doctoral support group. Our five years of ongoing mutual commitment may be unprecedented.

Committee members Dr. Carlene Riccelli and Dr. Mary Anne Bright are to be commended for their diligent and insightful suggestions at every stage of the process. I have truly valued their honesty and thoroughness in critiquing each chapter as well as their encouragement at critical points. A large debt of gratitude is owed to committee chairperson Dr. Janine Roberts for her unfailing support and thoughtful guidance. Her straightforward but constructive criticism was always presented in a way that empowered me to
move forward with greater courage. I feel very privileged to have been
influenced by Dr. Roberts both as a family therapist and as a faculty
member.

Two special women who gave generously of their time and skills must
certainly be acknowledged: Daryl Devoto and Edna McAveney, each of whom
provided continuous psychological support along with continuous direct
assistance. Daryl's faithful presence at all twelve of the group sessions and
during the countless hours of processing and analyzing the case notes was
indispensable. Edna's enthusiastic involvement in the research as reflected
in the many volunteered hours of data analysis was also of immeasurable
value to me. Warmest thanks are extended to both of them.

A very special expression of gratitude mixed with pride and love are
extended to my daughter and friend, Suzanne Stoneham, without whose
competence, patience, and unconditional support this work would not have
been accomplished. Finally, the help, love, and understanding received from
my entire family which enabled us to proceed with the work is also
acknowledged.
ABSTRACT

A ROLE FOR NURSING IN TEACHING AND COUNSELING WIVES OF ALCOHOLICS: A COMPARISON OF TWO GROUP APPROACHES

SEPTEMBER, 1989

NANCY BARTOT FISK

B.S. UNIVERSITY OF CONNECTICUT
M.S. UNIVERSITY OF MASSACHUSETTS
Ed. D UNIVERSITY OF MASSACHUSETTS

Directed by Professor Janine Roberts

The purpose of this study was to examine and compare the behavioral outcomes of two group approaches to helping wives of alcoholic men. Both were psychoeducational approaches combining didactic teaching and group counseling techniques. Both approaches were aimed at the ultimate goal of facilitating more effective coping by the wives despite their husbands' active alcoholism and its consequences. Both approaches were expected to result in decreased use of negative coping behaviors ("survival behaviors") and both were expected to facilitate entry into and involvement with Al-Anon.

One group, Group A, received a program based on a family-systems perspective of family alcoholism using adapted techniques from Berenson, Wegscheider, and Borwick; Al-Anon was mentioned but not actively encouraged. A second group, Group B, received an identical format of six, two-hour sessions. However, the second group received a more person-focused approach with a more conventional program stressing the disease concept of alcoholism and Al-Anon concepts. Al-Anon attendance was directly encouraged in the latter group but not in the former.
The "Spouse Survival Behavior Scale" which was developed by this investigator was administered to both groups at the first and again at the last session. Group A wives reported decreased use of "survival behaviors"; group means for the scale as a whole and for two of six sub-scales significantly decreased. However, none of the wives reported attending Al-Anon on one month and two month follow-up calls.

Group B wives did not significantly decrease their self-reported use of "survival behaviors" when comparison of pretest and posttest group means were subjected to a t-test. However, analysis of adjunctive qualitative data raised the possibility that Group B wives were using less denial as a defense and had emotionally detached to a greater degree than Group A wives. One month and two month follow-up telephone call data on Al-Anon attendance revealed that 2 of the group B wives had also been regularly attending Al-Anon.

Differences in gain scores between Group A and Group B were not shown to be statistically significant when examined at the level of the whole test. However, changes in one sub-scale (Cluster V: Blaming/Punishing) showed significantly less self-reported use of behaviors in this category by Group A as compared with Group B who increased their use of these behaviors. The latter was the only statistically significant finding of this study which supported one of the research hypotheses.
<table>
<thead>
<tr>
<th>Chapter 1: THE PROBLEM</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>4</td>
</tr>
<tr>
<td>Statement of the Problem Situation</td>
<td>6</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>13</td>
</tr>
<tr>
<td>Rationale and Theoretical Framework</td>
<td>14</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>16</td>
</tr>
<tr>
<td>Overview of the Methodology</td>
<td>23</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>23</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>23</td>
</tr>
<tr>
<td>Selected Distinctions</td>
<td>25</td>
</tr>
<tr>
<td>Summary of Chapter One</td>
<td>26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 2: REVIEW OF THE LITERATURE</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>28</td>
</tr>
<tr>
<td>The Literature on Wives of Alcoholics</td>
<td>28</td>
</tr>
<tr>
<td>The Literature on Treatment of Wives of Alcoholics</td>
<td>34</td>
</tr>
<tr>
<td>The Literature on Group Approaches to Treatment of Wives of Alcoholics</td>
<td>40</td>
</tr>
<tr>
<td>Other Treatment Modalities</td>
<td>45</td>
</tr>
<tr>
<td>The Literature on Co-Dependency</td>
<td>46</td>
</tr>
<tr>
<td>The Literature Comprising the Conceptual Framework</td>
<td>48</td>
</tr>
</tbody>
</table>
APPENDICES

A. AA INFORMATION................................................................. 144
B. SUMMARY OF FAMILY TREATMENT OF ALCOHOLISM........ 147
C. "SOME THOUGHTS ON CODEPENDENCY".......................... 150
D. BERENSON'S MAP OF EMOTIONAL HEALING.................. 152
E. "SYSTEM DYNAMICS OF THE ALCOHOLIC FAMILY"........ 154
F. PHASES OF RECRUITMENT OF SUBJECTS......................... 156
G. CONSENT FORMS.............................................................. 176
H. INSTRUMENTS................................................................. 179
I. SUMMARY OF TEACHING/COUNSELING PACKAGES AND
   TEACHING/COUNSELING OUTLINE................................. 192
J. INTAKE INFORMATION....................................................... 209

REFERENCES........................................................................... 213
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Stages of Adjustment to Alcoholism</td>
<td>31</td>
</tr>
<tr>
<td>3.1 The Two Polarities</td>
<td>89</td>
</tr>
<tr>
<td>4.1 Pretest Group Means</td>
<td>101</td>
</tr>
<tr>
<td>4.2 Posttest Group Means</td>
<td>103</td>
</tr>
<tr>
<td>4.3 Group A Pretest and Posttest Data</td>
<td>104</td>
</tr>
<tr>
<td>4.4 Group B Pretest and Posttest Data</td>
<td>109</td>
</tr>
<tr>
<td>4.5 Difference in Gain Scores Between Group A and Group B</td>
<td>115</td>
</tr>
<tr>
<td>4.6 Rank Ordering of Both Polarities Together: Detachment &amp; Acceptance</td>
<td>121</td>
</tr>
<tr>
<td>4.7 Rank Ordering of Denial&lt;--&gt;Acceptance Polarity</td>
<td>122</td>
</tr>
<tr>
<td>4.8 Rank Ordering of Undifferentiation&lt;--&gt;Self Differentiation Polarity</td>
<td>123</td>
</tr>
<tr>
<td>5.1 Family-Systems and Person-Centered Combination Program</td>
<td>140</td>
</tr>
</tbody>
</table>
CHAPTER I
THE PROBLEM

Introduction

In the recent mushrooming of a popular body of knowledge on alcohol and the family, there has been considerable attention focused upon the effects of growing up with alcoholic parents. All of the major weekly news magazines (Time, Newsweek, People [Chu, Johnson, Armstrong, Ash & Gold, Apr., 1988], etc.) and many documentary and talk shows on television and radio have featured cover stories which cite famous (expensive) alcoholism treatment programs, famous (rich) recovering alcoholic people and famous sons and daughters of alcoholic parents. The "buzz words" are usually prominently displayed and stressed; they include such terms as "co-dependency" "COA" (children of alcoholics), and "ACAP" (adult children of alcoholic parents).\footnote{Also known as ACOA (Adult Children of Alcoholics).} This movement is heartening to those who have struggled to gain services and support for the families of alcoholics just as they had previously struggled for public attention and support for the alcoholic individual. Such headlines as "Changing Attitudes and New Research Give Fresh Hope to Alcoholics" (Time, Desmond, Nov. 30, 1987, p. 80) and "The Children of Problem Drinkers are Coming to Grips with their Feelings of Fear, Guilt, and Rage" (Newsweek, Leerhsen & Namuth, Jan. 18, 1988, p. 62) illustrate a remarkable degree of progress toward bringing these problems out of the shadows.
Still in the shadows, however, are the spouses of alcoholics, mostly wives\(^2\). While wives are sometimes mentioned in passing, no significant interest has been demonstrated in supporting this group. Yet they are potentially the key to early family recovery and even prevention of future alcoholism because of their role as the gatekeeper to family health. Outside help is rarely sought by these women, sometimes for many years, even though the likelihood of recovery is best in the early stages of the problem. An important reason for this reluctance to seek help includes a feeling that they are somehow to blame for their husband’s drinking. This and other reasons revolving around keeping the problem hidden, appear to be consistent with the survival role that these wives often play in an alcoholic marriage.

The well-known self-help group, Al-Anon, has proved to be helpful for those who attend but there is tremendous resistance to Al-Anon involvement (Gorman & Rooney, 1979). The common wisdom among alcoholism treatment personnel is that it seems even more difficult for wives to engage in Al-Anon than it is for alcoholic husbands to engage in Alcoholics Anonymous (AA). Many if not most alcoholism counselors would agree that Al-Anon involvement for relatives and friends of alcoholics is desirable, however wives are frequently hesitant to go or do not continue after one or two meetings. Reluctance to labeling the problem, a sense of blame and other reasons have resulted in costly delays in obtaining help (Gorman & Rooney, 1979).

\(^2\) While the percentage of female alcoholism may be very close to that of males, it is well-known in the alcoholism industry that many more wives of alcoholic men stay in the marriage while husbands of alcoholic women more often leave.
Nurses and other health professionals have the opportunity and capability to counterbalance resistance and to initiate a recovery process which might include facilitating entry into Al-Anon. This may be possible through use of brief group counseling approaches which include a specific teaching component and specific counseling techniques which both inform and arouse interest in obtaining ongoing help. The term "psychoeducation" has been applied to this type of combined informational and therapeutic group approach applied to families of the mentally ill (T. Williams [personal communication, Oct. 6, 1988]; Berheim & Lehman, 1985).

This paper describes a demonstration project testing two particular teaching/counseling approaches designed for use in groups with wives of alcoholic men. One model was developed from a family-systems perspective, and combines several specific techniques from family therapy. The other is a more traditional teaching/counseling program, based on an individual perspective, directly encouraging Al-Anon attendance. The effects of each approach are evaluated in terms of self-reported decrease in the use of ineffective coping behavior and increase in the use of Al-Anon; the results have been compared.

An important point to emphasize about this project is that it did not seek to prove that one model is more effective or preferable than the other in working with wives of alcoholic men. Rather, the aim was to elicit information about both models, their comparative usefulness; their strengths and limitations; and their teachability to students of nursing at the various levels of educational preparation and to other helping professionals.
The rationale for this is that there is so little service available to this population other than a token session or two as adjunct to the husbands' treatment. Possible benefits in terms of whole system recovery from alcoholism, if wives receive adequate help, are worthy of examination. This chapter argues that recovery from alcoholism can begin to occur in the family system whenever one member presents for help. That person need not be the alcoholic member; that person can quite logically be the spouse. Both models may prove to be useful by different practitioners for different purposes thus increasing the availability of services to wives and thereby to whole families where alcoholism is the core problem.

Background of the Problem

It is impossible to overestimate the magnitude of alcoholism as a major threat to health. Outranked now in overall concern by the deadly AIDS epidemic, but ranking with heart disease and cancer, it is one of the leading public health problems in the United States today. It is by far the most neglected of the diseases mentioned (National Council on Alcoholism [NCA], 1986). Even the most conservative figures indicate that there are at least 10 million alcoholics in this country alone (1 in every 10 people who drink at all) (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1978 & 1981) but less than 10 percent of the primary victims of alcoholism ever receive help of any kind.

In addition, when "other victims" of alcoholism are taken into account (i.e. spouses, parents, children and other close associates of the alcoholic, also known as "co-alcoholics" or "co-dependents") the numbers increase dramatically. The damaging effects of alcoholism on all members of a
system can present life-long problems unless some type of treatment and/or spiritual recovery occurs (Gallant, 1987; Steinglass, Bennett, Wolin, & Weiss, 1987). Furthermore, there is a tendency toward projection downward through successive generations if the process is not halted in the present generation (Kaufman, 1985). At any given moment, therefore, it can be estimated that at least 50 million persons require some type of counseling or therapy for this disease (NCA, 1986). This does not begin to consider the more long-term societal need for primary prevention.

Most recently public awareness of alcoholism has escalated not only on this continent but worldwide; the association of drug and alcohol addiction with the spread of AIDS has greatly enhanced our preoccupation with substance abuse in general and with alcohol abuse as well. Though volumes have been written, no single, accepted definition or etiological perspective seems to have evolved; and no consensus among scholars concerning the nature of the problem appears to have emerged in relation to alcoholism. A recent Supreme Court decision (April 22, 1988) has cast doubt on the disease concept, which the alcoholism treatment industry has long accepted, by ruling that the VA (Veterans Administration) had the right to label alcoholism "willful misconduct" in one particular test case. It follows, therefore, in such a climate of confusion that there would be no interdisciplinary agreement concerning prevention or control of the problem.

Generally speaking, during this century an important cultural change has gradually moved alcoholism out of the domain of sinful or deviant behavior and, despite some attitudinal remnants of this moral definition, into the domain of nonmoral personal sickness (Pattison & Kaufman, 1982). This
cultural definition has placed the locus of responsibility for "cure" squarely within the health care institutions of the society. Despite considerable research and many advances in scientific knowledge about the problem there is still a great deal of uncertainty and controversy within the health care system with respect to alcoholism. The "who, what, when, and where" of medical treatment have not been delineated with anywhere near the degree of consistency and integration that is seen in most other illness management whether physical or psychological in nature despite a fair degree of articulation of the problem in the language of the medical model.

Nevertheless, there seems to be a "mainstream" agreement within the addictions treatment industry itself which bypasses much of the controversy. This view also is consistent with the belief system of Alcoholics Anonymous whose recovered members frequently find a career in the field. It is this view that is presented here with full acknowledgement that it carries certain assumptions and biases which may not be universally held by physicians, nurses, psychologists and other health care personnel.

Statement of the Problem Situation

The Sixth Special Report to the U.S. Congress on Alcohol and Health (NIAAA, 1987) has clearly stated the need for services to the non-alcoholic members of alcoholic families.

In the past decade, clinicians have come to recognize family members as primary patients deserving of treatment in their own right, and not simply as adjuncts to treatment of the alcoholic. Modern treatment of spouses and children recognizes that the stress of living in an alcoholic family situation can, in some instances, have devastating effects upon the emotional and psychological health of the family members. These problems must be addressed therapeutically
whether or not alcoholic family members recover. Treatment of spouses, dependent children and adult children of alcoholics have become central therapeutic issues; demand is increasing for therapeutic services for these groups independent of alcoholism treatment per se.

With growing recognition of the need for treatment of family members, regardless of the course of alcoholism in the alcoholic family member, evaluation of family therapy must begin to address questions other than the impact of such therapy on the drinking behavior of the alcoholic. (p. 129)

This quotation reads as a rather strong mandate. Interesting questions arise concerning primary treatment for non-alcoholic members considering the enormous numbers of persons who need such services. Who would provide such therapy (what professional discipline(s))? What would the cost be? Who would pay? What type of setting (psychiatric, medical, etc.)? The present study suggests that there is a role for nursing in the resolution of these problems.

Nurses have traditionally, in education and in practice, concerned themselves with teaching and counseling individuals and families about their illness and its management. The disease of alcoholism deserves no different approach. It is only the resistance of the health professions, and the general public to truly accept the view of alcoholism as a primary illness that has prevented nursing from serving this category of families in the same way that they would serve families with other chronic but treatable illnesses. Physicians have historically been negative in their attitudes toward alcoholics (Chafetz, 1968; Fisher, Mason, Keeley & Fisher, 1975) and continue to neglect this population (Nace, 1987, pp. 33-46). Despite these barriers, there is no reason to believe that a group teaching/counseling program on
alcoholism would be any less beneficial for families with this health problem than are similar teaching/counseling groups for the other, more "popular" problems such as cancer, heart disease or diabetes.

Barriers besides those which relate to attitudes of helpers are also problematic. Most important is the enigma of denial. It is well accepted that denial is the most characteristic defense mechanism operating throughout the progression of alcoholism and the most malignant barrier to recovery (Anderson, 1981; Gallant, 1987; Gitlow, 1980; Nace, 1987; NIAAA,1978). This is as true for family members (including wives) as it is for the alcoholic himself and is also true for co-workers, friends and society at large. As the disease progresses, however, denial begins to break down in one or more levels of the drinker's social environments because of the increasing frequency of crises related to drinking. Typically the family's denial breaks down before that of the alcoholic (Jackson, 1954). It may be the closest person, a spouse, who begins to pinpoint alcohol as the problem. If it is the female spouse of a male alcoholic she frequently assumes personal responsibility for the excessive drinking and its consequences (McNamara, 1960). In an effort to assuage his own guilt for the baffling problem of why he again drank more than he intended, the alcoholic husband may also project blame onto his wife ("If you didn't keep nagging me and watching every drop I drank, I wouldn't do this"). This misplaced sense of guilt is a common reason articulated by Al-Anon wives of alcoholics for not seeking outside help early.

3 At times, the masculine pronoun is used where the feminine would apply as well. The writer recognizes that the male/female ratio in alcoholism could be close to equal. Ease of reading and not gender bias is the intent.
Another, perhaps even more basic barrier is the stigma associated with the label of "alcoholic". Personal stories heard at meetings of Alcoholics Anonymous have revealed that the label of "crazy person" (mentally ill) was more acceptable to some individuals. These individuals describe how they had sought help from psychiatrists rather than risk the embarrassment of the label "alcoholic" that would go with attending AA. Similarly, wives are reluctant to risk the stigma of naming the problem. Approaching Al-Anon for help may be viewed as not only husband-labeling but self-labeling because of its name and obvious association with AA. From a social perspective this has implications which may be subtler but even more at the core of the problem.

Society reflects extremely negative images upon wives of alcoholic men quite differently from what is reflected on husbands of alcoholic women. Empathy is more often expressed toward the latter who is seen as patient, noble, and hard-working, while contempt is more likely toward the former who may be seen as the root of the problem. Historically, social science has abetted this phenomenon as a review of the literature reveals. While the weight of recent research evidence has exploded the false beliefs of previous eras, the mythology persists in many minds. Semantic arguments continue to plague this field of study generally, and this is as true for those who surround the alcoholic as for the alcoholic and the alcoholism. New labels come into vogue and though some of them apply to all significant persons in the alcoholic system, the brunt of their effect falls on wives. Contemporary labels such as "co-alcoholic", "co-dependent", and "chief
enabler" have not made it any easier for wives of alcoholic men to reach out to Al-Anon.

Often such wives have been expending great energy toward maintaining an illusion of normalcy concerning their marital and family life. In this effort the wife of an alcoholic may have managed to hold the family together quite well despite her alcoholic husband's underfunctioning as parent, provider, and partner in the marriage. She believes increasingly, that the problem is his and is likely to defend herself against any suggestion that she needs help by saying, "He's the one with the problem not me! Why should I be the one to go for help?"

If at this particular critical time the person were to receive factual information and counseling from an understanding, non-judgemental nurse who has some credibility in relation to knowledge of health and illness, that difficult entry into Al-Anon might be eased. The long term known benefits of Al-Anon membership might be accessed through a process of informed decision-making based on essential knowledge about family alcoholism, and clarification of one's own options in the situation. To the extent that responsibility for the alcoholic spouse's problem underlies a wife's failure to act in self-preserving ways and to resort to certain typical maladaptive coping styles, teaching and counseling aimed at eliminating that responsibility should increase Al-Anon involvement.

Al-Anon is a self-help group of relatives and friends of alcoholics "who share their experience, strength and hope in order to solve their common problem and help others do the same" (Al-Anon, 1972, p.3). Numbering roughly half a million members, eighty percent of whom are women, Al-
Anon shares AA's twelve-step program of recovery (see Appendix A). While organizationally separate, Al-Anon uses AA's information base including its traditions, beliefs and much of the same literature (Robertson, 1988).

Al-Anon also shares the unique advantage of all non-professionally-managed mutual aid groups; that is, the therapeutic phenomenon which occurs when one human being having a particular problem encounters another having the same problem. This was the idea that first intrigued Bill Wilson, AA's co-founder, when he discovered in talking with a sober alcoholic friend that his own need to drink had vanished for a long period of time (during and after their time together). This, in fact, is the essence of AA/Al-Anon and other self-help groups: that the mere presence and exchanges of feelings and ideas between two alcoholics (two wives of alcoholics in this case) can have a direct effect on the craving/addictive behavior itself. Not what is being said but who is saying it is the critical variable in this experience.

Al-Anon believes that spouses of alcoholics become in many ways addicted to the alcoholic in parallel to the alcoholic's chemical addiction. For the non-alcoholic spouse however, this is manifested in coping behaviors that become more and more ineffective with exposure to the alcoholic's increasing addictive behavior. Ongoing Al-Anon involvement has been shown to reduce negative coping and is, in its own right, a positive coping mechanism which is health promotive. Recovery is usually a slow process, at times fret with set-backs or "slips" similar to those experienced by AA members. For this reason long-term, regular Al-Anon membership is encouraged; for best results even after; indeed, especially after, the alcoholic
family member has become sober. Because it is practically 100 percent available\textsuperscript{4} and costs nothing, Al-Anon can reach out to everyone. This is unmatched by any other type of service, professional or otherwise; it can be used before, during and after any other type of treatment or type of professional service. The focus of Al-Anon is not upon the alcoholic relative as one might expect but on the family member's own personal serenity and growth. Joan Jackson's message stated as long ago as 1971, bears some similarity to the previously quoted message from NIAAA:

\begin{quote}
It is no longer possible to think of alcoholism as if it involved the alcoholic only. Others in the family are affected. Family studies indicate that a minimum of one other relative is also directly involved. There is considerable evidence that it has disturbing effects on the personality of family members. (Al-Anon: Family Treatment Tool in Alcoholism, 1971, p4).
\end{quote}

Since that time much has been written about family alcoholism. Recently a whole body of literature has sprung forth on two related and overlapping concepts that have all but supplanted the interest and energy invested in the alcoholic member of the family: the concept of "co-dependency"; and the concept of "adult children of alcoholic parents" (ACAP or ACOA). Even long after direct exposure to an actively drinking alcoholic it appears that all family members need some kind of help. There is good evidence that when the mother receives the help that she needs, not only is the alcoholic more likely to seek help and have a better prognosis for recovery (Wright & Scott, 1978) but the young children are more likely to be

\textsuperscript{4} In most areas there are 10 to 15 meetings a week within reasonable driving distance. Additionally, members are encouraged to use the telephone during hours when help is needed and no meeting is being held.
protected from the negative effects of the disease. This may be particularly true when the non-alcoholic spouse attends Al-Anon. However, even if the alcoholic spouse never attains sobriety, the Al-Anon member and her children may be able to achieve a comfortable level of recovery through the program. The process of family recovery in alcoholism can begin with this first ripple of change, a notion that is consistent with family-systems thinking.

Purpose of the Study

The purpose of this study was to examine and compare the behavioral outcomes of two group approaches combining didactic teaching and group counseling techniques designed for spouses of alcoholics. Both approaches aimed at the ultimate goal of facilitating health-promotive responses to family alcoholism. It was believed that both of the approaches might have a facilitating effect toward decreasing negative coping behaviors of wives of alcoholics in relation to their husband's drinking problem and might facilitate Al-Anon involvement.

Common to both teaching/counseling approaches demonstrated in this study is that they are brief, encompassing little more than six weeks of calendar time and involving only two hours of client time each week. This presents one advantage over many other types of group therapy and more generally over many other models of psychotherapy. Economy of time and economy of cost, which are usually interrelated, are important goals in

---

5 No hard data was found to support the idea that Al-Anon involvement of mothers protects children from the negative effects of alcoholism. However, it is the common wisdom of the alcoholism field as well as Al-Anon that when non-alcoholic parents recover through Al-Anon, further harm to children can be prevented.
health care today. The overarching goal for this study was to provide practical, cost-effective, outpatient, group interventions which can be taught to nurses in order to facilitate more effective family coping when alcoholism is present.

The researcher expects to begin developing nursing curriculum materials which provide graduates of various nursing education programs the necessary knowledge and skills to intervene effectively in alcoholism (and other substance abuse). This study has added some important insights for this process.

Rationale and Theoretical Framework

A particular philosophical bias requires exposition at the outset of this section as it gives direction to much of the theoretical rationale for the work. The writer's bias concerns the role and importance of Alcoholics Anonymous and Al-Anon in the treatment and recovery of alcoholic individuals and families.

Although the goal of this demonstration project was to examine and compare two particular psychoeducational programs, both approaches were deliberatively designed to be compatible with the AA/Al-Anon programs. This was considered a necessary underpinning for the project and one that was purposefully constructed. Within the mainstream of modern substance abuse treatment it is generally believed that the 12-step self-help programs (AA/Al-Anon and others based on this model) are central to life-long abstinence and full recovery (AA, 1955; Al-Anon, 1973; Alibrandi, 1982). The researcher shares this belief and asserts that nurses and other health workers would do well to use approaches that are consistent with, or at least
are complementary rather than conflicting with, the recovery-promoting factors of the AA/Al-Anon programs. In a previous unpublished paper (Fisk, 1987) the writer analyzed three particular Family Therapy models in comparison with concepts and tenets of Alcoholics Anonymous on ten parameters. These three models in combination form the basic theoretical framework for one of the two psychoeducational approaches: the family-systems-oriented program. They are as follows:

1. David Berenson (emanating from the Georgetown University in Washington, D.C.)

2. Sharon Wegscheider-Cruse/Johnson Institute Model (emanating from Minneapolis)

3. Bela Borwick/Systemic Model (emanating from Milan, Italy)

In analyzing the three models it was discovered that all three models were essentially compatible with AA/Al-Anon philosophy.\(^6\) It also became apparent that they were quite congruent with each other and were complementary to each other as well as to AA. At least to the extent needed for this study, theoretical and practical elements of the three models can be applied concurrently and/or alternatively with each other while still remaining congruent with what clients might be assimilating from the AA and/or Al-Anon program presently or in the future.

The conceptual framework for the teaching/counseling program which is person-focused and more directly oriented toward the individual and the disease concept of alcoholism is quite closely allied to the thinking of Al-

---

\(^6\) There were minor exceptions to this. Both Berenson and Borwick have points of departure from AA/Al-Anon philosophy which are not central to the present researcher's clinical use of their models.
Anon (hence, AA). Information imparted was partly from Al-Anon conference approved literature and/or traditional didactic material aimed at encouraging Al-Anon involvement. The twelve steps, the twelve traditions, the disease concept, the slogans, "Big Book" (AA, 1955) and other basic AA guidelines provided the theoretical and philosophical premises.

A description of these models and the particular techniques used in the teaching/counseling programs are part of the literature review in the second chapter. The importance of the study in terms of its possible contributions to the understanding of family alcoholism treatment and recovery and to the training of personnel who might be instrumental in this treatment and recovery process will now be addressed.

**Significance of the Study**

This study has possible significance in each of two broad areas: 1) its significance for family treatment of alcoholism and therapist training and 2) its significance for the discipline of nursing: the nursing sphere of practice and nursing education. The two major domains overlap considerably, for example, in the education/training aspects and in the critical issue of health care cost containment. The latter is of primary concern to health care agencies and consumers as well as to local, state and federal governments.

For alcoholism family treatment there are many sound reasons for seeking out new approaches to the problem. Many of these have already been addressed in this chapter including the magnitude of the problem, its systemic nature, the social stigma which inhibits utilization of programs especially those dedicated to alcohol or drug related problems, the extremely limited availability of professional treatment programs for spouses of
alcoholics, and the reluctance of spouses to attend Al-Anon. Enoch Gordis, Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has been quoted as saying, "All we know for sure at this point...is that treatment of some sort is far better than doing nothing at all" (Holden, 1987). To go one step further, the present investigator would add that any conceptual model providing direction to professional teaching/counseling for wives of alcoholics is better than no conceptual model at all. Clearly there are good reasons to provide the treatment for these women which they have thus far not received.

Aside from the much discussed aspect of initiating their husbands' recovery, wives are not only in need of help for their own sake, but for the sake of the health of their offspring of this and future generations. A major element in the prevention of alcoholism and other addictions in future generations might well be arresting the problem with the achievement of good health in the present generation. Family therapy models provide us with theories about multi-generational projection processes (Bowen, 1978) which would be likely to enhance any genetic predisposition to the disease. The process of mate selection which would increase the likelihood of creating yet another alcoholic nuclear family system might also be influenced by family recovery through the recovery of the wife/mother of the family (Reich, 1987).

Among separated or divorced wives of alcoholic men a common occurrence is remarriage to another alcoholic husband. While no statistical evidence could be found to support this observation, family therapists, especially those of Bowenian persuasion would find this not coincidental.
Treatment and recovery might increase the chance of preventing this type of mate selection error or at the very least the marriage would not be entered blindly but by informed choice.

Women as the traditional caretakers and guardians of family health can have enormous influence for change in all of these areas. This fact seems to be largely ignored as is the fact that the women usually bear the brunt of family alcoholism no matter which member(s) of the family are the afflicted one(s). They need and deserve attention and the best of society's resources dedicated to their treatment and recovery.

For the discipline of nursing the study may also have some importance. Nurses do and will continue to encounter wives of alcoholics in every work setting whether they are aware of this or not. Generally, these wives are high level functioning persons who are very motivated to improve their health. They are also not usually seriously ill (in terms of clinical pathophysiology or psychopathology) though they may be prone to stress-related health problems, perhaps even psychosomatic symptoms. They are, generally speaking, an ideal clientele for nursing services in the areas of prevention of illness and health promotion. In some settings nurses would also have occasion to work with wives of alcoholics who are more seriously ill, whether acutely or chronically, and in these settings the illness management aspects of nursing would be foremost. Nevertheless, the impact of family alcoholism should not be ignored in any of these situations as it is often intimately related to the clients' health status and the treatment of any and all health problems.
Both models demonstrated in this project can be useful to nurses in these settings and situations as alternative approaches for working with wives of alcoholics (and perhaps other significant persons). For example, depending on each nurse's level of education and whether she is a generalist or specialist, one of the models might be more useful than the other. In hospital settings, depending on projected length of stay, a particular time frame might be more suitable than another; the models might be condensed or expanded or used in segments for out-patient situations. Generalist nurses might also simply introduce their patients to the idea of the availability of a specialized program for wives of alcoholics and then refer to the nurse specialists who hold teaching/counseling sessions.

There is excellent rationale for why nurses can and should work with alcoholic families, especially wives and other non-alcoholic members of the system. The fact is that they have not really had a clear mandate or a conceptual model for working with wives or other non-alcoholic members. Except in specialized alcoholism treatment centers, there is little attention paid even to the substance abuser by any health professional, each dealing only with the particular illness (often a complication of alcoholism) or surgical procedure of immediate concern. Little education on alcoholism and/or substance abuse is provided in most professional schools and this remains essentially true despite a presumably more enlightened social climate (NIAAA, 1987).

Naegle (1983) suggests that nurses have ambivalence toward alcoholics which stems in part from personal experiences such as being the child of an alcoholic or living with an alcoholic or even one's own personal
drinking habits. This would clearly present a barrier to interest and concern for the alcoholic himself, however, many of these nurses may not have similar responses toward the non-alcoholic spouse and thus may work effectively with this part of the family system.

The sheer numbers of potential patients (alcoholic and non-alcoholic family members considered together) warrant that all nurses help. Lack of knowledge and skill in assessing, and intervening in alcoholism is the other side of the coin however. In a past investigation, the writer observed that many nurses reported they would like to do something if they knew what to do and how to do it (Fisk, 1973). This may or may not be true today; however, it is clear that knowledge is needed, but also practical approaches and specific techniques are needed even more.

Innovative ways to reach out to wives of alcoholic men as an aggregate for nursing intervention seems a worthy goal, particularly when considered from the standpoint of family-systems thinking; that is, the notion that change in one part of the system will reverberate through the whole system. Thus, the opportunity is available to gain access and to make a difference to alcoholic families in a way that is not often considered, through the non-alcoholic spouse.

Cost containment is a critical issue in health care. Alcoholism treatment has only recently been a reimbursable medical diagnosis in the health care payment system, but issues of cost have already become a serious concern for third party payors. Despite questions about clients'
physical safety during the acute alcohol withdrawal phase, many are advocating for more out-patient treatment even during detoxification (Holden, 1987). This is because of the exorbitant cost of in-patient, medically-based care. Wives of alcoholics do not generally require nor would they generally choose in-patient care, expensive psychiatric intervention nor other expensive levels of long-term psychotherapy.

Although these statements do not account for a certain percentage who might do best with any of the aforementioned treatments and even with in-patient care, the largest percentage would clearly not require this. Not to be forgotten is the fact that the majority of the population of wives of alcoholics currently are receiving practically no definitive professional care for the family alcohol problem. Meanwhile, many health care dollars might be expended to finance their husband's "revolving door treatment" for alcoholism as well as the myriad medical complications which can be expected to increase year by year as the progression of the disease continues.

A primary care, group approach with wives of alcoholics which is time-limited and holds the potential for their own as well as whole family recovery later might be quite cost-effective. This is true whether psychiatrists or psychologists or social workers provide the therapy. For several reasons it may be more true when it is nurses who provide it. Because of nursing's wider scope in health and illness care a nurse may be able to assess, teach, counsel, and refer in relation to the whole gamut of health and illness matters a family might present. The cost per unit of time is relatively lower whenever non-physician, non-doctorally prepared health
care practitioners can be utilized. Generally, nurses can also be more flexible in terms of roles and functions in a variety of settings.

A final rationale for nurses doing this work with wives of alcoholics is that the prevalence of the problem warrants it. All health professionals ought to become educated to be able to intervene in alcoholism. The census of physicians, psychologists, and other allied health professionals is not large enough to reach adequate numbers of families and make significant inroads in combatting the disease. Nurses, though in short supply presently, still greatly outnumber all other health professionals.

Nursing has been striving to prove that its services are cost-effective, generally, in hospitals and other health care settings. The profession has taken the brunt of the recent cost containment initiatives known as DRG's (diagnostic-related-groupings) which are based on a prospective payment system. Short-sighted employers who at first layed-off large numbers of nurses soon found their hospital units dangerously understaffed as illness acuity levels increased. The resulting poor work conditions led to further losses of experienced nurses which coincided with a declining market of new graduates. Many hospital beds have been "closed"; as a result, the opportunity now exists for nursing to prove its economic worth. Nursing models of health care are one way to demonstrate that a costly medical model is not always necessary, especially in the case of certain health problems such as addictions. This project, is but a very small beginning toward a nursing model of intervention for alcoholism and other addictions.
Overview of the Methodology

This is a descriptive study in which a combination of AA/Al-Anon and conventional information, didactic teaching, and selected family therapy techniques were used in a context of brief group treatment. After an initial intake/screening interview, a teaching/counseling program consisting of six two-hour sessions was presented to two fairly evenly matched groups of six wives of alcoholics. The sample was obtained from diverse sources including word of mouth and newspaper advertisement. Timeliness of group formation made it impossible to achieve random assignment of subjects to the two groups as was initially proposed.

One group, Group A, received a program based on a family-systems perspective of family alcoholism using Berenson, Wegscheider, and Borwick techniques. A second group, Group B, received an identically structured program of six two-hour sessions. However, the second group received a more direct person-focused approach providing Al-Anon information and encouraging Al-Anon attendance. The effects of each program on the participants were evaluated in terms of changes in coping behaviors and Al-Anon attendance as self-reported. Results were compared. Follow-up contacts were made after 1 month and 2 months.

Definition of Terms

Operational Definitions

Co-dependent/Co-alcoholic. Someone who has developed recognizable patterns of ineffective coping behaviors in interpersonal relationships as a result of close personal involvement (past or present) with
chemically dependent persons/alcoholic persons. This includes parental and grandparental generations for some.

*Enabler(s).* Person(s) who engage(s) in behavior patterns which facilitate continued irresponsible drinking and progression of alcoholism in someone with whom they are closely associated (e.g. family members; employers or other work, school, community associates). The behavior patterns may be unconsciously and/or unwittingly performed in many cases.

*Enabling Behavior.* Specific types of ineffective coping patterns which may be purposefully, unconsciously, or unwittingly used by persons involved with chemically dependent persons which tend to maintain the problem.

*Ineffective Coping Behavior.* The tendency of non-alcoholic spouses to react to their alcoholic spouses' drinking problem in non-productive ways; that is in ways that do not allow the alcoholic to see and confront the reality of their alcoholism.

*Teaching/Counseling Programs* Two twelve hour programs (divided into six sessions each) one using selected family therapy techniques and family-systems-oriented didactic content; the other an individual-focused approach. A group format (7-10 members) for wives of alcoholics has been designed to concisely present the selected learning experiences for each group.

*Use of Al-Anon.* The number of meetings of Al-Anon the wife attends before during and after the research period.

*Wives of Alcoholics.* Women who are not themselves alcoholic and who identify themselves as wives of alcoholic men; they must be currently living in the same household with the person.
Survival Behavior. Specific types of coping behaviors used by wives of alcoholics which may or may not be facilitative of the alcoholics' drinking; however, the behavior is the wives' way of enduring and living through the usual progressive decline in family health and well-being that is alcoholism (The "Spouse Survival Behavior Scale" developed for this study is described in Chapter III).

Selected Distinctions

Some terms require special explanation not only because of their particular usage in this study and of their "political" implications for the field of chemical dependency but also for the personal politics of the writer.

While the terms "survival behaviors" and "ineffective (family) coping behaviors" are very close in meaning they are not actually interchangeable in this study. The former reflects the language of the Wegscheider-Cruse/Johnson Institute model while the latter reflects the language of nursing diagnosis. A third term "enabling behaviors" is also used by Wegscheider-Cruse and many others as well as Al-Anon. The latter is perhaps the most commonly understood term to both lay persons and professionals involved in alcoholism work or study. However, the writer prefers to avoid as much as possible any terminology having a blaming meaning or connotation. The accurately descriptive connotation of nursing diagnosis terminology (ineffective coping behaviors) which simply points to the fact that such behaviors do not result in the effects of their intent is acceptable. The connotation of "survival behaviors" seems least negative and thus is the writer's first choice in terminology.
A fourth term, "co-dependence", cannot be avoided because of its growing use in the chemical dependency field and in the popular literature. It has taken on new and controversial meaning; for this reason an operational definition will be offered here which attempts to circumvent the argument. Ironically, the controversy condenses to philosophical differences between a disease/illness perspective and a holistic/health promotion perspective. A large faction promotes a definition of co-dependence as a medical diagnostic entity which "exists independently within members of chemically dependent families" (Cermak, 1986). A smaller faction argues that "clinically, most of the clients we deal with are 'normal', experiencing levels of distress appropriate for their situation" (Gierymski & Williams, 1986). The literature review further elucidates these arguments.

**Summary of Chapter One**

A seriously underserved population, wives of alcoholics are potentially the key to early family recovery and even prevention of future alcoholism. Yet professional help is rarely received, particularly in the early stages when the likelihood of recovery is best. The well-known self help group, Al-Anon, has traditionally been the only help available and has demonstrated effectiveness for those who attend regularly. Counselors have noted, however, that it is somehow even more difficult to persuade a spouse to attend Al-Anon than it is to convince the alcoholic to attend AA.

There are many possible reasons for such resistance. A feeling of being responsible or blamed for the problem is but one explanation for this phenomenon. Others have been presented here. Consistent with both Al-Anon thinking and family-systems thinking is the belief that recovery
(change) in non-alcoholic member(s) of a family leads ultimately to whole system recovery (change).

Nurses and other health professionals have the opportunity, and with training, the capability to initiate a recovery process which might include facilitating entry into Al-Anon. This may be possible through the use of such brief group teaching/counseling packages as implemented in this study. Applied and evaluated with larger numbers of clients such approaches might ultimately prove to be very effective in combatting alcoholism not only in terms of time/effort but also in terms of cost considerations if professional nurses were to be taught to provide the service. Since both of the proposed approaches aim to facilitate entry and continued involvement in Al-Anon they may on a long term projection prove to be even more effective than treatments which target only the alcoholic members of the family system. The following chapter will review the literature related to treatment approaches for wives of alcoholics providing both historical and current perspectives.
CHAPTER II
REVIEW OF THE LITERATURE

Introduction

Several interrelated but distinct bodies of literature either directly or tangentially bear upon the central themes of the present study. These include: 1) descriptive studies on wives of alcoholics; 2) the literature on treatment of wives of alcoholics both generic and family-systems-oriented; 3) research reports on group approaches to the treatment of wives of alcoholics; 4) the printed material on "co-dependency" which emanates from the alcoholism treatment industry; 5) and the literature and rationale comprising the conceptual framework of this study as outlined in chapter one. The latter includes selected family-systems concepts, family nursing concepts and the Berenson, Wegscheider and Borwick Models.

These bodies of literature are reviewed in the above sequence. Much of the material will be summarized for the purposes of this analysis. Only the target literature for the present study will be presented in some detail: reports on comparable treatment approaches designed specifically for wives.

The Literature on Wives of Alcoholics

There is an enormous body of literature that concerns itself with wives of alcoholics\(^8\) attesting to a high degree of interest in the topic spanning four decades of more or less consistent fascination with this population. Given the likelihood that there are at least 5 million\(^9\) such

---

\(^8\) Many authors use the term "spouse" giving the impression that male partners are also included. However, there are extremely few studies which include husbands of alcoholic women.

\(^9\) This estimate is based on the writer's own calculations from the usually accepted incidence of alcoholism.
women in the U.S. the attention may well be warranted. Unfortunately most of it has been negative.

The largest portion of this literature has focused on the wives as individuals within a dysfunctional marital relationship; especially, their personality, character traits, and sometimes, their behavior. How wives influence their husband's drinking and/or abstinence from alcohol (if he is in treatment or recovery) seems to be the major concern of the largest proportion of research articles whether the study is descriptive in nature or treatment-focused. Seven detailed and comprehensive literature reviews serve to strengthen and focus the general impression that this literature is heavily biased toward wives and their contribution to the alcohol problem. (Ablon, 1976; Bailey, 1961; Edwards, Harvey, & Whitehead, 1973; Jacob, Favorini, Meisl, & Anderson, 1978; Janzen, 1977; Paolini & McCrady, 1977; Steinglass, 1976). Critiques of particular segments of this literature impart a flavor of controversy; for example, Jacob and Seilhamer's (1982) critique of Steinglass' experiments with "wet" and "dry" couples or Decker, Redhourse, Green, & Starrett's analysis of sexist stereotyping of wives of alcoholics in the alcoholism literature (1983).

Even the majority of studies on the "alcoholic marriage" (the couple relationship as apposed to the wife alone) have characterized the wives as either "villains" or "victims" as pointed out by Bailey (1961); "culprit" or "martyr" as pointed out by Rothberg (1986). In the "disturbed personality hypothesis" (Futterman, 1953; Kalashian, 1959; Lewis, 1937) which arose from a psychoanalytic view (Paolini & McCrady, 1977) the non-alcoholic wife was seen as having unconscious neurotic needs to marry a
weak, dependent male alcoholic in order to dominate him. Her psychopathology was believed to be severe and longstanding, predating her marriage (Steinglass, 1976). A corollary view, while slightly less pejorative, suggested that these neurotic traits and psychosocial disturbances were consequential to the problems of living with an alcoholic. Thus it was understandable that dominating, uncooperative behavior and seeming to sabotage her husband's abstinence was really a necessary coping mechanism. This has been labelled the "decompensation hypothesis" (Paolini & McCrady, 1977) based on a reported association between cessation of drinking by the alcoholic and the onset of symptoms (depression, psychosis) in wives (e.g. Macdonald, 1956). At no time were these findings considered generalizable to husbands of alcoholic women.

Sociological stress theory pioneered by Joan Jackson (1954) offered an alternative explanation in which the focus was shifted toward the marital unit rather than the individual personality and psychopathology of the wife. This model holds that the stressful conditions of an alcoholic marriage make necessary certain role redefinitions and that disorganized behavior in family members is not only natural but follows a predictable pattern. Jackson conceptualized seven stages of family adjustment to the crises of alcoholism as listed in Table 2.1.

While Jackson's work is widely respected and cited in detail in every account of this literature (including Al-Anon's printed information) her research has also been criticized methodologically. For example, her sample
Table 2.1  **Stages of Adjustment to Alcoholism** (Jackson, 1954)

1. **Attempts to Deny Problem**: need to create illusion of "perfect marriage"; wife feels she may be overreacting; friends are reassuring.

2. **Attempts to Eliminate the Problem**: family withdraws from social contacts and relatives; wife throws away the bottles; behavior is now organized around the drinking.

3. **Disorganization**: wife gives up trying to control drinking; she questions her normality; children increasingly disturbed.

4. **Attempt to Reorganize in Spite of Problems**: spouse assumes control of family; alcoholic left with no familial role.

5. **Efforts to Escape Problem**: spouse separates with children, needs considerable confidence to take this step; marriage may terminate at this point.

6. **Reorganization of Part of the Family**: spouse and children reorganize themselves as a family.

7. **Recovery and Reorganization of the Whole Family**: alcoholic is now sober; spouse and alcoholic renegotiate family roles; acceptance of sober personality undertaken.

consisted wholly of Al-Anon members, a rather unique subpopulation\(^\text{10}\); she also did not study husbands; and she relied on subjective impressions without quantifying her observations (Paolini & McCrady, 1977). Yet this model has contributed greatly to a common understanding of the alcoholic family in the broad sense, and in particular, the premise that wives engage in coping behaviors in response to their husband’s drinking. Jackson was the first not to blame the women that she studied. Unfortunately, a basic tendency toward negative images, sexist stereotyping and victim-blaming is still being disseminated based on old research which has been invalidated. For example, Whalen concluded in (1953) from her subjective observations of wives of alcoholics that there were four personality types which she labelled “Suffering Susan”, “Controlling Catherine”, “Wavering Winifred”, and “Punitive Polly”. Credence is still given to these and other such stereotypes of wives of alcoholics as they continue to appear in textbooks (Lawson, Peterson & Lawson, 1983; Nace, 1987) and even in public information pamphlets (Reddy, 1977) without disclaiming commentary. Decker, Redhourse, Green and Starrett (1983) present many other examples of sexist and negative themes re-appearing in the literature.

Stress theory proponents have subsequently established the concept that wives of alcoholics are not a unitary phenomenon of pre-existing intrapsychic and personality disturbance (Kogan & Jackson, 1965), and have also repudiated the assumption that wives become symptomatic during husbands’ periods of abstinence (Haberman, 1964). Bailey’s review of the

\(^\text{10}\) Hurwitz & Dalpat (1977) found non-Al-Anon (non-help-seeking) wives to be higher on ego strength than Jackson and Kogan found for Al-Anon wives.
research and professional literature on alcoholism and marriage (1961) criticized a lack of integration between stress theory and the disturbed personality hypothesis. During the mid-sixties some integration studies were done, for example, Bailey, Haberman and Alksne (1962) and Bailey (1967) which gave rise to a new "**Psychosocial Theory**". This theory recognizes the need to examine the spouse within a broader conceptual framework and in a multifactorial perspective (Jacob, 1986).

Wiseman (1981) interviewed seventy wives of alcoholics and thirty male alcoholics (not married to the interviewed women) to explore patterns of behavior during sober states of various length. She found that even during longer abstinence there is great tension and hypersensitivity for both partners. No respondent, alcoholic or wife, claimed that sobriety brought "normalcy" or that the alcoholic acted the way he always had before alcoholism. Although 50 of the 76 wives described positive personality changes in their husbands after longer periods of sobriety, both the women and the men reported feeling "on stage" or as though putting on a performance during sober time. While this research report seemed compassionate toward both parties in an alcoholic relationship, Wiseman speculates that what may appear to other researchers to be sabotage of treatment, controlling behavior, dominance, etc. may not be the wives' unconscious needs but strain, tension, self-consciousness. For the alcoholic, a heightened awareness as to how he should be acting can be the prelude to another period of drinking.

Since the mid seventies psychosocial theories began to advance the idea of "co-alcoholism" and "co-dependency" which leans, at times, toward a
more negative perspective; in this case, medical diagnostic terminology, i.e. illness. Once again, statements such as "sometimes the non-alcoholic spouse needs the alcoholic to be sick" have begun to appear as noted by Decker, et al.(1983). A later section of this chapter will explore this co-dependency literature.

The present researcher philosophically agrees with the beliefs of Wiseman and further advocates for a non-blaming more compassionate attitude toward women who are struggling to survive the difficult situation of family alcoholism. As aptly stated by Decker, et al. (1983): "Wives of alcoholics have essentially normal personalities which fluctuate with the stress of their husband's drinking but improve with increasing periods of abstinence much like other women with marital problems".

The literature fails to uphold any of the other hypotheses. In the present research, a non-blaming perspective will be upheld; neither will blame be shifted to the alcoholic, the family system, or the family of origin. A climate of warmth and mutual respect will be maintained in both groups. Another aim will be to foster a peer group relationship of trust and caring among the women in both groups. It is believed that self-esteem will thus be enhanced rather than diminished as might be the case if the older hypothesis were to prevail.

The Literature on Treatment of Wives of Alcoholics

An historical perspective on alcoholism, "family treatment" and how in recent times it has intersected with "family therapy" seems appropriate here. Only the landmarks relevant to this study will be presented. For a more comprehensive historical review of family treatment approaches in
alcoholism from 1950 to 1975, Steinglass (1976) has provided an excellent resource.

Alcoholism has for decades been considered a family problem by AA and Al-Anon and by those who work in the alcoholism field. Indeed, Al-Anon, the first and for many years the only treatment available to non-alcoholic members of the alcoholic family, originated out of AA wives' perception that they needed help too. Many felt "desperate, baffled by a problem not of their making." (Al-Anon Faces Alcoholism, 1973, p. xiv). So great was the need that between 1941 and 1951 informal groups were forming and spreading "spontaneously without any outside contact." (p 251). Thus, the first "family therapy" for alcoholism was Al-Anon, founded by Lois Wilson the wife of the co-founder of AA.

The alcoholism field, strongly influenced by AA/Al-Anon, developed its approaches to family treatment independently of professional psychotherapy methods (including family therapy) viewing these as "generic" and lacking awareness of the unique problems of alcoholic families (Kaufman & Pattison, 1981). The family therapy field has traditionally devoted little effort to modifying techniques for alcoholism treatment. Howland (1985) states the case strongly. "Any treatment approach to alcoholism that does not directly and forcibly address drinking as the first major issue is meaningless and perhaps even harmful." (p. 15). Alcoholism treatment personnel are thus suspicious of investigating family therapy approaches and remain unaware of useful techniques. Slowly, in the past decade, cross-fertilization between the two fields has begun to occur
(Kaufman & Pattison, 1982). This has been enriching to both fields and has begun to benefit families as a result.

Progress in the overall credibility of family therapy in alcoholism treatment can be noted in government documents. The Fifth National Report to the US Congress on Alcohol and Health (NIAAA, 1983) put forward no evidence or claims of demonstrated efficacy of family therapy with alcoholism. In fact, it reported that "considerable work in evaluating family therapy with alcoholic families is needed" in order to determine its unique contribution (p. 112). There is a clear difference in the subsequent report.

The Sixth Special Report to the US Congress on Alcohol and Health (NIAAA, 1987) states: "Therapeutic approaches that involve the family have given encouraging results... and controlled studies of marital or family therapy of alcoholics have found moderately better short-term outcomes than individual approaches" (p. 129). The tone of the latter report is generally more positive than all previous reports with regard to the whole outlook toward alcoholism treatment and recovery but especially family treatment/family therapy (in the broad sense). Since these reports serve both as historical reference points and current documentaries of progress in understanding alcoholism, the following statement in the sixth report may truly be a landmark: "Despite the complex issues involved in the evaluation of treatment, there is growing consensus that alcoholism treatment does work ... And in some instances with particular patient populations treated with particular methods, it works very well indeed. (pp. 129-130).
The notion of careful matching of treatment approach\textsuperscript{11} to client/family has been strongly emphasized in the sixth report ("Factors Affecting Treatment Outcomes" pp. 129-136). However, patient-treatment matching efforts have presented problems for researchers in terms of evaluating treatment efficacy. The sixth report recognizes this issue. "In order to show that particular characteristics are differentially related to different treatments it is necessary to vary patient characteristics and treatments simultaneously (NIAAA, 1987, p. 132). Surprisingly, there have been a few studies which meet these criteria (e.g. McLellan, Luborsky, Woody & O'Brien, 1980; & McLellan, Luborsky, Woody, O'Brien & Druley, 1983). The sixth report notes that these studies have demonstrated that treatment is effective even without matching but that matching improves effectiveness (NIAAA, 1987, p. 132). Patient-treatment matching reaches higher levels of complexity if the whole family is to be treated. Examining and comparing outcomes of differential treatment approaches at variable stages of alcoholism progression, stages of family adjustment, "wet" vs "dry" systems, and inpatient vs outpatient treatment may not be possible. Researchers would also need to co-vary family therapy approaches with all the other complex variables.

Treatment in alcoholism is increasing in variability and complexity. There is very little standardization of care. Only a few prolific authors such as Steinglass and associates 1977, 1979, 1980, 1981, 1982, 1985 & 1987) and Jacob and associates (1981 & 1986) have presented data which can be

\textsuperscript{11} Stage of alcoholism, intensity of treatment, modality of treatment, inpatient vs. outpatient treatment, family involvement, financial considerations are but a few of the factors considered in treatment matching.
compared both internally and with each other. The largest percentage of published articles are one-of-a-kind treatment reports which do not provide enough data or instruction to replicate (e.g. Estes, 1974; Igerscheimer, 1959). Non-research articles such as monographs describing a single treatment program frequently use the term "family therapy" very loosely to mean any kind of attention to spouses, and more recently, children, parents or siblings of alcoholics. For all of these reasons this literature presents a confusing array which was best clarified by Janzen (1977). Unfortunately, a published follow-up covering the last decade has not ensued. Appendix B presents a chronological overview, reorganized to suit the purposes of this study, from Janzen's 1977 review of the literature on family treatment research.

This makes it possible to compare all studies, for example, which report on multiple family groups as opposed to those which report on work with groups of alcoholics (separately) and groups of wives (separately). It is likewise possible to pick out outpatient versus inpatient contexts for comparison. A third type of comparison might be desirable for those who consider only abstinence (not decreased drinking) as a viable goal. The table makes it possible to isolate those studies where abstinence defines success.

For the purpose of the present study, the comparison of interest is wives who received outpatient group treatment where outcome is not measured by their husband's patient status or his drinking status. While several studies, both before and after Janzen's review, fit part of this description, no studies were found which did not consider the husband's decreased drinking as the measure of success.
The research of one particular team of investigators while not central to the present study either in conceptual framework, therapeutic approach or research methodology deserves special attention because of its stature within the family therapy field. Most investigators have greatly admired and praised the research and writing of Steinglass and his colleagues (1976 a and b, 1977, 1979, 1980, 1981, 1982, 1985, and 1987). Their work has been most prolific and the methodology basically sound. However, it is a good example of research based on premises and implications that are philosophically in opposition to the beliefs of the present investigator. For several reasons this research seems disrespectful or even detrimental to the family. The Steinglass team speaks of the "adaptive consequences of alcoholism" indicating that drinking serves to stabilize rather than disrupt the family and inferring that the family (or spouse) either provokes or perpetuates the drinking. Presumably, if the family would discontinue encouraging or supporting the drinking the alcoholic might automatically decrease his drinking. Success is measured in amounts of alcohol intake not necessarily abstinence. This is a most simplistic view of the problem and fails to consider such complex and interacting factors in the etiology of alcoholism as hereditary/genetic influences, addictive/pharmacological influences, and intergenerational influences. Furthermore, in some Steinglass experiments couples in which one member (usually the husband) is alcoholic are observed during "dry" and "wet" states in order to observe their interaction. This is all too similar to the controlled drinking experiments (Armor, Polich, & Stanbul, 1978; Pendery, Maltzman, & West, 1982; Sobell & Sobell, 1978) which are considered extremely hazardous to
alcoholic clients/families. Any approach involving alcohol intake by design, fails to take into account the serious, even fatal nature of alcoholism. Purposefully manipulating or even sanctioning alcohol or drug use in addicted persons for the sake of research seems to cross the line between ethical and unethical practice.

The present study does not attempt to alter alcohol use nor does it concern itself with the alcoholic husbands' drinking. David Berenson was among the original researchers working with Steinglass and associates at Georgetown University. Berenson (1987) has subsequently modified his outlook in keeping with the thinking of Alcoholics Anonymous for which he now strongly advocates. Among his changed views are his beliefs about abstinence from alcohol and/or other addictive substances as the necessary basis for recovery. Berenson's approach to working with alcoholic families will be reviewed along with the other family therapy models which constitute the conceptual framework of this study in the last section of this chapter.

The Literature on Group Approaches to Treatment of Wives of Alcoholics

A relatively small number of studies were found which evaluate outcomes of separate group work with spouses (mostly wives) of alcoholics (Gliedman, Rosenthal, Frank & Nash, 1956; Igersheimer, 1959; Smith, 1967). Several other such clinical studies emanate from the Behaviorism/Social Learning perspective (Cheek, Franks, Lancius & Burtle, 1971; Hedberg & Campbell, 1974; Kranitz, 1971; Sisson & Azrin, 1986). Epistemologically, these studies, present the same serious philosophical disagreement with the theoretical framework of the present study. However, because they do
involve groups of wives of alcoholics, and use some type of control or comparison group, one example of these will be offered as a prototype. Much controversy surrounds behavior modification research in the alcoholism field. Again, this relates to its association with "controlled drinking" experiments and the so-called Rand Report (Armor, Polich, & Stanbul, 1978). Based on the premise that as a learned behavior, excessive drinking can be unlearned, the goal of behaviorist approaches to alcoholism is not necessarily abstinence. AA members and others in the mainstream of alcoholism treatment believe that alcoholics have "experimented" with controlled drinking for centuries; many have died in the process.

Having an interactional focus, behavior modification shares some viewpoints with family-systems thinking; for example, the idea that drinking plays a role in the marriage or in family homeostasis and that spouses can inadvertently behave in ways that reward and maintain it. Also similar is the aspect that outcomes of behavior modification studies are generally measured in terms of the drinking behavior and whether it increases or decreases. Presumably, as the behavior of the non-alcoholic spouses is modified the undesirable behavior of drinking is either reinforced or discouraged.

A good example of this type of research is the work of Sisson and Azrin (1986) in which behavioral group treatment was received by non-alcoholic family members (mostly wives). A control group received traditional teaching and supportive counseling. Films and pamphlets stressing the "disease concept", "sympathetic listening" and a "firm" Al-Anon referral were the specific methods for the control group. The experimental
group received a very detailed behavioral program which the authors labelled "community reinforcement counseling". This included:

1) **awareness of problem training** ("Inconvenience Review Checklist" pointing out problems caused by drinking such as embarrassment, physical and emotional abuse, etc.)
2) **motivation training** (how to motivate the alcoholic to decrease his drinking and to obtain help)
3) **positive consequences** for not drinking (making his favorite foods, buying him little gifts, being pleasant, positive communication, having sex)
4) **competing activities** (scheduling fun which does not involve drinking: e.g. picnic, dinner, sports)
5) **outside activities for self** (to not depend on the alcoholic for psychosocial & economic needs; job finding etc.)
6) **awareness of drinking** (how to behave when he is drinking: encourage eating, drink non-alcoholic beverages; suggest other activities; make him aware of how much he is drinking and how pleasant it is when he is not drinking)
7) **negative consequences of intoxication** (ignore, withhold positive reinforcement, tell him in a neutral manner she does not want to be around him when he is drinking)
8) **accepting responsibility for self correction** (holding him responsible for his actions, not shielding him from consequences)
9) **handling dangerous situations** (violence)
10) **suggesting counseling**
11) **general procedures** (role playing)
12) **joint counseling** (if and when he agrees to enter the community alcoholism treatment program in which Antabuse is mandatory)

The reported outcomes were positive for both getting the alcoholics to agree to treatment and decreasing their drinking (N=12; 7 in the experimental group and 5 in the control group). None of the control group husbands and 5 of the experimental group husbands entered treatment.
The authors conclude that their approach shows promise and should be tried with a larger sample.

A striking aspect of this study is that the behavior prescribed to wives in the experimental group is not unlike the kinds of behavior seen in wives of alcoholics as a natural response to the problem drinking. Moreover, it is the kind of behavior that Al-Anon would discourage and that most alcoholism professionals would see as symptomatic of "co-dependency" or "enabling". The present investigator would suggest to the authors that they might be seeing the paradoxical effect of "prescribing the symptom"12 to the experimental group. However, there are other, more basic issues which discredit this and most other behavioral studies in the view of the present researcher. The premise that excessive drinking is simply learned behavior does not lead to interventions which facilitate abstinence and sobriety, only negligible fluctuations in alcohol ingestion. Besides this attitude of looseness concerning abstinence as the goal, there is serious objection to the assignment of stereotypical female role behaviors and placing the onus for changing husbands' drinking solely upon the wives who already have a high degree of stress. In this study, the wives were made responsible for all of the rewards and punishments, all the vigilance and monitoring and hence were the controllers of their husbands' behavior. The husbands only had to respond to the wives' manipulations. These behaviors are isomorphic with

12 Prescribing the symptom is a technique of strategic and systemic family therapy which seems to counteract "resistance" in some families by creating a double-bind. If she chooses not to comply with the prescription she will have to give up her symptom. If she chooses to comply, the behavior must be defined as her choice and therefore deliberate and not beyond her control.
the survival behaviors which the present study will examine as a measure of whether wives are coping effectively or ineffectively.

A study by Orford and associates (1975) also illustrates similar sexist attitudes. This British team were the developers of a scale for measuring the coping behaviors of wives of alcoholic which they tested on 100 women. They hypothesized that the wives' use of maladaptive coping behaviors would correlate with their husbands' drinking. They found that certain categories correlated more strongly with increased drinking than others. For example, withdrawing behaviors on the wives' part during the drinking was associated with worse drinking outcomes than was protecting behavior. Al-Anon attendance was considered maladaptive coping as were most categories in which wives were not strongly focused on the alcoholic. The outcome of this and similar studies which rely upon fluctuating drinking patterns as measures of success or failure tend to place the responsibility for the drinking problem and its solution on the wives (or significant persons and situations outside the alcoholic). This becomes yet another way of "blaming-the-victim".

While the latter study was not a treatment-outcome study, the implications for treatment would be aimed not at improving the wife's own health and well-being but at manipulating the environment for the alcoholic's health and well-being. The irony is that while she is busily focused upon his needs and protecting him, the alcoholic has no need or reason to seek help. AA and Al-Anon would find this quite contrary to their belief that each person take his/her own moral inventory and focus on their own recovery and growth.
The present study is mainly concerned with the health and well-being of the woman as the identified patient in a primary care context. It did not particularly focus upon the alcoholic's health and well-being. However, in the long run, it might be expected that change in the wife's level of health would reverberate through the family system and eventually lead to change in the alcoholic.

**Other Treatment Modalities**

Two nursing papers were found which focused specifically on wives of alcoholics (Estes, 1974; Estes and Hanson, 1976). The first was not research-based but the author described her individual counseling approach with this population. Estes stresses that learning about alcoholism is "very essential ... pervading all phases" of treatment. Improving self-esteem and modifying negative coping behaviors are among other important goals. Again, the burden of responsibility for making the marital relationship "more harmonious" is on the wife as is motivating her husband to seek treatment. The second nursing paper described a group approach for wives of alcoholics who were in the process of adjusting to sobriety. All of the women in this study were active in Al-Anon.

Other studies report outcomes of **conjoint couple therapy** (Bailey, 1968; Hedberg & Campbell, 1974; O'Farrell, 1986; O'Farrell & Cutter 1984; O'Farrell, Cutter & Floyd, 1985; Zweben & Perlman, 1983) **multiple couple groups** (Berman, 1968; Burton & Kaplan, 1968; Cadogan, 1973; Gallant, Rich, Rey & Terranova, 1970;) and **whole family** (Barnard, 1981; Esser, 1968; Meeks & Kelly, 1970; Pattison, 1965; Treadway, 1987). These studies provided small but valuable formative ideas about aspects of methodology
such as outcome measurement, minimal treatment vs. no treatment controls, etc.

The Literature on Co-Dependency

No empirical research was found on co-dependency despite considerable writing on the topic. Mainly internal to the alcoholism treatment industry, the literature takes the form of opinion articles, pamphlets and short paperback readers. Much of it is written by recovering professional and paraprofessional counselors at reputable treatment centers. The Hazelden Foundation in Minneapolis has published some of this literature despite its recently stated position rejecting the terminology: co-dependency; co-alcoholic (Hazelden, 1987).

Hazelden’s statement, entitled “Some thoughts on co-dependency” (see Appendix C), exemplifies a very new direction in the addictions field as well as in the health care industry in general. It states: “We have consciously chosen not to label problems that occur within the family system any diagnosis including the word co-dependency ... We are moving from a biomedical, causal approach, which emphasizes the study and treatment of disease, to a holistic, systems approach, which emphasizes the study and promotion of health.” This philosophical shift underlies Hazelden’s changed view of non-chemically dependent members of the family.

Those who advocate this nomenclature would like to see co-dependency as its own disease entity (Cermak, 1984, 1986; Johnson Institute, 1988) and as a new category in DSM III (Diagnostic & Statistical Manual). They argue that pioneer authors in the field have identified common themes leading toward more precise diagnostic criteria (signs,
symptoms, clinical course, etc.). They see co-dependency as a disease existing independently of the alcoholic’s drinking behavior, being present as a syndrome before marriage to an alcoholic, and continuing (if not treated) for decades after the alcoholic ’s death or recovery (Cermak, 1984).

There are two major categories of co-dependent persons 1) spouses or significant other adults, and 2) children and adult children of alcoholic parents. The latter group has captured a phenomenal degree of popular interest as evidenced by the mushrooming of self-help literature on the topic and a rapid development of ACOA groups both inside and outside of the aegis of Al-Anon.

The positive benefits of gaining new ”disease” status include the potential for third party reimbursement of treatment costs. For many families this is the only way in which counseling of any kind is affordable. Health promotion has not generally been reimbursable and although health maintenance organizations (HMO’s) provide for preventive care and some health promotive teaching of positive health practices, family alcoholism intervention and counseling is not yet widely available.

Gierymski and Williams (1986) provide detailed argumentation of Hazelden’s position on the issue. They highlight the fact that there have been no systematic studies underlying assertions of a specific diagnostic category; that intuitive statements, overgeneralization and anecdotes characterize the extant body of information being passed along. “The problems encountered by such families and their responses to these problems should not become prematurely stereotyped” (Gierymski and Williams, 1986 p. 8). Among the reasons given for Hazelden’s choice not to
use the term co-dependency are that responses of family members are too varied, that their problems exist at "multiple levels of interacting causation" and that most are "normal" experiencing appropriate levels of distress for their situation. "Research tends to support the position that while people involved with chemically dependent individuals do experience more emotional problems, no clearcut syndrome has emerged." The writer generally agrees with the latter perspective and has modified the present study to fit this viewpoint. The decision to design a scale of "survival behaviors" was largely based on philosophical rejection of terminology such as "maladaptive coping". Only one reservation remains relating to the lack of financing for health promotion. Professional help for families of alcoholics will thus be available only to the very wealthy unless major reforms in health care financing should occur.

The Literature Comprising the Conceptual Framework

As stated in Chapter 1, the conceptual framework for the family-systems-oriented program is comprised of a particular combination of selected aspects of three models from the field of family therapy. Before describing the very specific constructs which make up this conceptual framework it is important to consider certain relevant family-systems concepts which provide the largest level of information from which the study emanates. After this, the family-systems perspective will be joined with a nursing perspective so as to provide a sense of the writer's professional frame of reference. Finally, there will be a brief section on the three models that are being combined in the family-systems-oriented teaching/counseling program being tested.
Family-Systems Theory

Family-systems theories, including general systems theory (von Bertalanffy, 1968), communication theory (Watzlawick, Bavelas, & Jackson, 1967), cybernetics (Bateson, 1972; Keeney & Ross, 1983) and the idea of second order change (Bateson, 1972)) are the most basic perspectives from which this project has evolved. These theories are foundational to the field of family therapy which has until quite recently not concerned itself with alcoholic family-systems. The alcoholism treatment field, having long recognized the value of family involvement, has traditionally utilized referral to Al-Anon as its only real offering to the non-alcoholic members of the family. Recently, substance abuse counselors have begun to study family-systems concepts and a few, including this investigator, have begun to discover that certain approaches and techniques from family therapy pragmatically work with alcoholic families.

Many useful concepts from the body of knowledge of family therapy have been synthesized in the writer’s work with alcoholic families (Fisk, 1987). A few general but particularly important aspects for alcoholism and alcoholic family-systems are highlighted here. Perhaps the most important of these is the interactional perspective which allows for a non-blaming, circular view of the problem rather than a more traditional linear-causal perspective which can easily be translated to blame.

It is not difficult to see the advantage of a non-blaming attitude in the case of family alcoholism which carries such negative social stigma for all family members. This view is compatible with AA which also places blame outside the individual but in a way that is more closely aligned with the
modern medical scientific understanding of the nature of alcoholism as a "disease". This may be quite in contrast to the message received from others in the alcoholic's life (spouse, parent, employer) who more typically blame the individual considering him/her weak or immoral. Both views, the family systemic perspective and the disease concept, are plausible and can compatibly be integrated since they apply at different levels of systemic thinking. Release from blame is sometimes what enables the alcoholic to come forward and ask for help with treating his "disease" and may initially be his "ticket" into some form of treatment and subsequently, recovery.

Shifting blame from the alcoholic to the non-alcoholic member (especially if she is female) or from the alcoholic to the family system (Coppersmith, 1982) must be guarded against, however.

The family-systems concepts of homeostasis and morphogenesis also seem to have particular relevance in alcoholism and all three models of family therapy being used for this study share these as underpinnings. These concepts assist our understanding of ways in which families cope with change, and explain how well-meaning family members can inadvertently contribute to maintaining the problem-drinking. While this must carefully be distinguished from the notion of family members causing the problem or sabotaging the treatment efforts of the alcoholic, it is consistent with Al-Anon thinking about counterproductive "home remedies". Homeostatic behaviors (leaning more toward resisting change and retaining the status quo) increase as the alcoholism progresses and the alcohol becomes less and less able to fulfill his/her function and roles in the family. Increasingly, his behavior is rigid and ritualistic centering upon alcohol: obtaining and
maintaining a supply and hiding that supply. Only by keeping things the same can the delicate balance be maintained. The survival roles are also homeostatic in nature. Complementarity also eventually comes into play as the non-alcoholic spouse begins to compensate for the underfunctioning of the alcoholic or if struggle for control of his drinking characterizes their interaction. Over months and years of insidious deterioration of the alcoholic spouse, the non-drinking spouse may compensate more and more for the roles/functions of the alcoholic while still other family members (children) take over the roles/functions thus relinquished by the spouse. As the family's way of problem-solving becomes more entrenched and the same wrong solutions are applied, there is little room for the flexible give-and-take which allows for normal family developmental change, i.e. the morphogenetic side of the family balance which supports individual growth, health, individualization, etc.

There is little doubt in most helping persons' minds that alcoholism recovery requires change of a different order than the simple alteration of a behavior, that of picking up a drink. The phenomenon that A.A. calls "hitting bottom" has been described by Bateson (1972) as the "epistemological shift" or "second order" change. This involves... "a new understanding of mind, self, human relationship and power" (p. 309). "Hitting bottom" most often occurs in the non-alcoholic family member before it occurs in the alcoholic and is characteristically by the break down of denial. When this occurs, the possibility of earlier recovery for the whole family is created. Family-systems theory provides a framework for understanding that "bottom" in alcoholism is that point of qualitative shift (Berenson, 1987). When the
The concept of second order change is aligned with the systems concept stating that even a small change in one part of the system will have impact on all members of the system, the basis for family change becomes apparent. Thus in alcoholism, any intervention that facilitates new behavior in the wife of an alcoholic has the potential of not only being therapeutic to her as an individual but as a fringe benefit, also facilitating change in the alcoholic husband. This observation was a most compelling impetus for this study; all the more because it is consistent with the Al-Anon experience that a spouse’s recovery is often followed by recovery of the alcoholic person (Bowen, 1978; Nace, 1987).

Nursing Practice and Family-as-Client

The concept of “family-as-client” is a very familiar one in nursing because of the discipline’s holistic and contextual perspective. Nursing accommodates the idea that the unit of service encompasses the individual within the total context of the immediate social environment which is the family. The variety of settings in which nurses practice including client’s homes allows for much exposure to alcoholic families. Family-centered nursing is now the focus of every domain of nursing (community health, parental-child, physiological and psychosocial). Wright and Leahey (1984 and 1987) and Miller and Winstead-Fry (1982) are among nursing educators who have introduced texts which apply specific family-systems perspectives to nursing practice. Whall (1986) has additionally written a text for nurses at the graduate level who are practicing family therapy in advanced nursing roles.
At baccalaureate and higher levels nurses are educated to work with families as unified systems in relation to health and illness and are expected to teach, counsel and refer as well as assess, plan and evaluate at the level of the family system. The North American Nursing Diagnosis Association (NANDA) has approved to date the following family-oriented nursing diagnoses:

1. Adequate family coping: potential for growth
2. Alteration in family processes
3. Ineffective family coping: compromised
4. Ineffective family coping: disabled
5. Alteration in parenting

Several others apply at both individual client and family level:

1. Knowledge deficit: related to illness, management etc.
2. Potential for violence
3. Noncompliance with medical/nursing management
4. Post-trauma response
5. Altered role performance
6. Sexual dysfunction (at couple level)
7. Social isolation
8. Altered growth and development
9. Altered health maintenance
10. Impaired home maintenance management

A recent publication of the American Nurses Association (ANA) in collaboration with the Drug and Alcohol Nursing Association (DANA) and the National Nurses Society on Addictions (NNSA) sets forth the profession's
philosophy about addictions nursing and the parameters of the specialty’s content. Entitled "The Care of Clients with Addictions: Dimensions of Nursing Practice" (ANA 1987) the document clearly espouses a family-systems perspective as exemplified by the following statements. "In addictions nursing the family is viewed as an interrelated system in which the actions of one member affect all other members....The client’s family must be considered and involved as much as possible in the evaluation and treatment of patterns of abuse and addiction." (pp. 6-7). The most prescriptive statement for nursing practice in the realm of treating wives of alcoholics (and families) merits quotation in its entirety because of its significance for this study.

In the past, the treated client was discharged and returned to an untreated family environment. Exposed to a system that was unprepared for changes in the treated member, the client and the family were at risk for recurrence of the abuse or addiction problem, and the illness often became chronic. Today it is recognized that nurses should treat the client and the family; even if the diagnosed client refuses treatment, treatment of the family is appropriate and necessary as individuals should be assessed, treated and evaluated as a client. (p. 7).

ANA in association with NNSA has also very recently published "Standards of Addictions Nursing Practice with Selected Diagnoses and Criteria" (ANA 1988). As the national professional society for nursing in the United States, ANA has published a number of documents which delineate standards of professional nursing practice beginning with generic standards of the profession (1973) and encompassing each of the specialty practice areas (Medical-Surgical Nursing, Psychiatric and Mental Health Nursing,
Community Health Nursing, etc.). These standards provide the primary
direction for the quality of nursing care a client receives, and also mark the
recognition of a clinical specialty as a distinct practice area.

The publication of the above documents have finally made explicit
what nurses in the alcoholism field have long believed and practiced. The
fact that the standards address not only the specialist level (masters
prepared) but the generalist level (both the registered nurse in any health
care setting and the generalist in addictions nursing) is important for this
study. The need for education for nurses to incorporate these new
guidelines and standards into practice has made this study not only more
relevant but very timely. Until now there has not been a clear and
compelling mandate for nurses to intervene in alcoholism despite the great
need and despite nursing’s unique and broad access to such families.
Nursing education has not traditionally provided knowledge and skills for
working with such families.\textsuperscript{13} It can now be expected that this will change
to meet the standards.

\textbf{The Berenson, Wegscheider & Borwick Models}

These family therapy models are among the few which have been
modified and applied specifically in family-systems work with alcoholic
families by one or more family therapists. Each of the 3 models incorporated
into the family-systems teaching/counseling program are used in more
purist fashion by the therapists whose name is linked with the model. The
unique aspect of their use here is that specific techniques from each of the

\textsuperscript{13} In this respect it is not very different from other disciplines including medicine
and social work.
three models have been integrated in a different way and used in a group therapy context with wives of alcoholic men.

For the sake of relevance and clarity, the theoretical constructs which underlie the techniques used in the study will be the major focus here. However, the reader is again referred to the analysis previously mentioned for a more comprehensive understanding of the three models (Fisk, 1987). The major references for the following are: Berenson, 1976a, 1976b, 1979 & 1986; Berenson & Treadway, 1984; Borwick, 1985; Johnson, 1980; Satir and Baldwin, 1983; Selvini-Palazzoli, Boscolo, Cecchin, and Prata, 1978 & 1980; and Wegscheider, 1981.

**Berenson’s Choices.** David Berenson MD is a practicing psychiatrist whose focus on alcoholic families evolved out of his general psychotherapy practice. He found alcohol to be a major issue in many families and soon realized that his traditional psychoanalytic background did not yield answers that helped people become sober. Joining with Davis, Steinglass, and Davis (1974) he became involved in National Institutes of Mental Health (NIMH) funded research at Georgetown University in Washington D.C. He there began to study family groups and was influenced by Bowen (1973), Bateson (1972), and others who share systems philosophy and looked at behavior from an interactional perspective.

In observing the success of AA and Al-Anon, Berenson has gradually shifted his thinking about alcoholism recovery and the roles of AA vis a vis family therapy. At the same time he has also shifted away from a Freudian persuasion as his basic medical view toward a Jungian position especially
with respect to the relevance of spirituality to alcoholism. He points out the AA program "can be traced back to Carl Jung’s consulting room" (Berenson, 1987, p. 25). Much of Berenson’s work in alcoholism is based on a synthesis of AA, Jungian, and Batesonian perspectives as he equates the AA concept of "hitting bottom" to the Batesonian concept of surrender which "eventually leads to the epistemological shift or "Learning III".14 In Jungian terms this might be termed "the highest religious experience".

A unique problem in working with alcoholic families is the issue of whether the alcoholic is "wet" or "dry". Though Berenson works with various combinations of family members, his model offers a way of working with the family while the alcoholic is still drinking. Many family therapies are only useful with dry systems. When working with the non-alcoholic spouse alone, Berenson bluntly and with visual reinforcement (written out in full on a large black-board) offers her three choices as the only available alternatives (as outlined by Berenson, 1979):

1. Keep doing exactly what you are doing.

2. Detach, or emotion ally distance yourself from the alcoholic.

3. Separate, or physically distance yourself.

Each of the choices may seem impossible, yet they are, in actuality, the only options. Berenson relentlessly points out and labels the choice within which the spouses are currently operating. In choosing #1 they will now be doing it overtly and explicitly and will become more aware of their patterns of alternatively coddling and persecuting the alcoholic. In choosing #2, Al-Anon’s concept of detachment can be learned through continuing Al-

14 This is one step beyond second order change (Watzlawick, Weakland, & Fisch, 1974).
Anon involvement. Johnsonian-style family intervention\textsuperscript{15} is another method of achieving Choice \#2 (Johnson, 1986). Choice \#3 may appear at first to be the easiest way out for some yet is probably the most difficult as it requires either that she leave the home or that she insist upon his leaving. If the spouse indicates that she is considering the last alternative Berenson will point out the hazards of this choice and ask "what if" questions (e.g. what if he gets sick and is hospitalized?). Only if the spouse is firmly (and unshakably) ready to make this move would Berenson support her in this decision.

The aim of Berenson's approach is for the non-alcoholic spouse to experience her helplessness and powerlessness as these situations are being repeated and clarified: "to disrupt the system of small 'h' hope in favor of large 'H' HOPE" (Nov. 2, 1984). This can be interpreted as follows: Berenson notes that a wife's indefatigable efforts to manage or control her husband's drinking signify that she has hope. That is, if she is smart enough or if she and/or the children are perfect enough he will change. This belief system keeps her from the awareness of her powerlessness concerning his drinking which is necessary for "hitting bottom". It is only in hitting bottom that recovery can occur. Thus recovery is HOPE. As the logical consequences of each of the Berenson choices are traced, "surrender to powerlessness" eventually must occur and this may take the form of acceptance of Al-Anon.

Other elements of Berenson's approach include his model of the feelings uncovered (from anger to hurt to fear) as the therapist works with the spouse toward the qualitative shift into powerlessness and beyond. See

\textsuperscript{15} This method is described briefly on pp. 62-63.
Appendix D for visual representation of these concepts. Berenson's technique of presenting the three choices was used for the systems-oriented group in this study.

**Wegscheider-Cruse's Survival Roles.** Sharon Wegscheider-Cruse is a practicing family therapist who was among the first to conceptualize alcoholism as a family illness from a whole system perspective. Trained by Virginia Satir, one of family therapy's "great originals" (Hoffman, 1981), her model is growth-oriented and is also grounded in communication theory highlighting *rules* and *roles* (Satir, 1967). While Wegscheider-Cruse has tailored the model for application to chemical dependency she has not substantively deviated from Satir. She has, like Satir, integrated more spirituality into her practice as more families in later phases of recovery express the need for deeper meaning in their lives and a sense of inner peace. By her most recent work, *Choicemaking* (Wegscheider-Cruse, 1985) she shows quite clearly that she has incorporated AA and Al-Anon ideas about higher power, prayer, meditation, and spiritual growth into her own belief system.

While at Johnson Institute (Minneapolis), a growing firm which specializes in consultation, training and disseminating information (films, publications) about chemical dependency, Wegscheider crystalized her ideas about "the illness of co-dependency" and the various forms in which it manifests in various members of an alcoholic system. Training seminars in early intervention, treatment and recovery methods incorporate her

---

16 Just as Al-Anon and AA are always cautious in distinguishing between spirituality and religiousness, the writer also points out that spirituality is not used to denote organized religion.
conceptualization of the family system effects of alcoholism. She describes "survival roles" which protect family members' feelings as they adapt to the dysfunctional behavior of a spouse, parent, sibling or offspring who is addicted to alcohol or drugs.

The roles she describes are those which emerged in her own clinical practice over the years. While Wegscheider-Cruse's name has become a household word in the alcoholism field, she is not cited in scholarly publications or in refereed journals; her model has not been tested empirically or, if it has, this has not been published to date.

Six roles are described by Wegscheider in her family illness model of alcoholism. See also Appendix E "System Dynamics of the Alcoholic Family".

1. The Chemically Dependent Person

This person can be addicted to alcohol or to other drugs or a combination of drugs and alcohol. He or she develops a unique defense system to protect the painful storehouse of repressed feelings. The alcoholic's behavior or the outer "wall of defenses" (Johnson 1980) and the inner core of feelings is depicted for each role. The major point is that each role's behavior is incongruent with how he or she feels so that messages are usually communicated from a double level position.

2. The Chief Enabler

This role can be played by a spouse, a parent or even a close co-worker if there is no spouse. It is the person who is closest and most depended on by the alcoholic. This role provides responsibility to compensate for the dependent's increasing dysfunction. This person
attempts to manage or control the drinking person's life, especially his drinking. Enabling behavior is habitual and will endure separation.

3. **The Family Hero**

This role is usually played by the eldest child, especially a daughter. This is the person who sees and hears what is happening and takes responsibility for the family pain by becoming over-functioning, parentified, successful, popular, etc.

4. **The Family Scapegoat**

This role is often played by the second child or a middle child who cannot compete with the "hero" but can get attention by deviant behavior, running away or otherwise rejecting the family. This role "takes the heat off" of the alcoholic and the marital conflict.

5. **The Lost Child**

This is often played by a middle child who quietly and unobtrusively withdraws from the family system. He can compete with neither the "hero" nor the "scapegoat" for positive or negative attention. So he therefore opts for no attention. This is painful isolation rather than contented aloneness.

6. **The Family Mascot**

This role is often taken on by the youngest child who absorbs family tension while not having the information about what is happening. This person provides "comic relief" using humor and "cuteness" to cover his pain.

Wegscheider's workshops begin with a didactic presentation of her conceptual framework aiming to convey certain basic concepts about family-systems thinking as well as the family disease concept. She follows this by a fairly detailed explanation of the survival roles and engages in dialogue
about how the model all fits together inclusive of assessment, treatment, and recovery. The healing process of "family restoration" (Satir uses the term "reconstruction" which is very close) is the final stage of this work. This includes dramatization of family of origin roles in a supportive and affirming group process hopefully resulting in a sense of freedom to make new choices as old issues and old roles are left behind. The family-systems-oriented group approach will include a didactic presentation of the survival roles with discussion. The group will be encouraged to relate these to their own family of origin and family of procreation.

Also developed by the Johnson Institute and described by founder Vernon Johnson (1973, 1980) as well as Wegscheider (1981) (and later many others), is the procedure known as intervention. Designed for families where the drinker denies that alcohol is the problem, the process consists of a group confrontation with the alcoholic member. Several preparatory sessions are held with non-alcoholic members of the family and other key persons in the drinker's social system. Concrete data is gathered and carefully (and caringly) written up by each person; then it is edited by the therapist to ensure that it demonstrates concern rather than blame. Concurrently a treatment plan is developed and arrangements for entry are made, including transportation, luggage, health insurance clearance, and work clearance, if necessary. A "dress rehearsal" is held to smooth the rough areas, to discuss strategies for counteracting resistance and to reinforce each participant's sense of confidence and "rightness" in the procedure and their own part in it. When everything is in readiness, the meeting with the alcoholic is held. As each person presents him with the negative
consequences of his drinking, the alcoholic’s denial begins to erode. The intervention session ends when the alcoholic agrees to accept the family’s treatment plan or when the family accepts his refusal to do so.

Recall that an alternative method (besides Al-Anon involvement) for emotionally detaching (Berenson’s Choice #2) is the Johnson-style intervention. Berenson believes that the therapeutic element in the Johnsonian confrontation is that it requires detachment from the problem in the literal sense. It involves a refusal to continue “enabling” and a facing of reality. The family-systems-oriented teaching/counseling program will include an explanation of the intervention process.

**Milan Circular Interviewing.** There are very few published reports of applications of the Milan Systemic Model specifically with alcoholic families (Kimball, Healey, McIntire & Smith, 1982; Miller, 1983a & b; Wright, Miller & Nelson, 1985). Two other unpublished manuscripts have been submitted for publication (Lewis, 1986; Miller, 1984). Dr. Bella Borwick was introduced to the writer by Dr. Cecchin, one of the four Milan Associates, (Selvini-Palazzoli, et al., 1978), as one who has had considerable experience in applying the Milan Systemic Model to alcoholism. In particular, her way of using circular interviewing (also called circular questioning) with alcoholic families is relevant for this study. Circularity is the main concept of the Milan model that will be applied (along with Berenson and Wegscheider techniques) in sessions for the family-systems-oriented group. The Milan Model as practiced by Borwick is presented here based on several personal interviews

---

17 Borwick and her former colleagues at the University of Louvain Department of Psychiatry in Brussels are in the process of translating some of their writing for publication in the US.
with Dr. Borwick and one seminar which she presented in Boston where she now resides.

**Circularity** is one of the three basic concepts of Milan therapy which the team of four described as indispensible to correct interviewing of families (Selvini-Palazzoli, et al., 1980). The others are **hypothesizing** and **neutrality**. "Neutrality" is relevant because the writer has studied and patterned her interviewing style with families on descriptions and observations of Milan style neutrality; hypothesizing is not particularly relevant for this study. The remainder of this section will address only circularity as the underlying rationale for circular interviewing. Not all of it will apply when used with groups other than families. Obviously, certain advantages of this technique will not be as great with non-family groupings. For example, a family has through their mutual history evolved systems of meaning and patterns of interaction based on unspoken rules which will be much more developed than a group of unrelated persons who have no particular emotional ties.

"By circularity we mean the capacity of the therapist to conduct his investigation on the basis of feedback from the family relationships and therefore about difference and change" (Selvini-Palazzoli, et al., 1980, p.8). Karl Tomm (1984) helps us to understand further. A goal of the therapist is to look for the circular processes in the system of concern. Assuming the position of observer he is guided by the general question "What is happening in this family?" Specific questions are formulated to bring out this

---

18 E.g. "respectful curiosity", "positive connotation" of all family behaviors, joining with the whole system not individuals.
information. The questioning occurs in incessant patterns without answers from the therapist. The attitude of respectful curiosity, of not knowing and of exploring spreads from the therapist to the family. The therapist's questions trigger family members to release new information into their own and each others awareness. Depending on therapist intent questions may be descriptive (to try to understand the system) or reflexive (to facilitate therapeutic change) or both. Family member reactions to questions asked are continually monitored and questions are modified to maintain neutrality (Tomm, 1985). Boscolo (1984) states in relation to circular questioning "Everything that happens is information on which will have an effect on someone (and is a statement to someone)".

Exploration of differences is the theoretical basis for circular questioning. "Difference always defines a relationship between whatever categories, phenomena or entities that are being distinguished. This relationship, in turn, is always reciprocal and hence is always circular (Tomm, 1985, p.11). Systemic thinking and particularly Bateson's writing (1972 and 1979) heavily influenced the Milan team in elaborating the principle of circularity.

There are many categories of circular questions including before and after questions, difference questions, hypothetical questions, future-oriented questions, explanation questions and interaction-centered questions and probably others. An example of a before-and-after question might be "How are things different between you and your husband since you have been attending Al-Anon?" A difference question might be "Who in your family of origin is most worried about you in your home situation?", "Then
who?" (the latter can also be categorized as a rank order question).

Interaction-sequence questions would ask how each family member reacts to a particular symptom or behavior (perhaps drinking in this context). An explanation question might be "How do you make sense of his acting so agreeable when you got home?"

Borwick (1985) believes that "the real magical part of the Milan Model is circular interviewing" (personal discussion). With alcoholic families circular questioning may revolve around the family's responses and interactions related to the alcoholic member's drinking (Who does what when Dad starts drinking? Who notices first? Who gets most upset? Who else worries about this?). She will also look for social metaphors: the meaning that alcohol has for the system. The larger context is explored: Who in your company is best able to protect you? What would you need to do to get fired from your job? Would your boss be happy or sad if you ___? and similar content. Other future-oriented questions might relate to the meaning of sobriety for the system: Who would be happiest if Mom were to stop drinking completely? Then who? Who would be most effected? What are you going to find most difficult when your husband comes home from the Detox center? Thus Borwick adds to our understanding of circularity as it is applied to some common issues related to family drinking problems.

As indicated, a major modus operandi in the family-systems-oriented groups in this study was circular questioning. There were two levels or contexts to consider in this respect: one was at the level of the group itself and a view of the group as a system where questions of difference were asked of and about group members. The other level was the family of which
each of the wives is a member. The investigator attempted to use several types of circular questions to bring forth information and news of difference for both levels of systems. Neutrality was also maintained as Borwick describes including neutrality concerning Al-Anon attendance and husbands' sobriety. Positive connotation of behavior, curiosity, respect, not taking sides, joining equally with every member of the group were some of the ways in which neutrality was maintained.

Summary of the Chapter: Review of the Literature

In summary, this section has selectively reviewed written and oral presentations of philosophies, theories, and techniques which are the framework for the present study. These emanate from the field of family therapy in general and from three therapists' application of family therapy models in particular. Additionally, selected documents from the discipline of nursing were reviewed. The latter gave more than ample justification for the premise that nurses can and should provide such primary care to wives of alcoholics as was undertaken in this study.

The present study differs from other work found in the search of the literature not only in its particular manner of combining three family therapy approaches but also in its manner of defining success in alcoholism treatment in terms other than reduction in the husband's drinking. Al-Anon attendance and decreased use of survival behavior are seen as indications that the women are making gains toward improved functioning and serenity despite a potentially stressful home situation. The treatment given to wives of alcoholics in this study was not considered as an adjunct to the treatment of alcoholic husbands but as a primary care effort for wives in
their own right. A philosophical preference for therapeutic neutrality concerning the woman's choices and a non-blaming, understanding of their circumstances were ideals which this study sought to uphold.

The following chapter presents the details of the methodology for the current research. How the sample was obtained, how the groups were formed, procedures, instrumentation, and the two group teaching/counseling approaches are described. Finally, the method of data collection and analysis are delineated.
CHAPTER III
METHODOLOGY

Overview

Twelve self-identified wives of alcoholics were the subjects of this research project in which the effects of two separate treatment approaches were evaluated and compared. Ability to change ineffective coping behaviors and increased use of Al-Anon were the outcomes examined for both groups.

The context was identical for both groups: a group therapy setting consisting of six women with a therapist (the researcher) and an observer (trained by the researcher). The location was identical for both groups as all sessions were held in the same conference room of a visiting nurse agency centrally situated in the region for geographic convenience.

One group received a family-systems-oriented approach and is referred to as the family-centered program. The other group received a more individual person-focused approach which is more like what has been traditionally offered in alcoholism treatment programs. The latter is referred to as the person-centered program.

Differing combinations of didactic teaching, group-counseling, and selected family therapy techniques were applied for each of the two programs. However, the basic structure and format was the same for both groups. Six two-hour sessions spanning 6 consecutive Thursday evenings were preceded by an individual intake interview with each candidate. Screening procedures and delineation of the specific content and approaches used for each group are described in this chapter.
Research Design

This study is a descriptive analysis of two groups both receiving some type of intervention; due to ethical considerations a "no treatment" control group was not considered19. Wives' baseline use of "survival behaviors" and Al-Anon attendance were the variables for analysis.

Research Questions

1. Is there a difference in the use of survival behaviors between wives of alcoholics who have received a family-systems-oriented teaching/counseling program and those who have received a person-centered teaching/counseling program?

2. Is there a difference in Al-Anon attendance between wives of alcoholics who have received a family-systems-oriented teaching/counseling program and those who have received a person-centered teaching/counseling program?

Besides survival behaviors and Al-Anon attendance, other self-reported data which informally emerged in group sessions were also noted with the assistance of a non-participant observer/demographer. Such subjective information as new insights about alcoholism or an increased feeling of relaxation or signs of improved health were written in the form of case notes each week immediately after each group session.

Sample

This study was limited to the female spouses of alcoholic men. One reason for this limitation was the researcher's particular interest in the

19 The researcher considers it unethical to subject troubled women who come forward for possible solutions to their problems even to the temporary discomfort of a pretest and posttest without offering any assistance or potential benefit.
health problems of women generally and those related to alcohol and drugs in particular. As a group, wives of alcoholics are especially vulnerable to negative criticisms and generalizations concerning their role in their husband's illness. Their needs have been largely overlooked by society, and health professionals are no exception. Another reason for this limitation was to control for the extraneous variable of gender which might have accounted for outcomes as readily as the interventions of the study (especially because of the small size of the sample).

All clients who are wives of actively drinking alcoholic men and met the criteria for selection were considered as potential subjects for this study providing they were not members of Al-Anon; did not have a drug or alcohol problem of their own; and were not currently receiving psychotherapy of any kind. Also, all were to be currently involved in the relationship with the alcoholic partner living in the same household.

A non-probability sampling technique was used to obtain potential subjects for this research project. Many sources were tapped in attempting to obtain the sample: local substance abuse treatment agencies, mental health agencies, private counselors, clergypersons, local newspaper ads, community bulletin boards (including those on T.V.), posters placed in supermarket and laundry areas, and word of mouth.

Although the majority of subjects were expected to come from the local substance abuse treatment agencies not one referral was so obtained. Persons in each of several large public community alcoholism treatment

---

20 Husband's abstinence of shorter than three months duration was considered acceptable for this study.
agencies in Western Massachusetts were contacted by letter, phone and in person. Private agency personnel were also sent letters requesting referrals. The only geographical boundaries were the subjects' ability to travel to the location of the group sessions. The majority of referrals were word of mouth contacts from friends and former clients. Lists of the various recruitment phases and the agencies and personnel contacted in each phase can be found in Appendix F.

Problems in Obtaining the Sample. The designed method of referral from agencies was as follows: During the usual intake interview or at an initial assessment phase of counseling, an agency person would have presented a prepared statement saying that a nurse/family therapist specializing in alcoholism was forming groups to teach and counsel concerning the effects of alcohol on families and was also conducting a study to evaluate her approach. Interested clients would then have been interviewed at the agency. If they did not agree to participate their treatment at the agency would not be affected. If they did agree they would sign an informed consent form (Appendix G). This approach met with difficulty due to the federal confidentiality laws governing release of information by drug and alcohol treatment personnel. Other approaches were subsequently agreed upon by various agencies; however, none resulted in referral to the study despite many assurances of willingness and ability to locate such clients. In some, but not all cases, referral to the study may have been viewed as loss of a client to the agency or private therapist and therefore loss of revenue.
Random assignment of subjects to the two groups was planned as follows: As the first eligible and consenting subject was "enrolled" she would be assigned to Group A. The second would be assigned to Group B and the third to Group A, etc. This alternating assignment process would continue until there were 14 eligible clients capable of convening for a given time frame. The toss of a coin would determine which group receives which teaching/counseling program. This could not be carried out. After 4 months of concentrated recruitment activity, with awareness growing that the first two interviewed clients had been waiting three months, it was decided to form a single group of the eight clients. The toss of a coin determined that this group, Group A, would receive the family-oriented program. Group B, still to be recruited, would receive the person-centered approach.

An initial interview was held with each prospective subject during which she was asked to sign the informed consent form (and to complete the three brief screening tests). The consent form was simple and concise and ensured that anonymity would be maintained (See Appendix G). A commitment to all six sessions was sought; however, each woman was aware throughout that she had the option of withdrawing at any time.

Although a few potential clients were informally screened out in the initial telephone contact (e.g. because they were already active in Al-Anon or were not currently living with their spouse), no clients were screened out by the researcher because of the intake instruments or interview. Three eliminated themselves from the study, one after attending $21/2$ sessions.\footnote{This woman came to one session more than one hour late.}
and two reneging within a few hours before the first session of Group A. Reasons given for not participating were inconvenient meeting time, or lack of child care. In these cases the offer of an Al-Anon contact and/or a treatment referral was made but refused.

For reasons previously stated the researcher recognized that this would not be a readily obtainable sample. However, the extreme difficulty obtaining referrals even from agencies where strong connections had been made over many years was not anticipated.

**Instrumentation**

At the first session of both teaching/counseling programs the women were given the pretest. The Spouse Survival Behavior Scale, a scale developed by the present investigator (This and all other instruments can be found in Appendix H). Al-Anon attendance information had been obtained at the intake interview. At the final session both groups were retested with the same instrument as was used for pretesting and they were again asked about Al-Anon attendance during the research time period. Approximately one month after the initial contact each of the women were contacted by telephone and again asked the frequency of their Al-Anon attendance. The same procedure was repeated at the end of two months.

**The Spouse Survival Behavior Scale**

As stated, this instrument was used both pre and posttreatment as a measure of client improvement for both groups. It was assumed that if the teaching/counseling programs were effective this instrument would give

---

22 One of the two women later agreed to be in group B.
evidence in the women’s self-reported decreased use of certain ineffective but typical behaviors.

The Orford-Guthrie Scale of Maladaptive Coping Behaviors (1975; Orford and Edwards, 1977) was considered for use as the major instrument for this investigation. However, this idea was abandoned for several major and minor reasons. Minor reasons included certain semantic problems arising from the British origin of the instrument (e.g. two questions were worded “Have you had rows with him about...?”; another asked, “Have you consulted a solicitor or advice bureau about...?”). More important however, were the present researcher’s misgivings about the instrument’s blaming tone. The connecting of the wives’ “maladaptive coping behaviors” with the husbands’ drinking outcomes presented an area of concern that could not be overlooked by the present investigator in that it tends to place the responsibility for “fixing” the husbands’ problems on the wives.

Even more disconcerting were problems found in Orford and Guthrie’s interpretation of some behaviors as maladaptive which this investigator considers adaptive; for example, “contacting AA” or “making special arrangements about money matters”. This necessitated a substantial change which led ultimately to the recategorizing and relabeling of the cluster. From Orford and Guthrie’s 10 “components”, some of which had ambiguous and overlapping labels, were synthesized 6 mutually exclusive “clusters” with what the present researcher considers more self-explanatory labels.

The basic format and structure of the Orford-Guthrie scale was retained but the instrument was so radically overhauled that it will be treated as a new scale. With all due credit to those who devised the original,
of which this might be considered a "spin-off", the Spouse Survival Behavior Scale was devised. Many items from the original scale were included; others were revised and included; many were omitted; and many new items were constructed.

No claim can be made concerning content validity as no written objectives or domain specifications were drawn up as criteria for inclusion of items. However, other careful steps were taken to ensure comprehensive coverage of the full range of behaviors typical of wives of alcoholic husbands. This began with a search through a large number of lay and professional publications on the topics of "enabling", "enabling behavior", and "co-dependency".

Al-Anon pamphlets comprised a large segment of this material; Hazelden publications and Johnson Institute publications constituted other large segments. It was found that all sources tended to mix behaviors, feelings, attitudes, signs, symptoms, character traits, etc. Behaviors were distilled from the mixture for this scale. Natural clustering was sought and seven clusters were settled upon (for the first round) after considerable switching and reclustering.

The term "survival behavior" was adopted to avoid negative labeling (such as "maladaptive coping" and even "enabling"), and to avoid taking sides in the "co-dependency" controversy. This term also seemed fitting as it is congruent with the language of Wegscheider-Cruse's description of survival roles. Each of seven clusters was given a double title to cover a certain variability or range of behaviors considering their connotation or
intensity of meaning. The scale at this stage had a total of seventy items (behaviors) which were roughly evenly divided among the seven clusters.

**Pilot Procedure.** A panel of experts was called together to review and refine the Spouse Survival Behavior Scale. This panel consisted of the researcher and three other nurses who have not only worked in the alcoholism field but who have been Al-Anon members for many years (the range of years in Al-Anon was 12-18 years). The panel's task was to review the scale for 1) congruency with their experience and knowledge base; 2) appropriateness of clusters, logical typing within the category, no overlapping or redundancy; and 3) overall sense of "fit". In this process wording was changed, a few behaviors were eliminated, many behaviors were added, two clusters were merged into one, and one cluster was renamed but not changed substantively. A total of 88 items were now less evenly divided among the six clusters. Consensus was achieved and a sense of fit was unanimously verbalized. Face validity was thus established to the researcher's satisfaction.

To further pilot the instrument, a trial was carried out with three Al-Anon members who are wives of alcoholic men. Each of the panel administered the scale to one Al-Anon volunteer under strict confidentiality. The expert remained with the subject while the test was being completed in order to observe and record verbal and non-verbal data about the subjects' reaction to the scale. Without looking at the test responses, the expert mailed it directly to the researcher with no identifying data.

No problems were noted by the experts. Comments made by the volunteers who took the test were largely expressions of realization that
they had made some changes away from their former "crazy behavior". The
test was then passed on to an expert in psychometric testing. Some changes
were made based on the consultant's feedback: Closely similar responses
were either eliminated or combined into one statement. Additionally, the
frequencies for the four choices were clarified and some redundant language
was eliminated. Based on the combined findings of the pilot testing and the
advice of the expert, the tool and instructions were further refined and made
ready for use in the study. Reliability testing done on the combined sample
of 12 wives using Cronbach's coefficient to estimate internal consistency
gave the encouraging result: alpha= .86.

Intake and Screening

A face-to-face interview was arranged with each candidate prior to
the formation of the groups. At this interview, non-identifying demographic
data was obtained which encompassed information about previous treatment
including Al-Anon attendance. The research project was briefly explained
using written guidelines for uniformity of information across subjects. Upon
assurance that she understood what would be involved, the subject was
asked to read and sign the informed consent sheet.

After the consent was signed by the client the screening tests were
administered. These were three brief tests popularly used in the alcoholism
field. In this study they were used to determine the stage or extent of the
spouse's alcohol problem and the degree of marital dysfunction and
psychosocial complications related to the drinking. If a client's scores would
have fallen too far to the extremes of these tests (as delineated for each test)
she might not have been included in the sample. The researcher reviewed
each client as to eligibility or non-eligibility. A rationale is provided separately for each test in the descriptions which follow.

**The FCEA (Family Counseling and Education in Alcoholism)**

**Family Alcoholism Scale** (Howard & Howard, 1978) is a 20 item test requiring simple "yes" or "no" answers. Although this scale has been popularly used by alcoholism treatment programs, it was not found in the research literature by this investigator. Sample questions include "Do you worry about your spouse's drinking?" "Does your spouse avoid conversation pertaining to alcohol or problem drinking?" "Do you ever feel guilty about your spouse's drinking?" The authors state they "have worked with hundreds of families" over ten years and have based their scoring on these experiences. A yes score of two is considered "warning that a drinking problem may exist in your family". A yes score of four means "The chances are that a drinking problem does exist in your family." A yes score of five or more will be the criterion for inclusion in this sample. The interpretation for this is "there very definitely is a drinking problem in your family".

**The Spouse Hardship Scale** (Orford & Edwards, 1977) is a nine item test of one or two line statements requiring "yes" or "no" answers about recent behaviors of the spouse. This scale has been widely used in studies of wives of alcoholics. It was designed to reveal the level of conflict or abuse present in the relationship and hence the degree of stress on the non-alcoholic spouse. Questions range from "Does he sometimes let himself get dirty, unkempt, or smelly?" to "Does he ... break furniture (or windows, or doors, or china)?" No cut off score was determined for this; however, if a determination had been made that serious risk of abuse or violence was
present the client would be referred to counselors (known to the researchers) who specialize in family violence or back to their agency counselor. Extreme cases would not have been included in the study because this could tend to focus group interaction on one or two clients. (The internal reliability of this scale was reported as .76 by Orford et al, 1975; and .75 by Zweben, 1986.)

The Revised Marital Relationship Scale (Azrin, et al, 1973) is a 20 item test of one line statements which require "true" or "false" answers. Positive and negative situations are included. Such statements as "My spouse and I spend time together just having fun" and "I am generally happy with our sex life" contrast with such items as "We're like a couple of strangers living in the same house" and "My spouse doesn't care when I'm upset". If a client had scored extremely toward the "happy" side with little of the "unhappy" aspects to balance she might not have been included in the study as neither teaching/counseling program would have been likely to improve her coping ability. In such a case, questions would have arisen of the following nature: 1. Is there really a problem? 2. Is there an extreme degree of denial? 3. Is the client also a chemically dependent person? 4. Is there other severe psychopathology? To minimize such confusing variables those who test at extremes on this and other screening measures would have been screened out. Zweben (1986) estimated internal consistency reliability on this scale as ranging from .80 to .93.

Clients/subjects were asked about their own drinking patterns and their use of mood altering drugs of any kind; prescription drugs, over the counter drugs, or recreational drugs. While it is possible that there were
dishonest answers, the researcher has no reason to believe that any of the women in the study had any alcohol or drug problem themselves.

The Teaching/Counseling Programs

It had been expected that both groups would begin in the same week and would be scheduled so that the weekly two-hour sessions would match as closely as possible and be completed within days of each other. This attempt to minimize any differential effects due to external regional or world events was not possible to carry out due to the problems recruiting subjects in a timely fashion. Thus, one group met on six consecutive Thursday evenings from 7:30 to 9:30 p.m. and the second group began in the same time slot the Thursday after the last session of the first group (ie. the groups ran back to back encompassing 12 consecutive weeks).

Appendix I Summary of Teaching/Counseling Programs: "Wives of Alcoholics" provides the topical content outline for both groups in side-by-side format so that they can readily be compared.

Sessions one and six were identical for both groups as were all three follow-up telephone contacts. The women received the differential content during sessions two, three, four, and five. Session one was concerned with introductory material such as an "ice-breaking" exercise and "tone-setting" work promoting confidentiality, relaxation, and trust. The first session ended with the pretest (survival scale). Session six was concerned with terminating exercises. The posttest (survival scale) was administered and the groups were asked to evaluate the sessions first as a group and then

23 The researcher relied upon her expertise in addictions counseling to make these determinations.
individually in a brief written format asking "Is there anything you would like to add to the evaluation of these sessions that you did not wish to share in the group?"

**Sessions two and three** were primarily teaching sessions with some discussion. This is where the person-centered group received the basic content about alcoholism as a disease. How it effects families was presented from an Al-Anon point of view using films and literature from these organizations (but also from other sources) which focus upon individual family members and which encourage Al-Anon attendance as a way of learning more about the problem and of learning to detach from the problem. How to help children to do the same was also part of this presentation. To maximize treatment fidelity (e.g. to avoid overlapping with the systems-oriented material) the researcher stayed fairly close to formal materials such as pamphlets and the content of the films. The researcher relied upon an assistant to silently observe every group session and take notes on her observations of group process and especially any areas of contamination. In both groups, the women were asked to share with each other how they see themselves and their families in relation to the material presented.

In sessions two and three, the family-centered group received content which matches the above described material. However, the focus for this group was on the family system and how the family system becomes dysfunctional as alcoholism progresses. The Wegscheider "survival roles"

---

24 This material was analyzed immediately after each session. The major part of it became the case notes on individual group members and a small part became the brief summary statement about the group as a whole. No contamination was discovered.
were presented along with a description of a way in which families can intervene using the Johnson Institute approach. Berenson’s choices were presented and discussed in relation to participants’ present situations. The women were asked to share with each other how they see themselves interacting with their spouse at this time based on the material just presented. The researcher used Milan-style circular questioning as often as possible in the family-centered approach.

**Sessions four and five** were primarily group counseling sessions where clients shared their personal stories. The women were encouraged to provide feedback to each other concerning what they perceived about their situation. The tone for this in both groups was one of caring and gentleness. The facilitator stated this at the outset and tried to role-model a caring attitude.

The person-centered group was led in a straightforward way encouraging group members to ask for feedback from the group as well as to provide feedback. Honest expression of feelings in sharing personal stories and behavior that is supportive and respectful was role-modeled and encouraged. Al-Anon attendance was suggested whenever the opportunity presented itself as a solution to the marital/family problems group members brought forward.

The family-centered group was also asked to share their personal stories in the same way. However, Milan-style circular interviewing was used to explore the interactions of family members. An attempt was made to stay in this mode for a good percentage of the time especially in sessions four and five. However, the group members were not cognizant of this
technique and interacted with each other in their own style. The facilitator then came back to Milan-style questioning whenever the opportunity presented itself. As personal stories unfolded the group was led to question where each woman is at present in relation to the three Berenson choices. Such questions as "who in the group is closest to choice number three today?" and "then who?" and "who is the furthest from it?" also brought the circular questioning inside the group itself as a system. No attempt was made by the facilitator to directly suggest Al-Anon attendance or intervention of any particular kind except as presented in the Berenson model.\(^\text{25}\)

No referral for treatment was requested by clients although interest in Johnsonian Intervention was expressed. Attention was paid to ensure that no woman in either group was left in an emotionally precarious status at the end of the research project. Clients were invited to telephone the researcher if they wished. The group members also exchanged addresses and telephone numbers with each other (this was initiated by the participants).\(^\text{26}\) In the follow-up telephone contacts direct inquiry was made about emotional status. At the last telephone encounter the facilitator offered each client the potential for future contact free of charge if she finds it necessary. (This would be for two or three sessions or until a satisfactory referral can be arranged.)

\(^\text{25}\) The Berenson model includes Al-Anon attendance as one of the choices as will be described in the next chapter.

\(^\text{26}\) Although this could suggest clients' perceived need for ongoing group support at the conclusion of the sixth session, the follow-up telephone calls revealed no actual contacts were made.
Data Collection

Each of the three screening tests were scored by hand and the scores were interpreted as suggested in the key(s). The small sample size and the simple and brief nature of these tests did not require complex scoring procedures. The pretest Spouse Survival Behavior Scale was scored by computer to obtain total scores and 6 subscores (one for each cluster). This was repeated for the posttest and the results were compared.

The data from all tests was then entered on 5 X 7 index cards which are on file; one for each client. Each card contains all of the research data to be analyzed concerning one client. It includes most of the demographic data from the intake form, the scores from the screening tests, and the pre and posttest scores and subscores. Appendix J includes the format of the 5 x 7 data cards and the intake form.

The researcher and her assistant also recorded remarkable comments of clients and general impressions of their progress immediately after each teaching/counseling session. These evolved into weekly "case notes" kept on each client and on the group process as a whole. This essentially anecdotal and sporadic information intended to informally enhance the test data and to help determine the need for ongoing counseling became the more formal entity of "the qualitative data".

Another smaller data component was informal group and individual evaluation of the teaching/counseling programs by clients. This data was also somewhat sporadic as no written format was provided to clients. In

27 Some items will be stored for future use when accumulated data from ongoing additional groups would warrant further statistical analysis.
open forum the group was invited to discuss the strengths and limitations of the program. Then each client was given a blank sheet of paper and invited to write, if they wished, any further comments.

Finally, item analysis of spouse survival behaviors was carried out using a small index card for each behavior and noting the number of times in the pre and posttest each choice was checked by members of group A and members of group B (separately). This data will be stored for later analysis of the scale and to assist in developing and refining the scale and in establishing reliability and validity.

**Data Analysis**

**Analysis of the Spouse Survival Behavior Scale**

The pretests and posttests were computer scored for Group A and Group B. The total instrument and each subscale (cluster) were scored separately by summing the responses; the greater usage of survival behaviors was reflected in higher scores (and thus less effective coping) for the total instrument and for the subscales. Thus, the wives who were coping least effectively would have the highest scores, and conversely, those who were coping more effectively would presumably have lower scores.

The mean and standard deviation, were computed for the pretest and posttest score from Group A and Group B. For each group, the differences in the means between pre and posttests were then calculated. A "t" test statistic was used to determine the significance of the differences between the pre and posttest means. T values were obtained for the total instrument and the six subscales or clusters.
The qualitative data was then analyzed. The case notes written by the researcher, with the demographer, immediately after each session provided impressions of individual and group reactions to the material being discussed. These notes and other informal data were read several times. The first reading was for obtaining an overall sense of the storyline presented by each client’s case. The next reading functioned to identify any recurring themes within each client’s story. The third reading was to identify any themes across two or more clients.

The themes relating to the six clusters of behaviors were first isolated as were the themes relating to the three Berenson Choices. These data were not particularly useful as there were no unifying results. Continuing in iterative fashion however, other themes and patterns were discovered at a higher level of abstraction. These were more interconnected with each other as well as overarching to both of the teaching/learning approaches. The two new themes were “denial” and “detachment”.

In this process the investigator was assisted by the demographer who had been present at all twelve of the two-hour group sessions. This not only lent another perspective to minimize the effects of idiosyncratic bias of the researcher but also permitted additional input from an “inside” position of knowledge of the context of the experiences reported in the case notes.

Contextual analysis of the wives’ experiences as described by Belenky, Clinchy, Goldbey and Tarule 1986, p. 16) was attempted and a system of color-coding was devised to highlight three gradations of denial and three gradations of detachment. A different color overliner was assigned to each
of the 6 gradations (see Table 3.1). From this process evolved two polarities each with a middle segment as follows:

1) **detachment vs. overinvolvement** which might also be called differentiation vs. undifferentiation as per Bowen (1978); however the researcher wishes to retain the word detachment and all that it connotes in the Al-Anon usage. This was coded red at the detachment end, orange in the middle, and yellow at the overinvolvement end of the continuum.

2) **acceptance vs. denial** which might also be called ego-surrender vs. ego-inflation as per Tiebout (1954); this was coded lime at the acceptance end, green in the middle, and blue at the denial end of the continuum. From the color-coding system a picture of each subject’s progress from beginning to end of the six weeks was obtained.

After the color-coding process was completed the case notes were sorted by the researcher and the demographer searching together for an overall indication of color changes from the more negative ends of both polarities toward the positive ends. As this data did not represent a totality of interaction of any type (e.g. as would be the case of a transcribed whole interview or text) there did not seem to be a way to quantify or weight the case note colored segments. Counting lines of yellow, blue, or green would avail us nothing.

Looking only at the first page of notes which encompassed (on the average) notes from two to two and one half sessions, the 12 case note packets were sorted into "high" - "medium" - "low" piles; "high" indicating
Table 3.1  The Two Polarities

THEME I

OVERINVOLVEMENT                     DETACHMENT
(negative)                           (positive)

Undifferentiation of self
Obsessed with husband and his drinking or his abstinence
"He", "we" statements
Reactive to others' lives
Stuck in "survival behaviors

Self-differentiated (Bowen, 1978)
Focused on self; responsible for own happiness
"I" statements
Proactive in own living
Unwilling to accept blame or abuse

THEME II

DENIAL                                   ACCEPTANCE
(negative)                               (positive)

Denial of facts
Denial of conclusions
Denial of implications
Denial of feelings
Avoidance of reality
Conscious distortion

Not responsible for husband's disease or recovery
Recognition of disease as primary, chronic, progressive
Recognition of family disease
"ego surrender" (Tiebout, 1954)
the more positive or effective ends of both continuums and "low" the negative or ineffective ends. Still at a loss for what inferences could be drawn from this material, the piles were rank-ordered beginning with the "low" end pile which seemed clearest, followed by the "high" end which was still fairly clear, and finally the middle which was what we called the "rainbow segment". A sequential listing was made, lowest to highest, of the case numbers of the subjects. The same process was followed using the last page of each case note packet which encompassed (on the average) the last two to two and one half sessions. Again, a sequential listing by case number was made, lowest to highest.

At this point, the case numbers were checked against the names of the clients to note whether or not the rankings would align with general clinical impressions of client progress. After considerable discussion the researcher and the assistant who had been present at all 12 sessions both agreed that a sense of overall congruence and consistency was present. Nevertheless, at this stage this information did not reveal any particular pattern of support or non-support for the quantitative data.

Again, without deliberate planning but merely out of continued curiosity, it was decided to repeat the entire sorting and ranking process separately for each of the two polarities. Thus rank-orderings for the last two sessions could be compared with rank-orderings for the first two sessions for both the Overinvolvement - Detachment polarity and the Denial-Acceptance polarity. In an attempt to reduce the effects of rater bias, an
outside person was engaged to independently sort and rank-order for both polarities using the identical process.\textsuperscript{28}

Finally, this data was compared with the data obtained from the SSBS. The major purpose of the informal data was to amplify, clarify, and either dispute or verify the findings of the quantitative data.

**Limitations and Methodological Concerns**

The sample for this study includes only women who were essentially ready for help in that they were either responding to ads or were referred by friends or counselors who knew of their marital problems. This limits the generalizability of the study. As an initial project to test the viability of the idea of working in groups with wives of alcoholics to decrease their ineffective coping behaviors, however, the study suits its purpose.

Other limitations of the study include the small size of the sample and the narrow geographical area from which the sample was drawn. These will also impair the generalizability of the findings. The teaching/counseling programs being tested have been refined as much as possible so as to be compact and reproducible for other researchers to replicate. Continuing investigation could provide the significant numbers as well as the geographic distribution needed for broad generalizability.

This study also shares the problems inherent in all research which relies on self-report data; for example, the possibility that responses were biased toward what the subjects believe the researcher expected. Conversely, subjects might have withheld information not wishing to reveal behaviors they consider negative, or that the researcher might consider

\textsuperscript{28} This did not include the color-coding process.
negative. The researcher's interest and belief in both approaches would tend to equalize this effect to both groups however. Simple error variance due to misrecalling or misinterpreting meanings must also be considered as a methodological limitation of this study.

The Hawthorne effect (Borg & Gall, 1983) must also be considered in this context as the subjects were aware that they were participants in a research project. Thus, they might have altered their behavior on that basis alone. Were this the case, both Al-Anon attendance and decreased use of the survival behaviors might be expected in one or both groups.

Another limitation exists in the possibility that personal characteristics or the particular style of the researcher had important effects across both groups. While this was not controlled for in the present study, future replication using different personnel would elucidate this possibility.

There was also the risk of human error in the attempt to keep the two programs separate and distinct in such interactive teaching/counseling sessions. This might have been possible despite the most deliberate planning to avoid overlapping and despite caution and vigilance on the part of the researcher/therapist. The use of an observer/demographer whose role, in part, was to be mindful of this possible error and to note it, minimized this. No gross contamination was identified.

Methodologically, the additional qualitative data collection and data analysis must also be mentioned here, not so much as a limitation since its purpose was to add to and enrich the quantitative data, but as a caution. The more subjective and value-tinged nature of the method of collection of
this data and the imprecise and uncharted course for the analysis affects the
degree to which inferences should be drawn from such findings.

The researcher acknowledges all of these limitations while at the same
time reaffirming enthusiasm for the study. The potential the study holds for
ongoing research-based nursing practice and education remains an
important and worthwhile effort for this investigator.
CHAPTER IV
FINDINGS

Introduction

Data was collected on two groups of women, all wives of alcoholic men who received counseling from the researcher over a twelve week period from February 2, through April 20, 1989. Group A consisted of 6 women who assembled for two hours on six consecutive Thursday evenings (February 2 through March 9) and received a family-systems oriented psychoeducational approach. Group B consisted of 6 women who also assembled for two hours on six consecutive Thursday evenings (March 16 through April 20) and received a person-centered psychoeducational approach. Prior to the groups forming, individual intake interviews were conducted and candidates were screened for their appropriateness for the study.

Description of the Sample

Before presenting the pretest and posttest results for each of the groups, characteristics of the sample will be described. Group A and Group B characteristics will each be presented and then compared with each other.

Group A: Description of the Sample

The six women comprising Group A which received the family-systems oriented approach ranged in age from 25 to 72 with a mean age of 41 and a median age of 32.5. However, three of the six were in their 30's. All of the women were currently married and living in the same household with their alcoholic husbands who were actively drinking at the time of the study. The duration of the marriages ranged from 2 1/2 years to 45 years.
With the exception of one, who was in a second marriage, this was the only marriage for all women.

All of the women in Group A had at least one child; however, this characteristic ranged to as many as six. Two of the women had adult children, most of whom were married and had children of their own. One woman was pregnant with her sixth child. The ages of the children living at home ranged from 2 to 14 years of age with a mean age of 7 1/2 and a median age of 8.

There was a surprising degree of ethnic and cultural diversity considering the small size of Group A. Of the six participants, two were not American born or bred and were still having difficulty with the English language; one of these women was French born; the other was a Cambodian refugee. One woman was first generation Polish-American; the three remaining women had mixed ethnic backgrounds including French-Canadian/German, Ukranian/Irish, and German/French/Irish. The predominant religion of all of these women was Roman Catholic, comprising four of the six. The remaining were Protestant, one of whom had converted from Buddhism.

A modified family of origin genogram done at the intake interview revealed that all but one of the wives had a family history of alcoholism. In these histories, which encompassed 3 and in some cases 4 generations, there was at least one blood-line relative who clearly could be identified as an alcoholic by the respondent. In the majority of cases several alcoholic relatives were identified in the sibling subsystem and/or parental and/or
grandparental subsystems. Nearly identical configurations were seen in the family of origin genograms done for their husbands.

Four Group A wives held regular full-time jobs outside the home; one of these would be considered a blue collar worker; the remaining two were homemakers. The husbands presented a similar profile but not necessarily matched to the wives' employment status. The husband who held a professional position is now retired; four out of the five remaining were employed in blue-collar positions. The sixth husband had lost his job due to his substance abuse; however, when employed he was a blue-collar worker.

The level of formal education of the women in Group A ranged from no education to Associates' Degrees. Three of the women fit in the latter category; and two had started but did not complete high school. Formal education data was not obtained for the husbands.

Group B: Description of the Sample

The six women comprising Group B, which received the person-centered approach, ranged in age from 34 to 69 with a mean age of 52 and a median age of 40. However three of the six were in their 30's. All of the women were currently married and living in the same household with their alcoholic husbands who were actively drinking at the time of the study. The duration of the marriages ranged from 4 to 46 years with a mean duration 19 1/2 years and a median duration of 17 years. Two of the women were not in their first marriage; the remaining were.

One of the women in Group B had no children while all other women had children ranging from two to seven in number. Two of the women had adult children most of whom were married and had children of their own.
The ages of the children living at home ranged from 2 1/2 to 18 with a mean age of 9 and a median age of 7.

Group B was also culturally diverse for such a small sample. Of the six, two were not American born and had strong remnants in their speech of foreign language accents. However, their English language comprehension and speech were excellent in both cases. One of these women was born in Poland and lived there until she was 14 years old. The other was born in the Phillipines but came to this country at a young age. All other participants were American born of ethnicities similar to those in Group A, i.e. mostly mixed backgrounds of English, Irish, Scottish, German and French-Canadian. The predominant religion of Group B women was Roman Catholic comprising five out of the six; the sixth was of a Protestant denomination.

All but two of the wives in Group B admitted to having a family history of alcoholism as was obtained in a modified family of origin genogram which encompassed 3 and in some cases 4 generations. At least one blood-line relative (and in some cases many more) was clearly identified as an alcoholic. All of the husbands of Group B women had a family history of alcoholism within the 3 or 4 generation span.

Five of the Group B wives were regularly employed outside the home; one of these in a professional position, the remaining in blue collar work. One of the wives was retired from secretarial/managerial work. The husbands presented an identical profile which is matched to their wives' employment status; i.e. the professionally employed woman is the wife of the professionally employed man.
The level of formal education of the women in Group B was quite uniform in that all of the women were high school graduates. Three of the women additionally had associate degrees and one of the women a trade school degree. Formal education data was not obtained for the husbands.

Knowledge of Alcoholism and Treatment

It became apparent early in the data collection phase that it would be important to consider knowledge of alcoholism as a potential confounding variable. The researcher found that only one of the subjects was completely naive about alcoholism and other substance abuse. From TV and other media or from personal reading and conversation with others, most were familiar with such ideas as: alcoholism is a disease; Alcoholics Anonymous and/or Al-Anon have helped some people; treatment and recovery are available. Most had at least considered attending AA or Al-Anon and 4 of the 12 had attended one or more meetings many years ago but not recently. Even the most slightly informed participant had acquired and read some AA literature during her first husband's stay at a detoxification unit. In order to synthesize a composite picture and to allow comparison, a coarse method was devised to estimate this variable. Levels of knowledge and sophistication of participants about the subject matter of alcoholism (as understood by the researcher and the demographer) have been roughly estimated as follows: Based on a 0 to 10 point scale with zero signifying the least degree of knowledge and 10 signifying the highest possible level of knowledge attainable, each participant was independently rated by the researcher and the demographer. It is recognized that this is a subjective
measurement at best; however, the clinical intuition of two experienced counselors validating each other's impressions was relied upon.

An interrater reliability of 92% has provided a strong measure of confidence concerning use of this method. The researcher is fundamentally aware, however, that this index cannot be considered a true measure of actual knowledge but simply a way to discuss surface level differences between clients in the apparent level of knowledge about this issue.

At the outset of the first of the six group sessions, Group A wives' scores ranged from 0 to 3: one was scored at 0; two were scored at 2; and two were scored at 3. None were scored above this. At the outset of the first of the six group sessions of Group B wives' scores ranged from 1 to 3: two were scored at 1; one at 2; and three at 3. None were scored above this.

Group A and Group B Comparison: Description of the Sample

The researcher considers the two groups basically comparable in level of knowledge of the subject matter. However group B had a very slight edge on this characteristic. Since Group B was also slightly older on average and slightly more educated in the formal sense, it might be expected that the wives in Group B would have greater knowledge related to the facts of alcoholism and its treatment.

Group B wives were also on the average married longer to their alcoholic husbands. This might also lead to the expectation of a longer term quest for answers to their marriage dilemmas which in turn could increase their level of sophistication about the related topics.

On all other parameters of the intake interview data (marital history, number of children, religion, ethnic variety, employment, and husband's
treatment history) the two groups were evenly matched. One interesting and notable fact about the two groups was that an overwhelming majority of the women in both groups were themselves from families with a significant history of alcoholism: all but one in Group A and two in Group B. Additionally, two of the women in Group A and one of the women in Group B admitted to having an alcoholic offspring.

**Research Question One**

The first research question was: Is there a difference in the use of survival behaviors between wives of alcoholics who have received a family-systems oriented teaching/counseling program and those who have received a person-centered teaching/counseling program? To answer this question the subjects were given the Spouse Survival Behavior Scale at the first group session and again at the last group session of both Group A and Group B. A t-test comparison of the gain score means between the two groups revealed that there was no significant difference at the whole test level. However, the first research question can be answered partially in the affirmative based on the subscale data.

Again, at the whole test level, when the two group means on the pretests were compared, the Group A mean scores were significantly higher than the Group B mean scores. When the group means on the posttests were compared, the Group A and B scores were not significantly different. Table 4.1 illustrates the large difference between the two groups' pretest means for the whole test as well as the six subscales (or "clusters"). Although both groups' mean posttest scores were generally in the direction of decreased use of the survival behaviors, Group B scores did not change as much as
### Table 4.1 Pretest Group Means

<table>
<thead>
<tr>
<th></th>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family-Systems</td>
<td>Person-Centered</td>
</tr>
<tr>
<td></td>
<td>n=6</td>
<td>n=6</td>
</tr>
<tr>
<td>Whole test</td>
<td>163.17</td>
<td>124.50</td>
</tr>
<tr>
<td>Cluster I (Coddling/Rescuing)</td>
<td>27.17</td>
<td>22.50</td>
</tr>
<tr>
<td>Cluster II (Avoiding/Withdrawing)</td>
<td>30.83</td>
<td>30.50</td>
</tr>
<tr>
<td>Cluster III (Controlling/Thwarting)</td>
<td>28.17</td>
<td>20.17</td>
</tr>
<tr>
<td>Cluster IV (Pleading/Threatening)</td>
<td>28.83</td>
<td>19.17</td>
</tr>
<tr>
<td>Cluster V (Blaming/Punishing)</td>
<td>29.50</td>
<td>18.67</td>
</tr>
<tr>
<td>Cluster VI (Quarreling/Attacking)</td>
<td>25.17</td>
<td>15.83</td>
</tr>
</tbody>
</table>
Group A. This resulted in intergroup posttest mean scores which were quite close to each other (Table 4.2).

In the following sections Group A and then Group B findings from the Spouse Survival Behavior Scale (SSBS) will be described and the intragroup changes from pre to post tests will be presented. A comparison will then be made between the two groups' gain scores for the whole test and for the subscales (clusters).

**Group A: SSBS Results (Family-Systems Treatment)**

Group A mean scores for the whole test (80 items) and for each of the 6 clusters changed in the expected direction; that is, toward decreased use of survival behaviors during the 6 weeks of the treatment. The pretest mean total score was 163.17 with a standard deviation of 25.98, and the post test mean total score was 130.17 with a standard deviation of 37.98. A t-test showed this difference to be statistically significant (T=2.17; P=.041). Table 4.3 shows Group A pretest and posttest data for the total test and for each of the 6 clusters.

Of the six clusters, the mean score of only one cluster, Cluster V (Blaming/Punishing) changed to a statistically significant degree (T=2.40; P=.031) between the pretest and the post test. Three other cluster mean scores changed to a degree approaching statistical significance, however. Cluster II (Avoiding/Withdrawing) had a t-value of 1.82 and a 1-tail probability of .064. Cluster III (Controlling/Thwarting) had a t-value 1.83 and a probability of .064; and Cluster VI (Quarreling/Attacking) had a t-value of 1.74 and a 1-tail probability of .071.
<table>
<thead>
<tr>
<th>Table 4.2  Posttest Group Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Whole Test</td>
</tr>
<tr>
<td>Cluster I (Coddling/Rescuing)</td>
</tr>
<tr>
<td>Cluster II (Avoiding/Withdrawing)</td>
</tr>
<tr>
<td>Cluster III (Controlling/Thwarting)</td>
</tr>
<tr>
<td>Cluster IV (Pleading/Threatening)</td>
</tr>
<tr>
<td>Cluster V (Blaming/Punishing)</td>
</tr>
<tr>
<td>Cluster VI (Quarreling/Attacking)</td>
</tr>
</tbody>
</table>
Table 4.3 *Group A PreTest and Posttest Data* (n=6)

Family Systems Approach

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>T-Value</th>
<th>1-tail prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whole Test</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pre</td>
<td>163.17</td>
<td>25.98</td>
<td>2.17</td>
<td>.041</td>
</tr>
<tr>
<td>post</td>
<td>130.17</td>
<td>37.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster I</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coddling/Rescuing</td>
<td>pre</td>
<td>27.17</td>
<td>7.17</td>
<td>1.25</td>
</tr>
<tr>
<td></td>
<td>post</td>
<td>23.00</td>
<td>5.66</td>
<td>.134</td>
</tr>
<tr>
<td><strong>Cluster II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoiding/Withdrawing</td>
<td>pre</td>
<td>30.83</td>
<td>2.32</td>
<td>1.82</td>
</tr>
<tr>
<td></td>
<td>post</td>
<td>25.00</td>
<td>27.33</td>
<td>.064</td>
</tr>
<tr>
<td><strong>Cluster III</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling/Thwarting</td>
<td>pre</td>
<td>28.17</td>
<td>5.27</td>
<td>1.83</td>
</tr>
<tr>
<td></td>
<td>post</td>
<td>21.17</td>
<td>7.65</td>
<td>.064</td>
</tr>
<tr>
<td><strong>Cluster IV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pleading/Threatening</td>
<td>pre</td>
<td>28.83</td>
<td>5.27</td>
<td>.93</td>
</tr>
<tr>
<td></td>
<td>post</td>
<td>25.00</td>
<td>11.68</td>
<td>.199</td>
</tr>
<tr>
<td><strong>Cluster V</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blaming/Punishing</td>
<td>pre</td>
<td>29.50</td>
<td>8.64</td>
<td>2.40</td>
</tr>
<tr>
<td></td>
<td>post</td>
<td>19.00</td>
<td>7.98</td>
<td>.031</td>
</tr>
<tr>
<td><strong>Cluster VI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarreling/Attacking</td>
<td>pre</td>
<td>25.17</td>
<td>7.73</td>
<td>1.74</td>
</tr>
<tr>
<td></td>
<td>post</td>
<td>18.67</td>
<td>4.13</td>
<td>.071</td>
</tr>
</tbody>
</table>
Evaluation of Sessions: Family-Systems Approach

Generally, the women voiced very positive feelings about the sessions and a predominant sentiment was a wish that the sessions did not have to come to an end. However, one woman said that while she enjoyed the sessions and found them very helpful, she found it hard to make the time for them every week because of her busy life: "Knowing myself, I'd probably stop coming after a while even if we were to continue."

Another woman said..."I feel that it's helped me personally even though my home situation hasn't changed much." This was also a common idea expressed. Some of the ways in which the women stated they had been helped included the following:

"I don't think it's my fault anymore."
"I found it more difficult to cope before I came to the group; now I can walk away from him more."
"I don't ask him no more where he's going to be so we don't fight as much."
"I try to see through it more and stay calm, but I let him know how I feel."
"I don't get as wild, I mean ranting and raving."

Two related more puzzling feelings were expressed: "I do think about the three choices now all the time but I'm changing my mind from day to day in where I'm at. I now realize how volatile I am"; and "I feel more like an outsider looking in at the relationship now."

Of special interest was the response of the Khmer-speaking woman who understands so little English that the researcher feared nothing was
getting through. A few days after the last session, through a translator, she estimated that she had comprehended about 20\% of the material (+2 on a 10 point scale). Asked if she felt she had changed in any way because of attending the group sessions she responded that when her husband drinks she can sometimes stay calm and take it in stride. She also has stopped trying to cover up or lie about the problem now because people can help and drinking problems can be treated. Finally, she commented that she felt supported in knowing that she is not alone; that other wives live with the same problem.

In the follow-up telephone calls some of the women in this group volunteered additional comments about the value of the group sessions. These comments were not qualitatively different from those obtained during the evaluation. Essentially they reinforced the ideas expressed in the latter.

**Synopsis of Group and Individual Progress: Group A**

From the case notes, from the individual SSBS scores, and from the unrecorded mental notes of the researcher and her assistant, a brief synopsis of the women in each group can be drawn.

In Group A, four of the six women were deeply involved with the group process from the start; three of these four women were indeed eager to have the group form and had phoned the researcher to keep informed of the progress of recruitment. The remaining two women were more peripheral to the group process: one because of the language barrier; the other because of her apparent inability or unwillingness to accept the severity of her husband’s alcoholism.
In the latter case, neither her husband's alcoholic cirrhosis, nor his suicide attempt, nor his mental and social deterioration broke through her denial of the implications of her husband’s late stage alcoholism. Since the family-systems-oriented approach did not directly address denial, this woman was not confronted. She continued to subsist on small “h” hope (Berenson, 1986) deluded by the fact that her husband had “cut-down on his drinking and was being good.” The researcher had a sense of her wanting to detach (i.e. make choice number two) but in fact, she really was doing what she had always done (i.e. choice number one). Nevertheless her SSBS scores decreased dramatically in every cluster and for the whole test (182 to 91). This is explainable in part by her husband’s improvement during the time frame for the posttest, and in part by her sincere desire to change and have a better life as she settled into a pre-retirement stage.

In Group A, only one woman’s SSBS total score increased slightly for the posttest. This was the Khmer-speaking woman who clearly was trying out some new assertive behaviors. Two other women’s SSBS scores increased on two clusters but not on the whole test.

The findings from the SSBS were generally supported by the clinical impressions from this group which received the family-systems-oriented approach. There was an overall sense that modest improvement had been achieved.

Group B: SSBS Results: (Person-Centered Treatment)

The mean score for the whole test for Group B (80 items) changed in the expected direction; that is, toward decreased use of survival behaviors

29 This was the impression received from the paid interpreter.
Table 4.4  Group B Pretest and Posttest Data (n=6)

Person-Centered Approach

<table>
<thead>
<tr>
<th>Cluster</th>
<th>pre Mean</th>
<th>Standard Deviation</th>
<th>T-Value</th>
<th>1-tail prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Test</td>
<td>124.50</td>
<td>20.70</td>
<td>.27</td>
<td>.398</td>
</tr>
<tr>
<td>Clusters I</td>
<td>22.50</td>
<td>3.87</td>
<td>1.02</td>
<td>.178</td>
</tr>
<tr>
<td>Coddling/Rescuing</td>
<td>20.16</td>
<td>4.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clusters II</td>
<td>30.50</td>
<td>9.89</td>
<td>.92</td>
<td>.201</td>
</tr>
<tr>
<td>Avoiding/Withdrawing</td>
<td>27.33</td>
<td>13.87</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clusters III</td>
<td>20.17</td>
<td>4.35</td>
<td>-.78</td>
<td>.234</td>
</tr>
<tr>
<td>Controlling/Thwarting</td>
<td>17.83</td>
<td>4.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clusters IV</td>
<td>19.17</td>
<td>5.85</td>
<td>1.11</td>
<td>.159</td>
</tr>
<tr>
<td>Pleading/Threatening</td>
<td>17.83</td>
<td>4.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clusters V</td>
<td>18.67</td>
<td>7.84</td>
<td>-.26</td>
<td>.403</td>
</tr>
<tr>
<td>Blaming/Punishing</td>
<td>19.17</td>
<td>7.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clusters VI</td>
<td>15.83</td>
<td>2.32</td>
<td>0</td>
<td>.500</td>
</tr>
<tr>
<td>Quarreling/Attacking</td>
<td>15.83</td>
<td>2.04</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
"I liked the variety of ages and experience."
"Everyone was very supportive."

Also noted were particular components of the sessions:
..."the general information on the disease concept"
..."the sharing among all of us with feedback."
..."the film: 'If You Loved Me' and the Al-Anon tape."
..."the videos were most effective in bringing things back that were almost forgotten."

..."The teaching and discussions were very informative."

Most of the women did not speak or write of anything that was unhelpful and one stated "I can't think of anything that wasn't helpful". However, one woman did find two elements not helpful. One was Claudia Black's videotape about children of alcoholics which she found painful to watch and not applicable to wives of alcoholic husbands. The other was that she found some of the other wives too morally judgemental of their husbands and she thought the leader should have been more assertive in not allowing that.

Other negatively stated comments were really positive in meaning and intent:

"Sorry to see it end."
"I feel six weeks was too short but perhaps I'm just reluctant to disband the group."
"I wish there was a way we could keep this group going on."
"It should be longer than six weeks."
Only one person mentioned a perceived change in themselves as a result of this experience, "And if not for this, I probably would not have accepted by myself that drinking was the main problem in my situation". However, in a few of the follow-up telephone calls women volunteered comments indicating some degree of perceived change:

"I'm kind of stronger, so I'm doing better."

"I don't argue with him now when he's drunk."

"I feel much more relaxed, less frustrated."

"I'm detaching a lot more: I don't get as involved with his problem and yet I can spend some quality time with him."

Synopsis of Group and Individual Progress: Group B

In Group B, four of the (originally) seven women connected quite visibly with each other and with the researcher and the assistant at the very first session. Three remained more apart from the group. At about the same time as one of the women dropped out of the group (she had decided to file for divorce during the interim between intake interview and first session), a fifth member joined the nucleus of four. The sixth woman remained peripheral throughout the six sessions although she took up a good share of the "air time".

The latter woman was in many ways the counterpart of the Group A woman previously described who demonstrated considerable denial. Like the Group A woman, this client was apparently not able or willing to accept the implications of her husband's alcoholism or to gain access to her own feelings (e.g. hurt, anger, fear) in relation to this. Her focus constantly shifted to her daughter's alcoholism ("that's the real dark hole in our lives").
While she would describe her husband as an alcoholic who still drinks on a daily basis she would hasten to add that there was a time in the past when this was a problem but this no longer is so. Likewise, she admitted that her children also believe their father is an alcoholic but "they were never affected by it because it only started after they were out of the house."

In the person-centered approach there was considerable teaching content on denial as a defense mechanism (see Appendix K, Teaching/Counseling Outline). This provided the group with the language to raise the issue of her denial as feedback to her lovely word paintings of the happy family life and the good old days. These were the days before one daughter became an alcoholic ("because of her husband leaving her") and another daughter started Al-Anon and codependency counseling and became estranged from the family. This client's denial was most clearly illustrated in her written evaluation comments "...it has been a great lesson to hear of the stages being experienced by the others in this series of meetings" (italics are those of the researcher).

Her reaction to the gentle confrontation (pointing out of incongruencies noted) by the researcher and other group members was also quite revealing; again, from her written evaluation: "I feel I could not have contributed much of help to others and come away with the thought that I might still be accused of clinging to the blanket of 'Denial' - not so. We discuss my husband's problem on occasion at home, and much more often we have to confront the problem of the young member of the family - where there is no denial of her problem."
This client's response was extremely atypical for this group. All five of the other women had clearly exhibited less denial in their sharing at the last session when compared with the first session. To the researcher, and her assistant it seemed clear that the content on alcoholism as a disease (including the denial discussion) along with the videotape, "If You Loved Me" dramatically turned the tide for these five women. One woman sobbed for several minutes after the videotape, then she pounded her fists in the air yelling "I'm so angry! I could just scream! That woman in the story was me! That's me!"

Each of the women in Group B was at a slightly different stage of awareness or acceptance of the alcoholism when they came to the first session. The fact of their presence alone indicates at least the first chink in the armor of denial; it signifies that an initial questioning has occurred: is alcohol the problem? By the end of the last session, at least three of the women had achieved a major shift in their level of denial. Two others had decreased their level of denial to a lesser extent and one did not change.

These findings did not mesh well with the SSBS findings. For example, one of the women who seemed to decrease her denial the most increased her use of survival behaviors slightly on the whole test and on all six clusters. Only one woman in Group B decreased her survival behaviors in every cluster as well as the whole test. The woman in Group B whose denial level remained high increased her use of survival behaviors by 35 points for the whole test and this increase was across every cluster.
Comparison of Group A and Group B: SSBS Results

A t-test comparison of the two groups' mean gain scores on the Spouse Survival Behavior Scale for the entire test and for the six subtests can be found in Table 4.5. The gain scores represent the differences between pretest and posttest mean scores and thus are a measure of the before/after survival behavior changes (as self-reported).

In reporting the following findings a 2-tail probability was set at $P < .05$ level of significance.

1. Mean gain scores for the total test were not statistically significant ($T = -1.56; P = .149$) suggesting that there was no significant difference in the overall use of survival behaviors based on the effects of the particular teaching/counseling program the women received.

2. Gain scores in Cluster I (Coddling/Rescuing) in the pre to post test means were not significantly different ($T = -.41; P = .660$) indicating no effects based on the particular group treatment approach.

3. Gain scores in Cluster II (Avoiding/Withdrawing) from pre to post test were not significantly different ($T = -.57; P = .584$). The change in self-reported use of these survival behaviors can not be attributed to the particular group treatment approach.

4. Gain scores in Cluster III (Controlling/Thwarting) from pre to post test were not significantly different ($T = -1.94; P = .081$) indicating no effects based on the particular treatment approach.

5. Gain scores in Cluster IV (Pleading/Threatening) from pre to post test were not significantly different ($T = -.5; P = .583$) indicating no changes in
Table 4.5  **Difference in Gain Scores Between Group A and Group B**

<table>
<thead>
<tr>
<th>Group</th>
<th>Gain Score Mean</th>
<th>Standard Deviation</th>
<th>T-Value</th>
<th>2-tail prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whole Test</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-33.00</td>
<td>37.28</td>
<td>-1.56</td>
<td>.149</td>
</tr>
<tr>
<td>B</td>
<td>-3.17</td>
<td>28.25</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster I</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-4.17</td>
<td>8.18</td>
<td>-.45</td>
<td>.660</td>
</tr>
<tr>
<td>B</td>
<td>5.61</td>
<td>5.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster II</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-5.83</td>
<td>7.83</td>
<td>-.57</td>
<td>.584</td>
</tr>
<tr>
<td>B</td>
<td>-3.17</td>
<td>8.47</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster III</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-7.00</td>
<td>9.38</td>
<td>-1.94</td>
<td>.081</td>
</tr>
<tr>
<td>B</td>
<td>-2.17</td>
<td>6.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster IV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-3.83</td>
<td>10.15</td>
<td>-.58</td>
<td>.583</td>
</tr>
<tr>
<td>B</td>
<td>-1.33</td>
<td>2.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster V</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-10.50</td>
<td>10.73</td>
<td>-2.30</td>
<td>.044</td>
</tr>
<tr>
<td>B</td>
<td>.50</td>
<td>4.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cluster VI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>-6.50</td>
<td>9.14</td>
<td>-1.64</td>
<td>.151</td>
</tr>
<tr>
<td>B</td>
<td>0</td>
<td>3.23</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
self-reported use of these survival behaviors attributable to the particular treatment approach.

6. Gain scores in Cluster V (Blaming/Punishing) from pre to post test were significantly different (T = -2.30; P = .044). Group A scored considerably higher than Group B in the self-reported use of these survival behaviors on the pretest. However, on the posttest Group A decreased these behaviors significantly while Group B increased these behaviors slightly. The effect may be attributable to the family-systems-oriented approach received by Group A.

7. Gain scores in Cluster VI (Quarreling/Attacking) from pre to post test were not significantly different (T = -1.64; P = .151) indicating no changes attributable to the particular treatment approach.

Evaluation Comparison

Overall, both approaches were well-received by the participants and positive feelings were the dominant outcome for clients and the researcher and her assistant; the clients generally feeling that they had been helped and the researcher generally feeling that she had been helpful.

In the evaluation process Group A wives seemed more focused on how they had been helped and the ways in which that help had changed them while Group B wives seemed more focused on the components of the program that they found helpful. In other words Group B wives seemed to be more content-oriented while Group A wives seemed more process-oriented. This was true despite the fact that the same open-ended instructions were presented to both groups (see Appendix K: Session #6 item 2, of both outlines).
Another difference was that Group B wives expressed greater reluctance to end the group sessions and felt more strongly that six weeks was too short. It is difficult to account for this and the foregoing difference based on this evaluation data alone. However, it can be hypothesized that the family-systems approach lends itself more to brief time frames while person-centered work naturally takes longer. This would be consistent with the belief of much of the modern family therapy field, most notably, strategic and systemic schools of thought. Process-orientation as opposed to content-orientation is also a prominent feature of family-systems thinking in its reliance on communication theory.

**Synopsis of Group and Individual Progress**

It may be of value to clarify at this point that in neither group was there a direct focus on the survival behaviors per se. The research design did not call for explanation or discussion of these behaviors; nor, for that matter, was it even suggested whether these coping behaviors were considered effective or ineffective. Nevertheless, some of the women may have (consciously or unconsciously) internalized the behaviors as do's or don'ts or a combination of both.

Two observations reinforce this possibility: 1) two or three remarks overheard during a break or before or after group sessions in which incidents of the past week were being recounted and the "punchlines" were one or more of the survival behaviors (e.g. "...so this time I just poured his booze down the sink"); and 2) comments which had been made during the piloting of the scale (SSBS) such as "all that crazy stuff I used to do; I guess I've come a long way".
Clearly, the latter remark shows understanding that the behaviors were ineffective while in the previous example, it is not so clear whether the woman thought she was being effective or whether she was confessing what she considered an inappropriate reaction.

For this reason, it is difficult to explain how on an individual basis some of the scores on the SSBS increased from pretest to posttest. Did some of the women interpret some of the behaviors to be the desirable responses and model their behavior on that understanding? Equally provocative is the notion that a first reaction to increased consciousness of the problem (or breakthrough in denial) is aggressiveness or withdrawal (or fight-flight). The data from this study does not answer these questions.

**Research Question Two**

The second research question was: Is there a difference in Al-Anon attendance between wives of alcoholics who have received a family-systems oriented teaching/counseling program and those who have received a person-centered teaching/counseling program? To answer this question, follow-up telephone calls were made at one month and two months after the last session of each group.

At the one month follow-up call for Group A (the family-systems oriented program recipients) none of the wives reported attending any Al-Anon meetings. At the one month follow-up call for Group B (the person-centered program recipients) two of the wives reported attending a total of eight Al-Anon meetings. (Each had attended four.)

At the two month follow-up call for Group A none of the wives reported attending Al-Anon meetings. At the two month follow-up call for
Group B, the same two wives reported attending weekly Al-Anon meetings and a third reported attending two meetings of another 12-step group, Overeaters Anonymous.

Other Analyses

The qualitative data analysis of case notes presented a colorful array of material which one could interpret as both supportive to and non-supportive to the preceding, more quantifiable data. However, no clear meaning can be imputed to what was found even though it did present the temptation to speculate and to project beyond the scope of the data.

Of particular interest to the researcher was the possibility raised by the rank-ordering process findings that Group B wives who had reported less of a reduction in the use of SSBS behaviors than Group A wives may have changed more in relation to denial and enmeshment than Group A wives.

Tables 4.6, 4.7, and 4.8 show the outcomes of the rank-ordering process from the initial combination trial to the separate rank-ordering of each polarity. Each of these tables presents the rank-ordering for Time 1 (the first two sessions) and also for Time 2 (the last two sessions). Also shown are independent rank-orderings by the research assistant/demographer (x) and by an outside assistant (y).

Especially for the Denial - Acceptance polarity, but to some degree for the Overinvolvement - Detachment polarity, greater movement of Group B wives toward the higher (more adaptive) half of the ranks can be seen. What interpretation can be made of this; does this suggest that behavior change and insight are somewhat inversely related in these 12 women? Does it suggest that Group A wives who, on the average, started out at a
higher level in their reported use of survival behaviors decreased these behaviors to a level more closely aligned with the Group B wives whose more adaptive behavior allowed them to change at a deeper core level? These questions cannot be answered from the present data. However, many more new questions for further research have been generated in this attempt to triangulate softer data with the more concrete, quantitative data.

The following chapter will address some of these questions raised by the data. It will also attempt to draw some conclusions from the whole study and discuss the possible implications and applications of these findings.
Table 4.6 Rank Ordering of Both Polarities Together: Detachment & Acceptance

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>y</td>
<td>x</td>
</tr>
<tr>
<td>Lowest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A02</td>
<td>B06</td>
<td>B01</td>
</tr>
<tr>
<td>B01</td>
<td>A02</td>
<td>A04</td>
</tr>
<tr>
<td>B06</td>
<td>B01</td>
<td>A03</td>
</tr>
<tr>
<td>A04</td>
<td>A04</td>
<td>A05</td>
</tr>
<tr>
<td>B02</td>
<td>B02</td>
<td>B03</td>
</tr>
<tr>
<td>A05</td>
<td>A05</td>
<td>A06</td>
</tr>
<tr>
<td>B04</td>
<td>B03</td>
<td>B05</td>
</tr>
<tr>
<td>A03</td>
<td>A01</td>
<td>A01</td>
</tr>
<tr>
<td>B03</td>
<td>A06</td>
<td>B04</td>
</tr>
<tr>
<td>A01</td>
<td>B04</td>
<td>B02</td>
</tr>
<tr>
<td>Highest</td>
<td>A06</td>
<td>A03</td>
</tr>
</tbody>
</table>

Key:  
- x = Rank ordered by researcher and assistant together.
- y = Rank ordered by an outside person.
- A01 through A06 = Group A case identification numbers (Family-Systems Approach)
- B01 through B06 = Group B case identification numbers (Person-Centered Approach)
- T1 = Case notes for first two sessions
- T2 = Case notes for last two sessions
Table 4.7 **Rank Ordering of Denial → Acceptance Polarity**

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>x</strong></td>
<td><strong>y</strong></td>
<td><strong>x</strong></td>
</tr>
<tr>
<td><strong>Lowest</strong></td>
<td><strong>B06</strong> B01</td>
<td><strong>A04</strong> A04</td>
</tr>
<tr>
<td></td>
<td><strong>A04</strong> B06</td>
<td><strong>B01</strong> B01</td>
</tr>
<tr>
<td></td>
<td><strong>A02</strong> A04</td>
<td><strong>A02</strong> A03</td>
</tr>
<tr>
<td></td>
<td><strong>B01</strong> A02</td>
<td><strong>A01</strong> A02</td>
</tr>
<tr>
<td></td>
<td><strong>A01</strong> A01</td>
<td><strong>A06</strong> A05</td>
</tr>
<tr>
<td></td>
<td><strong>A06</strong> B02</td>
<td><strong>A05</strong> A06</td>
</tr>
<tr>
<td></td>
<td><strong>B05</strong> A06</td>
<td><strong>A03</strong> A01</td>
</tr>
<tr>
<td></td>
<td><strong>B03</strong> B05</td>
<td><strong>B05</strong> B03</td>
</tr>
<tr>
<td></td>
<td><strong>B02</strong> A05</td>
<td><strong>B03</strong> B06</td>
</tr>
<tr>
<td></td>
<td><strong>A05</strong> B03</td>
<td><strong>B02</strong> B05</td>
</tr>
<tr>
<td></td>
<td><strong>B04</strong> B04</td>
<td><strong>B06</strong> B04</td>
</tr>
<tr>
<td><strong>Highest</strong></td>
<td><strong>A03</strong> A03</td>
<td><strong>B04</strong> B02</td>
</tr>
</tbody>
</table>

**KEY:** Rank ordered by two assistants working independently

- **x** = assistant to researcher/demographer
- **y** = assistant not connected to this study

A01 through A06 - Group A case identification numbers

*(Family-Systems Approach)*

B01 through B06 - Group B case identification numbers

*(Person-Centered Approach)*

**T1** = Case notes for first two sessions

**T2** = Case notes for last two sessions
Table 4.8 **Rank Ordering of Undifferentiation<-->Self Differentiation Polarity**

<table>
<thead>
<tr>
<th></th>
<th>T₁</th>
<th></th>
<th>T₂</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>x</td>
<td>y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B06</td>
<td>B06</td>
<td>A04</td>
</tr>
<tr>
<td></td>
<td>B05</td>
<td>B05</td>
<td>B01</td>
</tr>
<tr>
<td></td>
<td>B01</td>
<td>B01</td>
<td>A03</td>
</tr>
<tr>
<td></td>
<td>A02</td>
<td>A04</td>
<td>A05</td>
</tr>
<tr>
<td></td>
<td>A04</td>
<td>A02</td>
<td>A02</td>
</tr>
<tr>
<td></td>
<td>B02</td>
<td>B04</td>
<td>B03</td>
</tr>
<tr>
<td></td>
<td>B03</td>
<td>B02</td>
<td>A06</td>
</tr>
<tr>
<td></td>
<td>B04</td>
<td>A06</td>
<td>B05</td>
</tr>
<tr>
<td></td>
<td>A06</td>
<td>B03</td>
<td>B02</td>
</tr>
<tr>
<td></td>
<td>A05</td>
<td>A05</td>
<td>B04</td>
</tr>
<tr>
<td></td>
<td>A03</td>
<td>A03</td>
<td>A01</td>
</tr>
<tr>
<td>Highest</td>
<td>A01</td>
<td>A01</td>
<td>B06</td>
</tr>
</tbody>
</table>

**KEY:** Rank-ordered by two assistants working independently:

- x = assistant to researcher/demographer
- y = assistant not connected to this study

A01 through A06 - Group A case identification numbers
   (Family-Systems Approach)

B01 through B06 - Group B case identification numbers
   (Person-Centered Approach)

T₁ - Case notes for first two sessions

T₂ - Case notes for last two sessions
CHAPTER V
CONCLUSIONS AND IMPLICATIONS

Introduction

The purpose of this study was to examine and compare the behavioral outcomes of two group approaches to helping wives of alcoholic men. Both psychoeducational approaches (combining didactic teaching and group counseling techniques) were aimed at the ultimate goal of facilitating more effective coping by the wives despite their husbands' active alcoholism and its consequences. Both approaches were expected to result in decreased use of negative coping behaviors ("survival behaviors") and both were expected to facilitate entry and involvement in Al-Anon.

Both groups included six subjects. One group, Group A, received a program based on a family-systems perspective of family alcoholism using Berenson (1986), Wegscheider (1981), and Borwick (1985) techniques; Al-Anon was mentioned but not actively encouraged. A second group, Group B, received a program with the same six, two-hour session format. However, the second group received a more person-focused approach providing a more conventional, disease conceptualization of alcoholism and Al-Anon information as well as encouraging Al-Anon attendance.

Group A wives reported decreased use of "survival behaviors" as measured by a scale developed by the present investigator. Group means for the scale as a whole and for two of six sub-scales significantly decreased; however, none of the wives reported attending Al-Anon on one month and two month follow-up calls.

Group B wives did not significantly decrease their self-reported use of "survival behaviors" when comparison of pretest and posttest group means
were subjected to a t-test. However, analysis of adjunctive qualitative data raised the possibility that Group B wives may have broken through their own denial to a slightly greater extent and that they may also have emotionally detached to a slightly greater extent. Al-Anon attendance by two of the wives and Overeaters Anonymous attendance by a third would lend support to this possibility.

Differences in gain scores between Group A and Group B were not shown to be statistically significant when examined at the level of the whole test. However, changes in one sub-scale (Cluster V: Blaming/Punishing) showed significantly less self-reported use of behaviors in this category by Group A as compared with Group B who increased their use of these behaviors. The latter was the only statistically significant finding of this study which supported one of the research hypotheses.

**Conclusions**

The first finding of interest to the researcher was that on the aggregate level both groups changed, however slightly this might have been, in the direction which would be considered desirable from the point of view of a positive response to intervention. This response was certainly more dramatic for Group A than it was for Group B as it held not only for the total score on the SSBS but also in all six of the clusters. Group B, while responding in a positive way on the total score and on 3 of the clusters (I Coddling/Rescuing, II Avoiding/Withdrawing, and IV Pleading/Threatening) responded in the opposite direction for two of the clusters (III Controlling/Thwarting and V Blaming/Punishing) and showed no change on the remaining cluster (VI Quarreling/Attacking). While statistical
significance was present for only a few of these findings, the general trend toward the expected direction was an encouraging result in terms of the overall value of both teaching/counseling approaches.

Secondly, the results for Group A which received the family-systems-oriented program validated this approach as an effective one in terms of at least short term reduction in the wives' use of ineffective coping behaviors. This applies to the behaviors overall and it applies especially to the Cluster V behaviors (Blaming/Punishing). Ongoing study with new groups could show that the 3 other clusters which approached statistical significance are also decreased to a more significant degree by this approach (Cluster II Avoiding/Withdrawing, Cluster III Controlling/Thwarting, and Cluster VI Quarreling/Attacking).

The results from Group B are more difficult to assess. No conclusions can be drawn from either the aggregate data or the cluster data in terms of the effectiveness of the more person-centered, traditional program. It is important that these results not be interpreted as suggesting that traditional teaching programs for wives of alcoholics is less effective; or, even worse, that the Al-Anon approach are less effective. While this approach did directly encourage entry into Al-Anon and did teach a little about Al-Anon, it was not Al-Anon. The fact that two women from Group B subsequently began attending Al-Anon meetings should not be ignored even though it

---

30 Zweben and Pearlman (1983) have used the terminology "average package of care" (p. 66) to describe the traditional course of therapy for alcoholics. This label is perhaps more descriptive of the program received by Group B than the terms "traditional" or "person-centered".

31 As noted in the previous chapter, a third woman began attending Overeaters Anonymous, another 12 step program between the first and second telephone follow-up calls.
cannot be considered a truly significant finding. If over time and many
groups it were to be shown that at least two women of every group of six
receiving an "average package of care" entered Al-Anon this might be
considered an excellent outcome.

It should be remembered that Group B started out at a lower point in
terms of overall use of the "survival behaviors". The maximum possible
score which would be received by someone who reported use of every
behavior to the highest degree would be 320. The Group B mean for the
pretest (total score) was 124.50 while the Group A mean was 163.17.

As illustrated in the previous chapter, the scores of individual group
members did not always reflect what had occurred at the aggregate level. In
Group B, one woman’s reported use of survival behaviors increased from 125
on the pretest to 160 on the posttest. As the case note and evaluation data
clearly demonstrated, this woman came in with an extremely high level of
denial. There were also many inconsistencies noted when her screening test
responses, case notes and SSBS responses were examined together. While
other members of Group B did slightly increase their scores from pretest to
posttest there was greater consistency across all other measures so that a
sense of congruence was present.

Reexamining the case note data in an attempt to better understand the
test data, the researcher looked for evidence that denial at the outset kept
this woman from even being aware of her own behavior vis a vis her
husband and his drinking. If this were so and if the group sessions had
broken through her denial, a higher score might be expected because of her
new awareness of her own coping behavior. No dramatic difference was
seen when comparing the beginning with the end case notes; while there were small incidences of breaking through denial at various points throughout the six sessions, these were always followed by a taking back of the denial. Ultimately, this remains inconclusive.

One finding merits the most serious consideration in terms of interpretation as well as its possible implications for treatment of family alcoholism, and for nursing practice. That is the finding that on Cluster V (Blaming/Punishing), Group A wives showed significantly less use of these survival behaviors when compared with Group B wives whose behaviors in this category increased. This finding, based on a t-test of the gain scores between the two groups, stands out as the finding of greatest significance and the only finding which supports one of the hypotheses of the study. That is, the group which received the family-systems-oriented teaching/counseling approach did decrease their ineffective coping particularly in the category of blaming/punishing behaviors.

Although this descriptive study was not expected to establish direct cause-effect relationships between variables, there is compelling cause to speculate that this outcome was related to the particular ingredients of the family-systems-oriented program which the person-centered program did not contain. It can be theorized that this is related to the non-blaming and perhaps more empowering nature of family-systems thinking which characterized the psychoeducational program received by Group A wives. This is clearly articulated in the Wegscheider-Johnson Institute approaches (1981) and quite apparent if not articulated in the Berenson (1976 b) and Milan (Borwick, 1985) approaches. The family-systems concepts of circular
causality and the Milan neutrality certainly bear upon this argument. This investigator believes there is good rationale to support such a theory. Further research evidence is needed.

With respect to the remaining five clusters it may be of interest to note that on Cluster II (Avoiding/Withdrawing) the two groups' means were approximately at the same point on the pretest. Even though the Group B posttest mean remained higher, the two groups were most similar in this cluster. Both groups had their highest cluster mean score in this category. This generates the hypothesis that it is the most common cluster of behaviors used by wives of alcoholics.

For Clusters I (Coddling/Rescuing), IV (Pleading/Threatening) and VI (Quarreling Attacking), Group A started out with a higher mean score and even though this group changed more on these cluster scores from pretest to posttest, the end point remained higher for Group A than Group B. On Cluster III (Controlling/Thwarting) the Group B mean score on pretest was lower than the Group A mean score. Since these mean scores changed in opposite directions, Group B posttest mean score was only very slightly higher than that of Group A. No interpretation is possible for these small differences in cluster scores between the two groups.

Conclusions from Qualitative Data

The findings from the analysis of the case notes when triangulated with the quantitative data raised more questions than they were able to answer. These will only be addressed in a hypothetical way because of the tentativeness of the qualitative findings and the imprecise nature of that methodology. Suppose that it could be definitively shown that indeed Group
B women, without showing any significant behavior change, achieved more acceptance and detachment, while Group A women decreased negative coping behavior without much acceptance or detachment, how might this be interpreted? The first inference that might be made is that the direct information given to Group B women gave them the necessary knowledge or insight about alcoholism and its effects to break down their denial but that this alone does not bring about behavior change. The corollary idea that insight is not necessary and in fact may not even be desirable in order to effect change is not an unknown idea to the family therapy field. This is in fact a basic principle underlying some strategic and systemic models. The use of rituals, metaphors, stories, and other more affective techniques essentially aim at by-passing linear thought processes to promote system change. While the data from the present study cannot make any such inference, it can raise the question for future study.

Another question raised by this data relates to the idea of empowerment as a necessary precondition to change. Group A received a program which in part centered upon making active choices; there was continued reiteration that these are the three choices; the essential message being that they do have choices. Group B heard more about powerlessness because the essential message of AA and Al-Anon as embodied in Step One of the Twelve Steps is: "Admitted we were powerless over alcohol; that our lives had become unmanageable". Although the intent concerns only powerlessness over the alcohol and the alcoholic, the message received may not have been this selective; it might have been generalized to powerlessness over all. This is what seems to be present in a Group B
member's comment in Session #5 "Sometimes I really hate him. I really
don't know what to do about it." Then in Session #6 the same woman said
"I'd like to get him out but I'm afraid; he threatens us; he has guns in the
house because he hunts".

In the experience of nursing colleagues of the researcher who
specialize in work with battered women, it is a sense of powerlessness that
keeps women in the violent home situation and a sense of empowerment
that allows them to change behavior and take action to physically leave the
battering mate. In some cases this may be for financial reasons; in the case
of the woman referred to above she admits she could easily become
economically independent. Future research might address this question by
comparing non-battered wives of alcoholics with wives of non-alcoholic
batterers on the dimension of powerlessness versus empowerment.

The findings from this study raised one final question which will be
mentioned as pure speculation. Returning for a moment to the SSBS data,
Group B wives either slightly increased or remained unchanged precisely in
their reported use of the behavior clusters that appear to this investigator to
be associated with a more overinvolved relationship: III
Controlling/Thwarting, V Blaming/Punishing, and VI Quarreling/Attacking.
Group A wives, on the other hand, decreased their reported use of these
same clusters to significant or near significant levels. This too suggests the
need for future study to determine if this might be another effect of a
family-systems approach.

To summarize the conclusions of this study, it must be said that there
were many diverse and intriguing findings which lent themselves to very
provocative interpretations. Much of the latter section has been extremely speculative and should remain as nothing more than that. For the rest, there were two statistically significant findings relating to intragroup changes in Group A (on the whole test and on Cluster V) and one statistically significant finding in direct relation to one of the two research hypotheses: that there was a difference between the two groups in the choice and use of the survival behaviors in Cluster V: Group A women reported significantly decreased blaming and punishing behavior in comparison with Group B.

**Implications**

The results of this study were encouraging with respect to the use of both approaches and thus the idea of continuing to work in groups with wives of alcoholics was reinforced. Both approaches appear to be effective in initiating change in the wives of alcoholics as was the primary target of the study. If other family members also benefitted from this, as might be expected by those who hold a family systems view of change, this would be a bonus outcome.

Both approaches present an early intervention model for alcoholism treatment as they do not wait for the alcoholic member of the family to come forward for help. It was clear to the researcher and the assistant that at least 9 of the 12 women in the study had husbands who were far from ready to decide they needed treatment. From this group of 12 women there were a total of 42 offspring (not including grandchildren) of which 23 were adults and 19 were 18 or younger. The possible ramifications of positive change in the non-alcoholic member can be readily imagined.
A psychoeducational approach makes good sense for wives of alcoholics. In contrast to 'psychotherapy', "it feels less threatening, less blaming, and no one tried to mess with their heads". This was how the assistant/demographer, a psychiatric nurse, phrased it. The majority of wives of alcoholics are essentially well people experiencing some stress related to living with an alcoholic husband. They do seem to need and appreciate and benefit from information and clarification of choices. In both approaches the women seemed eager to grasp didactic material and relate it to their own lives. Feelings emerged in relation to the content; there was no need to probe or confront; the response was ready and uninhibited.

For the family-systems-oriented approach there are some further implications and also applications. The consistent finding of a sense of release from blame and responsibility to "fix" the problem merits deeper consideration.

On the first follow-up telephone call to Group A women even the group member who seemed least involved stated, "The best thing the group did for me was to make me aware that it's not my fault. I used to think it was". This may or may not be related to the finding that wives in Group A changed the most in the Blaming/Punishing cluster. Perhaps one is less apt to project blame to another when she does not feel to blame herself.

This group approach, the family-systems-oriented approach, is certainly applicable to other groups of family members of alcoholics, e.g. children, adult children, and parents of alcoholics and/or drug abusing persons. The children in particular seem to carry for a life-time the feeling
of being blamed (Woititz, 1983). If this could be changed in a few short sessions it certainly would be worthwhile.

**Implications for Nursing and Nursing Education**

As stated at the outset, nurses in all settings have the opportunity to work with wives and other members of alcoholic families. Sometimes it will not be possible to form groups of four and five but even two or three assembled together would be more cost effective than one-to-one work with this population.

Examples might include school nurses working with a small group of children of alcoholics and occupational health nurses working with two or three wives of alcoholic men or husbands of alcoholic women. For children, the content would certainly need to be modified to be age-appropriate and some of the material would not be applicable (e.g. Berenson's choices). The essential messages would still show through: "you're not to blame", "no one's to blame", and "it's not your job to fix it".

Community health nurses might gather together two or three pregnant mothers or mothers with young babies who comprise a large percentage of the usual caseload for these nurses. A large enough number of the fathers of babies in such caseloads have drug and alcohol problems to warrant a "broad brush" approach. That is, the psychoeducation would be offered to every client in this aggregate. More examples could be given as nurses work in extremely diverse settings and this is an advantage that few other health professionals have. The flexibility of providing service even in the client's home may be nearly unique to nursing. All of these factors make it extremely feasible for nurses to be doing this work.
Both approaches are eminently teachable to nurses. Training could be provided as part of the regular baccalaureate curriculum. The researcher had expected greater difficulty in presenting the material to wives; that is, more resistance, more challenging and questioning of the ideas, maybe even rejection of some of the information. Had this been the case greater skill in teaching and counseling as well as greater depth of knowledge would have been required. However, the women in both groups received the information with ease and graciousness. Many expressions of enlightenment were heard ("That's interesting!" "Aha ---- that's why my son gets so upset if he doesn't get an A"). Most of the women readily identified with the content and though there was animated discussion there was no controversy. For these reasons, the researcher concludes that both approaches should be taught to baccalaureate level nursing students. Direct supervision by faculty should be required until both student and faculty feel comfortable about the student's performance.

For practicing nurses who have not had this content in their undergraduate programs two or three day workshops could be designed to be brought to large agencies which employ nurses (hospitals, visiting nurse agencies, clinics). For nursing students and practicing nurses alike, such training might be done using role-playing as well as actual clients with live supervision. The use of one-way mirrors, phone-ins and videotaping would facilitate supervision of the trainees in much the same was as family therapy teams train new therapists.

Masters students could take the basic training first and then become supervisors to undergraduates or assistants to the faculty responsible for the
course(s). Ideally, the masters training would be embedded in a whole course or track dealing with nursing care in addictions which would include assessment and case-finding as well as other intervention techniques.

This investigator believes that the time has come for nursing to take its rightful place in alcoholism and addictions treatment. Nursing education places great value on teaching for prevention and health promotion. In the case of alcoholism and other addictions, treatment, prevention and health promotion all converge. Treatment of one family member becomes prevention in another; and prevention if successful, makes it possible to place greater emphasis on health promotion.

**Implications for Family Therapists**

It is the opinion of this investigator that there was some therapeutic benefit in the family-systems approach which was not present in the person-centered approach. Perhaps this is attributable to the perspectives and techniques of family therapy; in particular neutrality and circular interviewing, and more generally, the non-linear, non-blaming approach of family-systems work. In counseling wives of alcoholics, this is particularly important since these wives obviously do feel blamed for their husband’s drinking. It seems possible that when the wives feel absolved from this blame, they can then more easily stop blaming and punishing their husbands and begin to perceive a no-fault situation of addiction. Such a change in the wives of alcoholics holds the potential of breaking ineffective circular interaction patterns between the spouses and ultimately leading to recovery.

The researcher also believes that the findings of this study have lent some support to the family-systems idea that brief-therapy can be useful;
the six sessions were sufficient to initiate small changes in behavior particularly in the group receiving the family-systems approach. This group also showed a greater tendency toward a process-orientation in evaluating the program; whereas, the person-centered group was much more content-oriented. This serendipitous finding might also relate to family-systems thought in the realm of communication theory and interpersonal rather than intrapsychic focus. These findings also demonstrate the merit of a family-systems approach in the opinion of the investigator.

What about Al-Anon; why did none of the women receiving the family-systems approach attend Al-Anon? There is no answer to this question other than the overly simple one that this group was not referred to Al-Anon; the other group was not only referred but strongly encouraged to attend. This encouragement took the form of explaining what Al-Anon was about, what happens at meetings; it included reading some of Al-Anon's literature and viewing an Al-Anon information videotape. The latter approach may have served to reduce the "fear of the unknown". The extent to which this is a barrier to attendance is not clear. Since many women who do go to Al-Anon once or twice do not continue, the fear element is not the major barrier.

The researcher would suggest to family therapists and to all persons who counsel wives of alcoholics to encourage Al-Anon. This should be done through a direct statement of referral as well as through providing Al-Anon information and meeting schedules. The findings of this study indicate that it would not be harmful to do this; that is, there does not seem to be a
paradoxical effect of non-attendance related to direct encouragement. In fact, it can be helpful in getting at least some of the wives to Al-Anon.

**Recommendations**

The women in both groups should be followed for at least one year; preferably two, to determine the long range effects of this brief intervention. This could take the form of a group reunion of a social nature. The SSBS could then be readministered and results compared with the present data. Al-Anon attendance and other indicators of progress toward recovery could also be assessed, e.g. detachment and acceptance. Reasons for Al-Anon attendance and non-attendance should be elicited and analyzed. Perhaps this variable would look quite different after six months or a year. The researcher is not able to offer any sound conjecture for total non-attendance of Group A women to Al-Anon.

The study should be replicated in its entirety with two new groups so that a larger group of data can be compiled for the purpose of obtaining more accurate statistics. No changes should be made in the process or the psychoeducational approaches prior to completing at least a second round so that the results might be truly comparable. The study should also be replicated by (an)other researcher(s) to correct for the effects of the personality of the "therapist" and other idiosyncracies. In particular, the coding process for the case note data would hopefully be attempted by other researchers in order to further assess its value as a method for similar types of qualitative data.

Later on, the teaching/learning programs might be revised based on the composite evaluation of two or more trial runs. For example, it may be
decided to add content on Johnson Intervention for both groups and introduce Al-Anon more directly for both groups. Depending on future findings it might even be advisable to combine the best elements of both approaches into a third model of 8 or 10 sessions. Table 5.1 illustrates one possible way to structure a combination model.

The researcher and the assistant both agreed that the maximum size for a group should be five as each member seems to require a good share of time to ventilate about the weekly occurrences in her life. In order to allow this, the groups frequently went 10 to 15 minutes overtime. Three, four, or five members would also allow for less lag time for the first enrolled members while the rest of the group was being recruited as only 2 more members would be needed.

The problem of recruitment will not, of course, entirely disappear. To bring forward a wife of a still actively drinking alcoholic who is still living in the same household and who has reached the minimum level of awareness where she believes his drinking is central to their problems but has not previously sought outside help is no small task. To bring forward a group of such women all at once is a truly formidable task; two groups at once is nearly impossible. A few new ideas have emerged from this experience; each has its disadvantages but nevertheless may be worthy of trial.

1. Place a deadline of four weeks on an all-out recruitment effort and close intakes at whatever number has enrolled whether it is one, two, or five. (Obviously, the smaller the number the less cost-effective.)
Table 5.1 Family-Systems and Person-Centered Combination Program

(eight sessions minimum, expandable to ten)

<table>
<thead>
<tr>
<th>Session 1</th>
<th>Introductory Exercises</th>
<th>30 min</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Explanation of Program (Overview)</td>
<td>45 min</td>
</tr>
<tr>
<td></td>
<td>Pretest</td>
<td>45 min</td>
</tr>
<tr>
<td>Session 2</td>
<td>Individual Concepts (Person-Centered)</td>
<td>90 min</td>
</tr>
<tr>
<td></td>
<td>Disease Concept/Stages/Denial</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Discussion/Questions/Sharing Experience</td>
<td>60 min</td>
</tr>
<tr>
<td>Session 3</td>
<td>Family Concepts (Marital Relationship)</td>
<td>60 min</td>
</tr>
<tr>
<td></td>
<td>Videotaped Drama: &quot;If You Loved Me&quot;</td>
<td>60 min</td>
</tr>
<tr>
<td></td>
<td>Discussion/Questions/Sharing Experience</td>
<td>60 min</td>
</tr>
<tr>
<td>Session 4</td>
<td>Family Concepts (Children &amp; Whole System)</td>
<td>60 min</td>
</tr>
<tr>
<td></td>
<td>Videotaped Lecture &quot;Children of Denial&quot; (Black)</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Videotaped Lecture &quot;The Family Trap&quot; (Wegscheider)</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
<td>60 min</td>
</tr>
<tr>
<td>Session 5</td>
<td>Present: Berenson's Choices</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Detachment: Al-Anon</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Intervention: Johnson</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Discussion/Questions/Sharing Experience</td>
<td>30 min</td>
</tr>
<tr>
<td>Session 6</td>
<td>Sharing Experience in Choice Framework:</td>
<td>2 hrs</td>
</tr>
<tr>
<td></td>
<td>Where I'm at Today in the Three Choices</td>
<td>2 hrs</td>
</tr>
<tr>
<td></td>
<td>(Circular Interviewing by therapist)</td>
<td>2 hrs</td>
</tr>
<tr>
<td>Session 7</td>
<td>(Optional add-on here an 8th, 9th session)</td>
<td>2 hrs</td>
</tr>
<tr>
<td></td>
<td>Same as session 6</td>
<td>2 hrs</td>
</tr>
<tr>
<td></td>
<td>Homework: Al-Anon Pamphlet (General Al-Anon Information)</td>
<td>2 hrs</td>
</tr>
<tr>
<td>Session 8</td>
<td>Al-Anon: Videotape: &quot;This is Al-Anon&quot;</td>
<td>15 min</td>
</tr>
<tr>
<td></td>
<td>Discuss videotape &amp; homework pamphlet</td>
<td>30 min</td>
</tr>
<tr>
<td></td>
<td>Distribute meeting schedules</td>
<td>15 min</td>
</tr>
<tr>
<td></td>
<td>Posttest/Evaluation of Program</td>
<td>60 min</td>
</tr>
</tbody>
</table>
2. Negotiate artfully over an unlimited time with alcoholism treatment centers for "built-in" populations such that the agency would be paid for the service rendered. (Problems with agency policies, confidentiality might continue to preclude this.)

3. Design and implement well-publicized free workshops on alcohol and family health aimed at recruiting small cohort groups from each one. These could be given through schools, churches, health agencies, etc. Nursing students could do these workshops as teaching projects for existing course credit or independent study. (This could not be limited to wives or even women; also the turnout would be unpredictable; however, someone might benefit even if recruitment is unsuccessful.) Ultimately, through word of mouth and from the development of a track record of helpfulness a steady trickle of referrals might eventually provide adequate numbers of clients for training purposes.

Discussion

The findings of this study must be evaluated with caution given the limitations of the study. In particular, it should be kept in mind that this was a highly self-selected sample. This was very clear from the extreme difficulty in recruiting the women for the study. In some cases, crisis circumstances surrounded their coming to the six group sessions.

For example, one woman discovered she that was pregnant and decided to have an abortion, and at the last minute had a change of heart. Another woman started divorce proceedings after experiencing a violent episode which occurred between the time of the admission interview and the first session. (This woman dropped out of the study later but not because of...
events in the group.) Additionally, many of the women shared, either during sessions or informally, that their husbands either stopped or greatly decreased their drinking during the formation of each group. Although, this is a typical occurrence when the alcoholic husband becomes aware that "the heat is on", this sometimes renews the wife's illusion that "everything will be O.K. now, put me back into my comfortable cocoon."

Initially, there was enormous reluctance about coming and then staying, but ultimately, nearly all the women were coming quite willingly for both groups and there was considerable expression of sadness that the group had to end. However, under "normal" clinical circumstances this researcher, as a therapist, would never counter clients' resistance to come to group or to stay. Moreover, as a therapist, this researcher would never turn away a client asking for help on the grounds that she has too much Al-Anon knowledge or is not currently living in the same household with the alcoholic.

Philosophically and ethically the level of manipulation of variables done for this study is about as far as this researcher would ever be willing to go for the sake of uncovering new knowledge. It is purposeful, therefore that no recommendation was made for more controlled study. This is for reasons of human concern that became all the more clear while carrying out this study. Naturalistic studies, and other less manipulative methodologies need to be developed, improved, and promoted. For example the case study method and grounded theory have special value for application to the study of families. However, there is considerably less expertise and less mentorship for these methods. As evidenced in research courses and
textbooks, there is generally less encouragement in academia for non-quantitative methods. In particular, the methods of analysis need to be formulated and shared and taught to graduate students. This investigator would prefer in the future to collect data from clinical situations as they exist in actual practice when a client or family comes for therapy by natural referral and is assessed and treated in a way that best meets unique needs. Sometimes it will be group teaching/counseling as in this study. Sometimes it will be couples work or whole family therapy depending on the stage of alcoholism, the degree of conflict between the spouses and many other factors. Recently, several referrals have contacted the researcher requesting Johnsonian Intervention right from the start and have entered therapy at a high level of sophistication about the problem and its treatment. How does one begin to analyze such data as might be naturalistically gathered from these sessions? Much remains to be studied and learned from these sessions but what are the guidelines for scholarly investigation?

This study was most satisfying to the researcher because of its focus upon wives of alcoholics as persons requiring and deserving of intervention in their own right. The outcome measures focused wholly on the wives’ behaviors, learning and other indications of their own growth; not on the effect their behavior has on their alcoholic husband or on his drinking. For this, the investigator feels especially gratified.
The 12 Steps of AA
1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made direct amends to such people wherever possible, except when to do so would injure them or others.
9. Continued to take personal inventory and when we were wrong promptly admitted it.
10. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.
11. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The 12 Traditions of AA
1. Our common welfare should come first; personal recovery depends on AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend its name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. AA should remain forever nonprofessional, but our service centers may employ special workers.
9. AA as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

The Twelve Steps and Twelve Traditions reprinted with permission of Alcoholics Anonymous World Services, Inc.
Al-Anon and other 12-step groups have adapted AA's Steps and Traditions for their own use.
The following statement, based on Al-Anon’s Conference-Approved Literature, is written with the hope it will help you understand the Al-Anon concept of detachment.

Alcoholism is a family disease. Living with someone who has this disease is too devastating for most people to bear without help.

Detachment, a recovery tool for the family in Al-Anon, helps members to help themselves.

In Al-Anon we learn individuals are not responsible for another person’s disease or recovery from it.

We let go of our obsession with another’s behavior and begin to lead happier and more manageable lives, lives with dignity and rights; lives guided by a Power greater than ourselves.

In Al-Anon we learn:
- Not to suffer because of the actions or reactions of other people;
- Not to allow ourselves to be used or abused in the interest of another’s recovery;
- Not to do for others what they should do for themselves;
- Not to manipulate situations so others will eat, go to bed, get up, pay bills, etc.;
- Not to cover up for another’s mistakes or misdeeds;
- Not to create a crisis;
- Not to prevent a crisis if it is in the natural course of events.

Detachment is neither kind nor unkind. It does not imply evaluation of the person or situation from which we are detaching. It is simply a means for us to recover from the adverse affects on our lives of living with someone afflicted with the disease of alcoholism. Detachment helps families look at their situations realistically and objectively, thereby making intelligent decisions possible.

AL-ANON IS...
the only worldwide organization that offers a self-help recovery program for the families and friends of alcoholics whether or not the alcoholic seeks help or even recognizes the existence of a drinking problem. Members give and receive comfort and understanding through a mutual exchange of experiences, strength and hope. Sharing of similar problems binds individuals and groups together in a bond that is protected by a policy of anonymity.

AL-ANON IS NOT...
a religious organization or a counseling agency. It is not a treatment center nor is it allied with any other organization offering such services. Al-Anon Family Groups neither express opinions on outside issues nor endorse outside enterprises. No dues or fees are required. Membership is voluntary, requiring only that one’s own life has been adversely affected by someone’s drinking problem.

Reprinted by permission of Al-Anon Family Group Headquarters, Inc.
APPENDIX B: SUMMARY OF FAMILY TREATMENT OF ALCOHOLISM
<table>
<thead>
<tr>
<th>Date</th>
<th>Authors</th>
<th>Context</th>
<th>Type of Treatment</th>
<th>Outcome/Def. of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>1956</td>
<td>Gledman</td>
<td>Outpatient</td>
<td>Concurrent separate groups Alcoholics/wives</td>
<td>Reduced drinking, fewer psychological problems</td>
</tr>
<tr>
<td>1960</td>
<td>Preston</td>
<td>Outpatient</td>
<td>Conjoint for spouses Conjoint groups</td>
<td>Ability to discuss problem; Reduced anxiety &amp; hostility; Increased satisfaction</td>
</tr>
<tr>
<td></td>
<td>Thomas</td>
<td>Outpatient</td>
<td>Multiple couples groups adjustment health</td>
<td>Decreased drinking; Improved family &amp; occupational functioning</td>
</tr>
<tr>
<td>1965</td>
<td>Pattison</td>
<td>Hospital follow-up</td>
<td>Home visits entire family</td>
<td>Reduced drinking; Improved family functioning</td>
</tr>
<tr>
<td>1967</td>
<td>Smith</td>
<td>Hospital</td>
<td>Concurrent group for wives</td>
<td>Decreased drinking; social stability</td>
</tr>
<tr>
<td>1968</td>
<td>Bailey</td>
<td>Outpatient</td>
<td>Conjoint with alcoholic Individual for spouses</td>
<td>No research data</td>
</tr>
<tr>
<td></td>
<td>Berman</td>
<td>In &amp; Outpt.</td>
<td>Multiple couples group</td>
<td>Detailed advantages listed in article</td>
</tr>
<tr>
<td></td>
<td>Burton &amp; Kaplan</td>
<td>Outpatient</td>
<td>Multiple couples group</td>
<td>Improved marriage; Reduced drinking</td>
</tr>
<tr>
<td></td>
<td>Esser</td>
<td>Outpatient</td>
<td>Whole family in home including extended family</td>
<td>Abstinence or reduced drinking</td>
</tr>
<tr>
<td></td>
<td>Ewing &amp; Fox</td>
<td>Outpatient</td>
<td>Concurrent groups alcoholic &amp; spouse/unilateral for spouse</td>
<td>Changed marriage; Reduced drinking Continue in treatment</td>
</tr>
<tr>
<td>1970</td>
<td>Gallant et al.</td>
<td>Hospital aftercare</td>
<td>Multiple couples group</td>
<td>Abstinence; Marital improvement</td>
</tr>
<tr>
<td></td>
<td>Loescher</td>
<td>Non-hosp. Post-hosp</td>
<td>Conjoint couples group</td>
<td>Abstinence; Stable marital status</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Type of Care</td>
<td>Treatment Groups</td>
<td>Outcomes</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
<td>-------------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1971</td>
<td>Binder</td>
<td>Part of Hosp. Hosp. Prog.</td>
<td>Couples</td>
<td>Abstinence; Improved fam. relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient</td>
<td>Wives; couples</td>
<td>Improvement in marriage</td>
</tr>
<tr>
<td></td>
<td>Cohen &amp; Krause</td>
<td>Part of Hosp. Hosp. Prog.</td>
<td>Couples/groups</td>
<td>Improved family life; Abstinence; Improved financial support; Less difficulty with law</td>
</tr>
<tr>
<td></td>
<td>Kranitz</td>
<td>Hospital</td>
<td>4 day intensive couples</td>
<td>Improved social, interpersonal &amp; marital relationships</td>
</tr>
<tr>
<td>1972</td>
<td>Corder et al.</td>
<td>Part of Hosp. Hosp. Prog.</td>
<td>Family excluding alcoholic</td>
<td>Abstinence; Improved marital relationship; Employment</td>
</tr>
<tr>
<td></td>
<td>McDowell</td>
<td>Outpatient</td>
<td>Family excluding alcoholic</td>
<td>Improved functioning of alcoholic &amp; family</td>
</tr>
<tr>
<td></td>
<td>Woggon</td>
<td>Part of Hosp. Hosp. Hospital</td>
<td>Multiple couples</td>
<td>Change in handling conflict and stress</td>
</tr>
<tr>
<td></td>
<td>Cadogan</td>
<td>Residential</td>
<td>Alcoholic and key family members</td>
<td>Change in drinking &amp; marital communication</td>
</tr>
<tr>
<td></td>
<td>Cantanzaro</td>
<td>Outpatient</td>
<td>Available family members</td>
<td>Less drinking &amp; difficulty handling marital problems</td>
</tr>
<tr>
<td>1974</td>
<td>Bowen</td>
<td>Outpatient</td>
<td>Couples</td>
<td>Possible outcomes described in detail</td>
</tr>
<tr>
<td></td>
<td>Hedberg &amp; Campbell</td>
<td>Outpatient</td>
<td>Couples groups</td>
<td>Abstinence or reduced drinking</td>
</tr>
<tr>
<td>1975</td>
<td>Madden &amp; Kenyon</td>
<td>Outpatient</td>
<td>Couples groups</td>
<td>Abstinence</td>
</tr>
</tbody>
</table>
APPENDIX C: "SOME THOUGHTS ON CODEPENDENCY"
(Hazelden, 1987)
There is no doubt that people who are involved emotionally with chemically dependent individuals are likely to suffer more emotional problems than people who are not. In fact, any chronic illness creates stress within the family system. Certain patterns of similar responses emerge.

Our prediction, as trained clinicians and as individuals, is to try to classify these patterns, define them, identify their cause, and prescribe a solution. This tendency rises out of our cultural bias toward a biomedical approach to health problems: if we find the cause of a problem, its solution is not far behind. This model also fits within the current health care system, which requires diagnosis in order to justify reimbursement for treatment.

But there is an important shift underway in the way our society responds to health problems. We are moving away from a biomedical, causal approach, which emphasizes the study and treatment of disease, to a holistic, systems approach, which emphasizes the study and promotion of health. The difference in these two approaches becomes apparent when we compare the views of the 17th century philosopher, Descartes, with those of contemporary systems thinkers. Descartes saw the body as a machine which, if fully understood, could be taken apart and reassembled. In contrast, systems thinkers view health as an integrated state of mental, physical, spiritual, and emotional well-being. Both views are helpful.

We think that the controversy over the term codependency is one manifestation of the conflict between these two views. Support for the concept arises, in part, out of our culture's biomedical bias. We can't help people who aren't diagnosed, and the term is one way of describing the distress that chemical dependency creates for people who live with it.

At the Hazelden Family Center, we have consciously chosen not to label problems that occur within the family system with any diagnosis, including the word codependency. We have made this choice because:

- Our clients exhibit a remarkable variety of responses to the problem of chemical dependency within the family. For us, these responses are too varied to classify into a single phenomenon.
- The family exists as a system and problems within that system have complex, multiple levels of interacting causation that resist diagnosis.
- Emphasizing a particular diagnosis and its symptoms may lead clients to focus on problems rather than solutions.
- Clinically, most of the clients we deal with are "normal", experiencing levels of distress appropriate for their situation.
- The research that we have seen tends to support the position that while people involved with chemically dependent individuals do experience more emotional problems, no clearcut syndrome has emerged.

The view we take at the Hazelden Family Center is rooted in health promotion and a systems approach to health problems. We believe that each member of the family has an innate power of self-healing, and we try to awaken that power within our clients. Our practices are based on a combination of Al-Anon principles and the family systems theories developed by Murray Bowen, Ph.D. Both de-emphasize the need for a diagnosable sickness, instead requiring a sincere desire to change.

There are many ways to help families return to health, and we respect the philosophical differences that shape various practices in our growing field. Codependency, both as a clinical and popular term, brings some of those differences into focus. We look forward to hearing your views.

Reprinted from Hazelden Viewpoint with permission from Terrence Williams
APPENDIX D: BERENSON’S MAP OF EMOTIONAL HEALING
Ping-ponging back and forth

**Thoughts & feelings**
- Jumbled together:
- Non-productive/"crazy"

**SPACES**
- "The Observer" Aloneness
- Bliss (Neutral) Joy Compassion Nothingness or "Beautiful Sadness"
- Gratitude Nowhereness Love

**EMOTIONS**
- Shame→
- Humiliation→Fear→Hurt Despair→Terror Failure→
- Hopelessness*→ Anger→

**MOODS**
- Resentment→Anxiety→PAIN
- Blame→Panic→Suffering→
- Pride Confusion Self-Pity→
- Disgust Desperation Resignation

**TRANSITION**
- Powerlessness Emptiness

Literally:
- All-one-ness
- No-thing-ness
- No-where-ness

Important to feel the **emotions** that correspond with the moods e.g. stay with the hurt and then go to the fear. Flow is left to right.

*Need to deplete the "h" = hope for the "H" = HOPE which you know as HEALING*
APPENDIX E: "SYSTEM DYNAMICS OF THE ALCOHOLIC FAMILY"
(Wegscheider, 1981)
# System Dynamics of the Alcoholic Family

<table>
<thead>
<tr>
<th>Role</th>
<th>Motivating feeling</th>
<th>Identifying symptoms</th>
<th>Payoff For individual</th>
<th>Payoff For family</th>
<th>Possible price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent</td>
<td>Shame</td>
<td>Chemical use</td>
<td>Relief of pain</td>
<td>None</td>
<td>Addiction</td>
</tr>
<tr>
<td>Enabler</td>
<td>Anger</td>
<td>Powerlessness</td>
<td>Importance; self-righteousness</td>
<td>Responsibility</td>
<td>Illness; &quot;martyrdom&quot;</td>
</tr>
<tr>
<td>Hero</td>
<td>Inadequacy; guilt</td>
<td>Over-achievement</td>
<td>Attention (positive)</td>
<td>Self-worth</td>
<td>Compulsive drive</td>
</tr>
<tr>
<td>Scapegoat</td>
<td>Hurt</td>
<td>Delinquency</td>
<td>Attention (negative)</td>
<td>Focus away from Dependent</td>
<td>Self-destruction addiction</td>
</tr>
<tr>
<td>Lost Child</td>
<td>Loneliness</td>
<td>Solitariness; shyness</td>
<td>Escape</td>
<td>Relief</td>
<td>Social isolation</td>
</tr>
<tr>
<td>Mascot</td>
<td>Fear</td>
<td>Clowning; hyperactivity</td>
<td>Attention (amused)</td>
<td>Fun</td>
<td>Immaturity; emotional illness</td>
</tr>
</tbody>
</table>

Reprinted with permission of Science & Behavior Books, Inc.
APPENDIX F: PHASES OF RECRUITMENT OF SUBJECTS
**PHASE ONE: Alcoholism Treatment Programs/Agencies:** Letters sent and follow-up telephone contacts made in most cases.

### A. Detoxification Centers

<table>
<thead>
<tr>
<th>Center</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beacon Detox Center</td>
<td>774-5272</td>
</tr>
<tr>
<td>59 Sanderson St., Greenfield, MA  01301</td>
<td></td>
</tr>
<tr>
<td>Contact: Linda Hoar, RN, Head Nurse</td>
<td></td>
</tr>
<tr>
<td>Holyoke Detox Center (The Elm St. Center”)</td>
<td>736-0334</td>
</tr>
<tr>
<td>210 Elm St., Holyoke, MA  01040</td>
<td></td>
</tr>
<tr>
<td>Contact: Phil Day</td>
<td></td>
</tr>
<tr>
<td>Alcohol and Drug Services of Greater Springfield</td>
<td>736-0334</td>
</tr>
<tr>
<td>1402 State St., Springfield, MA  01109</td>
<td></td>
</tr>
<tr>
<td>Contact: Betty Mesick, RN</td>
<td></td>
</tr>
<tr>
<td>Thomas W. McGee Unit</td>
<td>443-4761</td>
</tr>
<tr>
<td>Alcoholism Help Unit</td>
<td></td>
</tr>
<tr>
<td>Hillcrest Hospital</td>
<td></td>
</tr>
<tr>
<td>165 Tor Ct., Pittsfield, MA  01201</td>
<td></td>
</tr>
<tr>
<td>Doyle Detox Center</td>
<td>499-0337</td>
</tr>
<tr>
<td>793 North St., Pittsfield, MA  01201</td>
<td></td>
</tr>
</tbody>
</table>

### B. Inpatient/Rehabilitation Units

<table>
<thead>
<tr>
<th>Center</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarry Hill Alcoholism Rehab Center</td>
<td>568-1695</td>
</tr>
<tr>
<td>137 East Mountain Rd., Westfield, MA  01085</td>
<td></td>
</tr>
<tr>
<td>VA Medical Center</td>
<td>584-4040</td>
</tr>
<tr>
<td>Ward 9 Alcohol Dependence Treatment Program</td>
<td>(x 347, 348)</td>
</tr>
<tr>
<td>Northampton, MA  01060</td>
<td></td>
</tr>
<tr>
<td>Contacts: Dr. Meridith McCaron Director and Dr. Amy Hirsch</td>
<td>(508)75-9167</td>
</tr>
<tr>
<td>G.B. Wells Human Services Center</td>
<td></td>
</tr>
<tr>
<td>Harrington Memorial Hospital</td>
<td></td>
</tr>
<tr>
<td>29 Pine St. Southbridge, MA</td>
<td></td>
</tr>
<tr>
<td>Brattleboro Retreat</td>
<td>(802)257-7785</td>
</tr>
<tr>
<td>75 Linden St., Brattleboro, VT  05301</td>
<td></td>
</tr>
<tr>
<td>Contacts: Judith Brown Saunders</td>
<td>(x 447)</td>
</tr>
<tr>
<td>Audrey Renaud MSN, HN of Osgood Unit</td>
<td>(x 345)</td>
</tr>
<tr>
<td>Bev Fleming MSN Alcohol Unit</td>
<td></td>
</tr>
<tr>
<td>Naukeag Hospital</td>
<td>(508)827-5115</td>
</tr>
<tr>
<td>216 Lake Rd., Ashburnham, MA  01430</td>
<td></td>
</tr>
</tbody>
</table>
Chemical Dependency Services
Mary Lane Hospital
85 South St., Ware 01082
967-6211
(x196)

Wing Memorial Hospital
Palmer, MA 01069
283-7651

C. Outpatient Clinics:

Multi Service Health Inc.
76 Pleasant St., Northampton, MA 01060
586-8550

Beacon Clinic
Marie Hutton
57 Beacon St., Greenfield, MA 01301
772-6388

Sloane Clinic
1400 State St., Springfield, MA 01109
732-7476
Contact: Margaret Coughlin

Providence Hospital Adolescent Program
1233 Main St., Holyoke, MA 01040
788-0896

Alcohol Outpatient Clinic
131 Bradford St., Pittsfield, MA 01201
499-0337

Alcohol Abuse Counseling Center of Northampton
245 Main St., Northampton, MA 01060
586-9408

D. Halfway Houses

Opportunity House
61 St. James Springfield, MA 01105
Contact: Mr. Osgood, Chris Bauer, Jim Bump

Beacon House
53 Beacon St., Greenfield, MA 01301

E. DWI & EAP

Alcohol and Drug Services of Greater Springfield
Division of Court Programs
380 Union St., W. Springfield, MA 01089
734-5624

Alcohol and Drug Services of Greater Springfield
Employee Development Systems
380 Union St., W. Springfield, MA 01089
732-0040
**PHASE TWO: General Services**: Letters sent and/or telephone contacts made

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Phone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Beats Health Services</td>
<td>P.O. Box 71, Amherst, MA 01004-071</td>
<td>1-800-342-3794</td>
</tr>
<tr>
<td>Contact: Ron Godfrey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amherst Family Center</td>
<td>Box 541 No. Amherst, MA 01059</td>
<td>549-4969</td>
</tr>
<tr>
<td>Children’s Aid and Family Service of Hampshire Co.</td>
<td>8 Trumbell Rd., Northampton, MA 01060</td>
<td>584-5690</td>
</tr>
<tr>
<td>Displaced Homemakers</td>
<td>38 Gothic St., Northampton, MA 01060</td>
<td>584-9111</td>
</tr>
<tr>
<td>Franklin/Hampshire Comm. Mental Health Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greenfield FHCMHC Emergency Services</td>
<td>60 Wells St., Greenfield, MA 01301</td>
<td>774-3785</td>
</tr>
<tr>
<td>Community Multiservice Agency &amp; Co.</td>
<td>320 Riverside Dr., Northampton, MA 01060</td>
<td>584-0249</td>
</tr>
<tr>
<td>Family Planning</td>
<td>16 Center St., Northampton, MA 01060</td>
<td>586-2016</td>
</tr>
<tr>
<td>Dept. of Public Health</td>
<td>23 Service Center St., Northampton, MA 01060</td>
<td>586-7525</td>
</tr>
<tr>
<td>Contact: Jean Day MSW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lutheran Service Assoc.</td>
<td>263 College St., Amherst, MA 01002</td>
<td>253-9753</td>
</tr>
<tr>
<td>Contact: Me Me English, M.Ed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mt. Tom Institute for Human Services</td>
<td>507 Appleton St., Holyoke, MA 01040</td>
<td>536-5473</td>
</tr>
<tr>
<td>Contact: Tom Ostiguy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necessities</td>
<td>16 Center St., Northampton, MA 01060</td>
<td>586-5066</td>
</tr>
<tr>
<td>Womanshelter</td>
<td>Box 6099, Holyoke, MA 01040</td>
<td>536-5473</td>
</tr>
<tr>
<td>Northampton Center for Children &amp; Families Inc.</td>
<td>78 Pomeroy Terr., Northampton, MA 01060</td>
<td>584-1310</td>
</tr>
</tbody>
</table>
NELCWIT  
219 Silver St., Greenfield, MA 01301  
Contact: Mary Cociello (Clinical)  

Osborne Clinic  
299 Walnut St., Agawam, MA 01001  
Contacts: Dr. William Osborne, Polly de Sherbinin  

Kaiser Permanente  
   a. AMA - Mental Health Services  
      University Dr., Amherst, MA 01002  
      Contacts: Sarah Wolfe, Nancy Haffey, Stacy Lundin  
   b. Mental Health Services - Northampton Health Center  
      70 Main St., Florence, MA 01060  
      Contact: Kathy Dardeck - Director  

Everywoman's Center Wilder Hall  
U-Mass/Amherst 01003  
Contact: Kathy Alexander  

LIFT Program  
208 Middlesex House/UMA, 01003  
Contact: Director, Pat Ouellette  
Sandy Hart, Jerry Wise  

U-Mass Mental Health  
Contact: Jeff Hirsch  

U-Mass Psych Services  
Contact: Ted Slovin  

Employee Assistance Program  
University Health Services/UMA  

East Spoke of Franklin Medical Center  
Greenfield, MA 01301  
Contact: Rob Simpson, MD - Director
PHASE THREE: Substance Abuse Nurses and Counselors: Letters sent and/or telephone contacts made.

A. Nurses

Susan McCarthy, RN  
c/o GCC 1 College Dr., Greenfield, MA 01301  
369-4461

Lenore Goldstein, RN, LICSW  
155 Main St., Northampton, MA 01060  
584-0866

Judy Harrington, RN  
Exec. Dir. Hospice/VNA of Springfield  
PO Box 51947, Springfield, MA 01151-5947  
(H) 589-0136  
781-2317

Ruth Connors, RN  
Correctional Alcoholism Treatment Program  
734-1050

Colleen O'Conner, RN  
785-1946

Peter Buckley, RN  
(H) 739-7498

Donna Bird, RN  
(H) 592-6098

Holly Boulanger, RN  
(H) 267-4448

Cynthia Williamson, RN  
(H) 773-0865

Tom Ostiguy, RN  
786-4949

Carl McNeely, RN  
108 High St., Greenfield, MA 01301  
773-8044

Gail Higgins, RN  
253-7829

Gerri Templeton, RN  
586-2043

Marie De Cristo, RN  
(H) 253-7416

Rosemary Costa, RN  
(H) 593-3391

Carole Barrett, RN  
534-5691

B. Counselors (Non-Nurse)

Roget Lockard & Susan Loud  
Lynn Dr., Southampton, MA  
Office: 23 Main St., Northampton, MA 01060  
584-8685
John Novo  
23 Main St., Northampton, MA 01060  
585-5132

Maureen Frazier & Marian Frazier  
Rolling Green Apts., Amherst, MA 01002  
(H) 253-7710

James D. Shea, C.A.C.  
12 Maiden Lane, Wilbraham, MA 01095  
596-6979

Fran Deats EAP Coordinator  
University Health Services  
U-Mass Amherst 01003  
545-0350

Me Me English  
(H) 367-9585

Amy Leos Urbell  
(H) 584-3515

Patsy LaBelle/Brian Andersen  
586-1695

Judy Davis  
545-0333

Linda Johnson  
253-7762

Fred D'Amato  
732-3175

Laurie Detenber  
253-7514
PHASE FOUR: Media - Newspapers: Ads were placed in the following publications:

Valley Advocate (Classifieds)

Hampshire Life (Volunteer Section)
Dan De Nicola
115 Conz St., Northampton, MA 01060

Holyoke Transcript (Health Page)
Jean Mooney
120 Whiting Farms Rd., Holyoke, MA 01040

Daily Hampshire Gazette
Region Briefs/Announcements 584-5000

Family Journal
2095 Wilbraham Rd., Springfield, MA 783-8785

Springfield Union/Republican
1860 Main St., Springfield, MA 788-1234

Greenfield Recorder
14 Hope St., Greenfield, MA 01301 772-0261

Greenfield Town Crier
393 Main St., Greenfield, MA 01301 774-7226

Franklin Ledger
103 Avenue A., Turners Falls, MA 01376 863-9573

The Sentinel
Arlena Mac Pherson
10 So. Main St., Belchertown, MA 01007 323-7040

Town Reminder
PO Box 61, South Hadley, MA 01075

Posters:
Supermarkets - Price Chopper, Louis Foods, Stop n Shop, Food Mart,
Big Y, Bradlees
Laundromats
Beauty Parlors
Bulletin Boards

TV & Radio:
ACT 549-0777
Box 138 Amherst, MA 01004
(Community Calendar) Public Service Announcement
WWLP - Channel 22 Television Station
PO Box 2210, Springfield, MA 01102-2210
Notebook 786-2200

WREB
PO Box 507, Holyoke, MA 01041
Date Book 536-3930

WTTT
PO Box 67, Amherst, MA 01004
1-800-225-9888

WHMP
PO Box 268, Northampton, MA 01061
Hampshire Bulletin Board 586-7400

WMUA
Attn. Becky Zumbruski
102 Campus Center U-Mass, Amherst 01003 545-2876

WPOE
154 Federal St., Greenfield, MA 01301 774-2717
PHASE FIVE: **Clergy and Physicians**: Letters sent and follow-up telephone contacts made in most cases.

Newman Center, Amherst  
Fr. Quigley, Sr. Millie, Fr. Albertson, Fr. Bondi, Lucien Miller

St. Brigid, Amherst  
Fr. John Roche

Immac. Heart of Mary, Granby  
Fr. John J. Shea

Sacred Heart  
101 King St., Northampton  
Fr. Donald La Pointe

St. John's, Hadley  
Fr. Roy Ducette

Holy Family  
Holy Family Rd., Holyoke  
Fr. Thomas Shea

St. Patrick's  
319 Broadway, Chicopee  
Fr. Leo Hoar

Holy Trinity  
PO Box 308, Greenfield  
Fr. Franklin Darling

Holy Family  
235 Eastern Ave., Springfield  
Fr. Warren Savage

Jericho House  
PO Box 1039, Holyoke  
Fr. Robert Wagner

Springfield Diocese  
Director of Marriage Counseling  
Fr. John Johnson  
Marriage Tribunal, 73 Chestnut St, Spfld

North Congregational, Amherst  
Rev. Philip S. Hall

Amherst Episcopal  
Rev. Clark
First Congregational
165 Main St., Amherst
Rev. Jeanette Good

Passionist Retreat House
Monastery Ave., W. Springfield
Rev. James Greer

39 Oakland St., Springfield
Rev. Scott Seabury

Southampton Episcopal
92 Line St, Southampton
Elise & Raymond Feeley
Dear Colleague in the Chemical Dependency Field,

I need your help in finding clients for my dissertation research. My study focuses on teaching and counseling wives of alcoholics in a group setting. To avoid confusion in evaluating outcomes, my sample should consist solely of women who have had no previous exposure to Al-Anon. Finding such a sample may be a difficult matter; perhaps, impossible, without your assistance.

My request is that you ask any new clients who are wives of alcoholics and have never attended Al-Anon if they would be willing to participate in a colleague’s study. In addition any married male alcoholic clients could be asked to refer their wives to you to be referred for this project.

Enclosed are two consent forms for the purpose of getting permission from a prospective client for you to give me her first name and phone number. Upon giving me the name and phone number, no further action is required of you. I will explain the study and answer any questions the client may have.

For your information, the study will entail an intake interview; six - 2 hour group teaching-counseling sessions; a brief exit interview; and three follow-up telephone calls at 1, 2 and 3 months after the last group session. My name may be familiar to you as one who has been working in the substance abuse field in Western Mass. since 1972 and who is sensitive to the issues surrounding family alcoholism.

I would be happy to answer any questions you or any other agency counselors may have about the procedures of this study. I can be reached at 253-7706. Please feel free to pass this letter on to other counselors.

Thank-you in advance for your efforts to help me. I believe that we have the same overriding goal: that is, improved service to families who live with this problem.

Sincerely,

Nancy B. Fisk, RN, MS
Doctoral candidate
(Family Therapy)
Dear Colleague,

I need your help in finding clients for my dissertation research. My study focuses on teaching and counseling wives of alcoholics in a group setting. To avoid confusion in evaluating outcomes, my sample should consist solely of women who have had no previous exposure to Al-Anon. Finding such a sample may be a difficult matter; perhaps, impossible, without your assistance.

My request is that you ask any new clients who are wives of alcoholics and have never attended Al-Anon if they would be willing to participate in a colleague’s study. In addition any married male alcoholic clients could be asked to refer their wives to you to be referred for this project.

For your information, the study will entail an intake interview; six - 2 hour group teaching-counseling sessions; a brief exit interview; and three follow-up telephone calls at 1, 2 and 3 months after the last group session. My name may be familiar to you as one who has been working in the substance abuse field in Western Mass. since 1972 and who is sensitive to the issues surrounding family alcoholism. I can assure you that anonymity, privacy, respect, and other such ethical considerations are of paramount importance to me. Clients will be referred back to the referring agent/agency upon completion of the study or if screening criteria are not met.

I would be happy to answer any questions you or any other agency counselors may have about the procedures of this study. I can be reached at 253-7706. Please feel free to pass this letter on to other counselors.

Thank-you in advance for your efforts to help me. I believe that we have the same overriding goal; that is, improved service to families who live with this problem.

Sincerely,

Nancy B. Fisk, RN, MS
Doctoral candidate
(Family Therapy)
Revised Phase One Form Letter

Dear Colleague in the Chemical Dependency Field,

I need your help in finding clients for my dissertation research. My study focuses on teaching and counseling wives of alcoholics in a group setting. To avoid confusion in evaluating outcomes, my sample should consist solely of women who have had no previous exposure to Al-Anon. Finding such a sample may be a difficult matter; perhaps, impossible, without your assistance.

Enclosed are some form letters addressed "Dear Family Member" (on colored paper). My request is that you hand one of these letters to wives of male patients who have an active alcohol problem. If you do not have contact with such a patient's wife you might hand a letter to any other family member (including the patient himself) and request that he or she pass the letter on to the wife. The ideal candidate for my research would be one who has never attended Al-Anon and who is still living in the same household with the drinking spouse. No further action is required of you beyond handing out the letter.

For your information, the study will entail an intake interview; six - 2 hour group teaching-counseling sessions; a brief exit interview; and three follow-up telephone calls at 1.2 and 3 months after the last group session. My name may be familiar to you as one who has been working in the substance abuse field in Western Mass. since 1972 and who is sensitive to the issues surrounding family alcoholism.

I would be happy to answer any questions you or any other agency counselors may have about the procedures of this study. I can be reached at 253-7706. Please feel free to pass this letter on to other counselors.

Thank-you in advance for your efforts to help me. I believe that we have the same overriding goal; that is, improved service to families who live with this problem.

Sincerely,

Nancy B. Fisk, RN, MS
Doctoral candidate
(Family Therapy)
Revised Phase Two Form Letter

Dear Colleague,

I need your help in finding clients for my dissertation research. My study focuses on teaching and counseling wives of alcoholics in a group setting. To avoid confusion in evaluating outcomes, my sample should consist solely of women who have had no previous exposure to Al-Anon. Finding such a sample may be a difficult matter; perhaps, impossible, without your assistance.

Enclosed are some form letters addressed "Dear Family Member" (on colored paper). My request is that you hand one of these letters to wives of male patients who have an active alcohol problem. If you do not have contact with such a patient's wife you might hand a letter to any other family member (including the patient himself) and request that he or she pass the letter on to the wife. The ideal candidate for my research would be one who has never attended Al-Anon and who is still living in the same household with the drinking spouse. No further action is required of you beyond handing out the letter.

For your information, the study will entail an intake interview; six - 2 hour group teaching-counseling sessions; a brief exit interview; and three follow-up telephone calls at 1, 2 and 3 months after the last group session. My name may be familiar to you as one who has been working in the substance abuse field in Western Mass. since 1972 and who is sensitive to the issues surrounding family alcoholism.

I would be happy to answer any questions you or any other agency counselors may have about the procedures of this study. I can be reached at 253-7706. Please feel free to pass this letter on to other counselors.

Thank-you in advance for your efforts to help me. I believe that we have the same overriding goal; that is, improved service to families who live with this problem.

Sincerely,

Nancy B. Fisk, RN, MS
Doctoral candidate
(Family Therapy)
Dear Family Member,

Sometimes when a loved one is having problems with alcohol and/or drugs and he or she is being treated the other members of the family have mixed emotions. Perhaps they are relieved on the one hand that something is being done for the "patient". On the other hand, they may feel that as the "sober" one holding things together, their own distress deserves some sort of attention too not necessarily "treatment" but recognition and understanding. Wives in particular may feel that no one cares how they're feeling! Some may even feel that people blame them for the problem.

I am a nurse/family therapist with 20 years of experience in the field of substance abuse and I, for one, am really interested in that wife! Her struggles and pain are quite familiar to me and I would like the opportunity to try to provide some short-term help FREE OF CHARGE.

If you are the wife of someone in treatment at this agency, I would appreciate hearing from you. You can call me any time of the day or night at 253-7706. I will explain the project that I am working on as a part of my doctoral studies. If it sounds as though it would be helpful to you we can meet to discuss it further.

There are no strings attached! I'll be frank with you: I am providing counseling free of charge in order to complete a study designed to evaluate my work. I need wives who have not previously had a lot of treatment or a lot of Al-Anon involvement. This does not mean that I'm not concerned about husband's or other family members (children, parents, etc.) but just that this study must focus on one discreet group.

Anonymity will be protected. When we speak on the phone I will answer any questions or concerns before you decide if you wish to volunteer. There will be no pressure to participate and you may change your mind at any time.

I will be looking forward to hearing from you!

Sincerely,

Nancy B. Fisk, RN, EdD Candidate

P.S. If I am not at home when you call, you might wish to leave your first name and phone # on my answering machine. No one else will hear the message. Again, my Number: 253-7706
Phase Four Advertisement Form

Would you kindly run the following ad in your public service announcement broadcast:

DO YOU WORRY ABOUT YOUR HUSBAND'S DRINKING? A NURSE/THERAPIST IS CONDUCTING GROUP SESSIONS FOR WIVES WHO HAVE NOT PREVIOUSLY SOUGHT HELP FOR THIS PROBLEM. PLEASE CALL 253-7706 TO FIND OUT HOW YOU CAN BENEFIT FROM THESE FREE AND STRICTLY CONFIDENTIAL SESSIONS.

Thank you for your help.

Nancy B. Fisk
591 West St.
Amherst, MA 01002
253-7706
Phase Four: Variations on Ads

1. FOR CLASSIFIED AD:
   WIVES: Free and confidential help for women who are worried about their husbands' drinking. Call 253-7706 for further information.

2. SHORT ANNOUNCEMENT:
   WIVES: Free and confidential teaching-counseling sessions for wives of problem drinkers who have not previously sought help. Schedule depending on group needs. For further information call 253-7706.

3. ALL PURPOSE #1
   ARE YOU UPSET ABOUT YOUR HUSBAND'S DRINKING? A NURSE-RESEARCHER IS CONDUCTING WORK-SESSIONS FOR WIVES WHO HAVE NOT PREVIOUSLY SOUGHT HELP FOR THIS PROBLEM. PLEASE CALL 253-7706 TO FIND OUT HOW YOU CAN BENEFIT FROM THESE FREE AND STRICTLY CONFIDENTIAL SESSIONS.

4. ALL PURPOSE #2
   ARE YOU UPSET ABOUT YOUR HUSBAND'S DRINKING? A NURSE-RESEARCHER IS CONDUCTING WORK-SESSIONS FOR WIVES WHO HAVE NOT PREVIOUSLY SOUGHT HELP FOR THIS PROBLEM. PLEASE CALL 253-7706.

5. ALL PURPOSE #3
   DO YOU WORRY ABOUT YOUR HUSBAND'S DRINKING? A NURSE/ THERAPIST IS CONDUCTING COUNSELING SESSIONS FOR WIVES WHO HAVE NOT PREVIOUSLY SOUGHT HELP. PLEASE CALL 253-7706.
Dear Pastoral Counselor,

I am writing to ask your help in finding clients for my doctoral dissertation research. My study focuses on teaching and counseling wives of alcoholics in a group setting. To avoid confusion in evaluating outcomes, my sample should consist solely of women who have had no previous exposure to Al-Anon. Finding such a sample may be a difficult matter; perhaps, impossible, without your assistance.

My request is that you ask any counselees who are wives of alcoholics and have never attended Al-Anon if they would be willing to participate in a study being conducted by a nurse/family therapist. If she agrees you would then simply give her my name and phone number; no further action is required of you. I will explain the study and answer any questions the client may have during the first telephone contact. If she is still interested I will meet with her for a more complete interview. You may emphasize that participation is entirely voluntary throughout and she may change her mind and withdraw at any time.

For your information, the study will entail an intake interview; six - 2 hour group teaching-counseling sessions; a brief exit interview; and three follow-up telephone calls at 1, 2 and 3 months after the last group session. Participation in these group sessions may be very helpful in aiding understanding of alcoholism and what a wife can do to help herself, her children and improve her home situation. All sessions are free of charge. I have been working in the substance abuse field in Western Mass. since 1972 and am sensitive to the issues surrounding family alcoholism. I can assure you that anonymity, privacy, respect, and other such ethical considerations are of paramount importance to me. Clients will be referred back to the referring person upon completion of the study or if screening criteria are not met.

I would be happy to answer any questions you have about the procedures of this study. I can be reached at 253-7706. Please feel free to pass this letter on to other counselors.

Thank-you in advance for your efforts to help me. My overriding goal is, quality service to families who live with this problem. I hope you agree that this is a worthwhile endeavor.

Sincerely,

Nancy B. Fisk, RN, MS,
Doctoral Candidate
(Family Therapy)
Recruitment Activity Summary Sheet

I Alcoholism Treatment programs/Agencies:
- Detoxification Centers 5
- Inpatient/Rehab Units 8
- Outpatient Clinics 6
- Halfway Houses 2
- DWI & EAP Programs 3
(24 letters & follow-up calls x 2)

II General: Community Health/Mental Health Programs:
- Children's Service Agencies 3
- Women's Centers 5
- CMH Services 8
- HMO Mental Health Services 2
- Inpatient Mental Health 1
- General Service agencies 6
(25 letters & follow-up phone calls on some)

III Substance Abuse Nurses and Counselors:
- Nurses 20
- Counselors (non-nurse) 13
(33 letters & follow-up calls)

IV Media and Other Public Advertisement:
- Daily Newspapers 4 for 4 wks.
- Weekly Newspapers 7 for 3 wks.
- Flyers: (Made out about 200)
  - Supermarkets
  - Laundromats
  - Bulletin Boards
- TV & Radio 7 stations
(18 letters and/or calls)

V Clergy / Pastoral Counselors:
- Priests, Ministers 21
- Religious Women 2
(23 letters)

About 123 letters
- Dear colleague in Alcoholism field
- Dear colleague
- Dear Pastoral Counselor

About 72 phone calls

About 200 flyers on community bulletin boards

About 20 open letters to wives delivered to 3 detoxes, to Quarry Hill, to East Spoke, to AMA Mental Health
APPENDIX G: CONSENT FORMS
You are being asked to participate in a study designed by Nancy B. Fisk, a doctoral candidate who is also a nurse/family therapist. Nancy is interested in implementing and evaluating teaching/counseling about alcoholism. This will involve your attending 6 two-hour sessions one week apart and completing anonymous questionnaires.

Participation in these group sessions may be very helpful to you in aiding your understanding of alcoholism and what you can do to improve your home situation. It is entirely voluntary and refusal to participate is perfectly acceptable. Should you decide to participate you may change your mind and withdraw at any time you wish by simply informing the researcher.

This study is not connected with this agency. Your relationship with this agency will not be affected should you decide not to participate or should you withdraw after consenting. Anonymity and confidentiality will be maintained throughout the study. Only group data will be reported. Neither your name nor any other identifying characteristics will be released at any time.

The procedures will be fully explained to you and you will have the opportunity to ask questions before you decide if you wish to participate. At present you are being asked to permit this agency to give your first name and telephone number to the nurse researcher.

Please sign below that you have read, understand and have been allowed to question these statements.

Signed:_______________________
Witness:_______________________
Date:_________________________
INFORMED CONSENT - GROUP SESSIONS

You are being asked to participate in a study designed to evaluate teaching/counseling about alcoholism. This will involve your attending 6 two-hour classes one week apart and completing anonymous questionnaires. Participation in these group sessions may be beneficial to you in enhancing your understanding of alcoholism. You may also gain useful information about what you can do to improve your home situation.

Your participation is entirely voluntary and refusal to participate is perfectly acceptable. Should you decide to participate you may change your mind and withdraw at any time. You will not suffer any harm as a result of participating in the research. You may feel some mild momentary anxiety while completing some of the questions. The researcher will be available to you to discuss concerns which your participation may raise for you.

Anonymity is guaranteed. The researcher will not use your name in any verbal or written reporting. No other identifying characteristics will be released at any time. Only group data will be reported. The data will be kept in a locked file until destroyed after the research.

Please sign below that you have read and understood these statements and that the procedures have been explained to you. If you have any questions please ask them before signing this.

Signed: ___________________________  Witness: ___________________________

Date: ______________

Researcher: Nancy B. Fisk
Division of Nursing
225 Arnold House
U-Mass, Amherst, MA 01003
APPENDIX H: INSTRUMENTS

INSTRUMENTS

1. FCEA FAMILY ALCOHOLISM SCALE
2. ZWEBEN SPOUSE HARDSHIP SCALE
3. ZWEBEN REVISED MARITAL RELATIONSHIP SCALE
4. SPOUSE SURVIVAL BEHAVIOR SCALE
FCEA FAMILY ALCOHOLISM SCALE

ID #______________

To provide a baseline of information about your view of your mate's drinking, please carefully consider each of the following 20 questions and check either "yes" or "no" for each.

1. Do you worry about your spouse's drinking? □ □
2. Have you ever been embarrassed by your spouse's drinking? □ □
3. Are holidays more of a nightmare than a celebration because of your spouse's drinking behavior? □ □
4. Are most of your spouse's friends heavy drinkers? □ □
5. Does your spouse often promise to quit drinking without success? □ □
6. Does your spouse's drinking make the atmosphere in the home tense and anxious? □ □
7. Does your spouse deny a drinking problem because your spouse drinks only beer? □ □
8. Do you find it necessary to lie to employer, relatives, or friends in order to hide your spouse's drinking? □ □
9. Has your spouse ever failed to remember what occurred during a drinking period? □ □
10. Does your spouse avoid conversation pertaining to alcohol or problem drinking? □ □
11. Does your spouse justify his or her drinking problem?

12. Does your spouse avoid social situations where alcoholic beverages will *not* be served?

13. Do you ever feel guilty about your spouse's drinking?

14. Has your spouse driven a vehicle while under the influence of alcohol?

15. Are your children afraid of your spouse while he or she is drinking?

16. Are you afraid of physical or verbal abuse when your spouse is drinking?

17. Has another person mentioned your spouse's unusual drinking behavior?

18. Do you fear riding with your spouse when he or she is drinking?

19. Does your spouse act remorsefully after a drinking occasion and apologize for behavior?

20. Does spouse seem to get the same effects from drinking less alcohol than he used to?
Scoring of FCEA Family Alcoholism Scale

Family Counseling and Education in Alcoholism, Inc. Columbia, Missouri suggests the following scale in scoring their twenty item questionnaire.

If you have answered YES to any two of the questions, there is a definite warning that a drinking problem may exist in your family.

If you have answered YES to any four of the questions, the chances are that a drinking problem does exist in your family.

If you have answered YES to five or more, there very definitely is a drinking problem in your family.

Footnote: Minor language modifications have been made by the present investigator; they are not substantive and should have no effect on results or scoring.
SPouse HARDsHIPS SCALE

ID #________

The following questions are about the recent behaviors of your spouse. Please check the appropriate answer for each question:

1. Is he/she restless at night or wakes up with bad dreams?
2. Does he/she sometimes let himself get dirty, unkempt, or smelly?
3. Does he/she fail to join in family activities?
4. Does he/she pick quarrels with you?
5. Has he/she sometimes threatened you?
6. Has he/she ever attempted to inflict physical harm on you?
7. Does he/she sometimes go on and on for hours arguing with you?
8. Does he/she, when he/she's like this, break furniture (or windows or doors or china?)
9. Is he/she very possessive and jealous toward you, asking you questions about everyone you meet?
## REVISED MARITAL RELATIONSHIP SCALE

**ID #______________**

Listed below are statements that may be used to describe one's marriage (living arrangements). Please read each statement carefully and decide whether this is true or false about your marriage (living arrangement). Indicate your answer by circling T if true; F if false.

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My spouse should do a better job of keeping things tidy.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>2.</td>
<td>My spouse and I spend time together just having fun.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>3.</td>
<td>I feel that my spouse should be more careful when spending money.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>4.</td>
<td>When we’re upset we share our problems with each other.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>5.</td>
<td>My spouse is too dependent on me for making decisions.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>6.</td>
<td>My spouse only cares for me as long as I do what he/she wants.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>7.</td>
<td>My spouse usually does his/her share of jobs around the house.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>8.</td>
<td>Because my spouse wouldn’t understand, I seldom tell him/her what’s bothering me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>9.</td>
<td>Often I’m not sure if my spouse still loves me.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>10.</td>
<td>We seldom argue about money.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>11.</td>
<td>I am generally happy with our sex life.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>
12. We're like a couple of strangers living in the same house.  
13. We talk things over when important decisions are to be made.  
14. There are times when I'm not sure when my spouse is coming home.  
15. Despite our problems I'm happy that we're married.  
16. My spouse is easy to talk with.  
17. My spouse doesn't care when I'm upset.  
18. I am not satisfied with our social life.  
19. If my spouse was sexually involved with another person, I would be very upset.  
20. I rarely feel neglected by my spouse.
SPOUSE SURVIVAL BEHAVIOR SCALE

ID # ________

Most women whose husbands have a drinking problem try different ways of helping the situation at one time or another. Some of these are listed on the following pages. Read each statement carefully while reflecting on the past 2 months (approximately). Indicate the degree to which you have engaged in each behavior by placing a checkmark in one of the four boxes at the right.

0 = no 1 = yes, once or twice 2 = yes, about once a week 3 = yes, more often than once a week

0 1 2 3

1. Trying to keep his drinking light by inviting friends and relatives in

2. Reminding him of the "stupid things" he did last night while drinking

3. Trying to stop his drinking by reasoning with him before he goes out

4. Withdrawing from affectionate contact

5. Reminding him of all the good things he could have if he stopped drinking

6. Going out with single friends more

7. Making sarcastic remarks at him in front of others

8. Getting drunk yourself to try to get him to stop drinking too much

9. Taking over his household chores or other responsibilities

10. Threatening to leave him

11. Cleaning up messes or repairing damage caused by his drinking

12. Pleading with him to stop drinking

13. Refraining from talking about certain subjects

14. Drinking with him to keep him happy

15. Keeping out of the way when he is drinking

16. Making excuses to others for his behavior

17. Nursing him through withdrawal symptoms

18. Calling his workplace to say he is ill when he has a hangover

19. Pouring some of the alcohol down the drain
0= no 1=yes, once or twice  2=yes, about once a week  3=yes, more often than once a week

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Getting drawn into his argumentative mood when he is drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Delivering ultimatums (i.e. go to A.A.or else...)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Trying to make him feel guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Making sure he gets to bed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Quarreling about whether he is drunk or not</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Arranging special constraints on his access to money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Leaving home for a period of time to give him a scare</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. &quot;Making up&quot; or taking him back one more time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Avoiding sleeping in the same room with him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Retaliating for insults or hurt feelings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Slamming cupboards or doors at him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Checking his breath for the smell of alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Shouting or screaming hysterically at him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Fighting about how much money is being spent on alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Throwing things at him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Becoming emotional and crying</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Making sure he gets up on the morning after</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Refusing sex to punish him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Failing to follow through on ultimatums</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Showing him that his drinking is making you ill</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Comparing him unfavorably to another man who doesn't have a drinking problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. Screening phone calls from his drinking &quot;buddies&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. Calling him &quot;a drunk&quot; or similar name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. Keeping him away from social situations where he might drink too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44. Avoiding kissing him &quot;goodbye&quot; when he leaves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. Using sex to manipulate him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46. Pleading that he stop drinking for the sake of the children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Blaming him for a poor sexual relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. Giving him the &quot;silent treatment&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49. Telling him he's damaging the children because of his drinking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. Resisting going home when he's apt to be there</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51. Allowing the children to belittle him or show disrespect</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52. Hiding your purse and other valuables from him</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
0= no 1=yes, once or twice  2=yes, about once a week  3=yes, more often than once a week

53. Hitting him or trying to hurt him physically
54. Quarreling about how much he has had to drink
55. Calling his relative or friend to say, "he's drunk again!"
56. Avoiding talking to him whether he's drinking or not
57. Avoiding social situations where he might embarrass you
58. Fighting with him about his drinking when he is already drunk
59. Leaving him alone more (e.g. taking the children with you)
60. Threatening to find another man
61. Avoiding kissing him "hello" when he comes home
62. Locking him out of the house (in the absence of real threat to your safety)
63. Recoiling from sexual advances
64. Making a firm no-drinking-in-the-house rule
65. Going to work to compensate for the extra money spent on alcohol
66. Making sure he gets something to eat even though he is drinking
67. Forcing him to go to A.A. meetings
68. Being secretive about your own activities
69. Threatening to file for divorce or legal separation
70. Searching for his hidden alcohol supply
71. Extracting promises from him about how much he will or will not drink
72. Pretending to everyone that all is well
73. Going without to provide him with money
74. Keeping the children away from him whether he's drinking or not
75. Going out to bring him home
76. Questioning his masculinity when alcohol decreases his sexual performance
77. Paying his debts or bills
SPOUSE SURVIVAL BEHAVIOR SCALE
Clusters and Spouse Survival Behaviors

Cluster I. Coddling/Rescuing
- Making sure he gets something to eat even though he is drinking
- Going to work to compensate for the extra money spent on alcohol
- Paying his debts or bills
- Pretending to everyone that all is well
- Making sure he gets to bed
- Going out to bring him home
- Going without to provide him with money
- Taking over his household chores or other responsibilities
- Drinking with him to keep him happy
- Calling his workplace to say he is ill when he has a hangover
- Cleaning up messes or repairing damage caused by his drinking
- Making sure he gets up on the morning after
- Nursing him through withdrawal symptoms
- "Making up" or taking him back one more time
- Making excuses to others for his behavior

Cluster II. Avoiding/Withdrawing
- Refraining from talking about certain subjects
- Being secretive about your own activities
- Keeping out of the way when he is drinking
- Avoiding talking to him whether he is drinking or not
- Avoiding sleeping in the same room with him
- Leaving him alone more (e.g. taking children with you)
- Resisting going home when he's apt to be there
- Withdrawing from affectionate contact
- Avoiding kissing him "hello" when he comes home
- Avoiding kissing him "goodbye" when he leaves
- Recoiling from sexual advances
- Keeping the children away from him whether he's drinking or not
- Going out with single friends more
- Avoiding social situations where he might embarrass you

Cluster III. Controlling/Thwarting
- Trying to stop his drinking by reasoning with him before he goes out
- Arranging special constraints on his access to money
- Hiding his bottle when he brings it home
- Searching for his hidden alcohol supply
- Hiding your purse and other valuables from him
- Making a firm no-drinking-in-the-house rule
- Forcing him to go to A.A. meetings
- Getting drunk yourself to try to get him to stop drinking too much
- Trying to keep his drinking light by inviting friends or relatives in
- Checking his breath for the smell of alcohol
- Pouring some of the alcohol down the drain
- Screening phone calls from his drinking "buddies"
- Keeping him away from social situations where he might drink too much
- Using sex to manipulate him

Cluster IV. **Pleading/Threatening**
- Pleading that he stop drinking for the sake of the children
- Threatening to leave him
- Threatening to call his boss or A.A. sponsor to try to stop him
- Pleading with him to stop drinking
- Threatening to get a restraining order
- Reminding him of all the good things he could have if he stopped drinking
- Threatening to find another man
- Leaving home for a period of time to give him a scare
- Threatening to file for divorce or legal separation
- Extracting promises from him about how much he will or will not drink
- Becoming emotional and crying
- Delivering ultimatums (i.e. go to A.A. or else...)
- Failing to follow through on ultimatums

Cluster V. **Blaming/Punishing**
- Refusing sex to punish him
- Showing him that his drinking is making you ill
- Telling him he's damaging the children because of his drinking
- Calling him "a drunk" or similar name
- Reminding him of the "stupid things" he did last night while drinking
- Allowing the children to belittle him or show disrespect
- Comparing him unfavorably to another man who doesn't have a drinking problem
- Blaming him for a poor sexual relationship
- Questioning his masculinity when alcohol decreases his sexual performance
- Trying to make him feel guilty
- Giving him the "silent treatment"
- Making sarcastic remarks at him in front of others
Cluster VI. Quarreling/Attacking
- Fighting with him about his drinking when he is already drunk
- Locking him out of the house (in the absence of real threat to your safety)
- Calling his relative or friend to say, "he's drunk again!"
- Quarreling about how much he has had to drink
- Quarreling about whether he is drunk or not
- Shouting or screaming hysterically at him
- Slamming cupboards or doors at him
- Fighting about how much money is being spent on alcohol
- Hitting him or trying to hurt him physically
- Getting drawn into his argumentative mood when he is drinking
- Retaliating for insults or hurt feelings
- Throwing things at him
APPENDIX I: SUMMARY OF TEACHING/COUNSELING PACKAGES AND TEACHING/COUNSELING OUTLINE
### Summary of Teaching/Counseling Packages: "Wives of Alcoholics"

#### Family Centered Group
- **6 - 2 hour sessions (e.g. 6 Tuesdays)**
- **Intake Interview Demographic Data**
- **Pretests/Screening**

<table>
<thead>
<tr>
<th>Group</th>
<th>Session</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>Session 1</td>
<td>Introductory Exercises  &lt;br&gt; Overview of session  &lt;br&gt; Spouse Survival Behavior Scale</td>
</tr>
<tr>
<td>Group</td>
<td>Session 2</td>
<td>Lecture/Discussion:  &lt;br&gt; Alcoholism: Family System Dysfunction  &lt;br&gt; Johnson Institute/Wegscheider  &lt;br&gt; Survival roles and J.I. Intervention  &lt;br&gt; Film: &quot;The family Trap&quot; 30 min.  &lt;br&gt; Berenson Choices Presented  &lt;br&gt; and discussed in relation to participants' present status  &lt;br&gt; Al-Anon included as one of Berenson's Choices  &lt;br&gt; (Circular/questioning style used)</td>
</tr>
<tr>
<td>Group</td>
<td>Session 3</td>
<td>Discussion/Personal Stories  &lt;br&gt; focused on Berenson's choices  &lt;br&gt; (Circular/questioning style used)</td>
</tr>
<tr>
<td>Group</td>
<td>Session 4</td>
<td>Discussion/Personal Stories  &lt;br&gt; focused on Berenson's Choices  &lt;br&gt; (Circular/questioning style used)</td>
</tr>
<tr>
<td>Group</td>
<td>Session 5</td>
<td>Summary and Post-tests  &lt;br&gt; Evaluation</td>
</tr>
</tbody>
</table>

#### Person-Centered Group
- **6 - 2 hour sessions (e.g. 6 Thursdays)**
- **Intake Interview Same as Family Centered Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>Session 1</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>Session 1</td>
<td>Introductory Exercises  &lt;br&gt; Overview of sessions  &lt;br&gt; Spouse Survival Behavior Scale</td>
</tr>
<tr>
<td>Group</td>
<td>Session 2</td>
<td>Lecture/Discussion:  &lt;br&gt; General Information Pamphlets  &lt;br&gt; Disease Concept of alcoholism  &lt;br&gt; Adjustment of the family to alcoholism</td>
</tr>
<tr>
<td>Group</td>
<td>Session 3</td>
<td>&quot;Children of Denial&quot; 28 min. videotape  &lt;br&gt; (Claudia Black)  &lt;br&gt; 30 min. Videotape: &quot;If You Loved Me&quot;  &lt;br&gt; Discussion of pamphlet given for homework</td>
</tr>
<tr>
<td>Group</td>
<td>Session 4</td>
<td>Al-Anon Presented  &lt;br&gt; 15 min. videotape  &lt;br&gt; &quot;Al-Anon Speaks for Itself&quot;  &lt;br&gt; Discussion/Personal Stories  &lt;br&gt; focused on traditional direct approach encouraging Al-Anon</td>
</tr>
<tr>
<td>Group</td>
<td>Session 5</td>
<td>Discussion/Personal Stories  &lt;br&gt; focused on traditional direct approach encouraging Al-Anon</td>
</tr>
<tr>
<td>Group</td>
<td>Session 6</td>
<td>Summary and Post-tests  &lt;br&gt; Evaluation</td>
</tr>
</tbody>
</table>
TEACHING/COUNSELING OUTLINE

GROUP SESSION #1 FAMILY-SYSTEMS APPROACH

<table>
<thead>
<tr>
<th>Approx Time</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>15&quot;</td>
<td>1. Introductions around room:</td>
</tr>
<tr>
<td></td>
<td>Researcher: general intro to the project: Commitment to Confidentiality/Caring/Communicating</td>
</tr>
<tr>
<td></td>
<td>Assistant/Demographer: Introduction by researcher explain her role (to help me keep on track and listen and take notes to understand my process)</td>
</tr>
<tr>
<td>45&quot;</td>
<td>Each participant asked to share, if they wished, a sentence or two about themselves: FIRST NAME ONLY</td>
</tr>
<tr>
<td></td>
<td>1) one thing they hoped they might get from sessions</td>
</tr>
<tr>
<td></td>
<td>2) one fear or concern they had about these sessions</td>
</tr>
<tr>
<td></td>
<td>3) show an item from purse or coat pocket or something on their person that has special meaning to them and gives us an idea about who they are.</td>
</tr>
<tr>
<td>30&quot;</td>
<td>2. Overview of 6 sessions: what to expect</td>
</tr>
<tr>
<td></td>
<td>Setting the tone: informality, sharing only what is comfortable; &quot;no blame; no fault; just surviving.&quot; clarifying choices; family disease; family roles</td>
</tr>
<tr>
<td></td>
<td>Brief, session-by-session overview (session # 2,3,4,5,6)</td>
</tr>
<tr>
<td></td>
<td>Sollicit questions, comments, etc.</td>
</tr>
<tr>
<td>15&quot;</td>
<td>- Refreshment Break -</td>
</tr>
<tr>
<td>45&quot;</td>
<td>3. Pretest administered: o.k. to ask questions to clarify etc</td>
</tr>
<tr>
<td></td>
<td>Adjournment</td>
</tr>
</tbody>
</table>
SESSIONS #2,3,4,5,& 6 FAMILY-SYSTEMS APPROACH

1. Start each group session after the first one with:

What happened in your house this past week since we saw each other last? (not more than a minute or two each). Did any changes occur, that you noticed, either in yourself or our spouse or any other family member?

2. Milan Circular Questions

How do you explain that? or How do you make sense of it? or Do you have any hunches why that is?

If I were to ask your husband the same question what would he say? What would the kids say?

SESSION #2 SPECIFIC CONTENT

1. Alcoholism: Family System Dysfunction


Using a mobile and visual aids, Sharon Wegscheider lectures to a large audience. The whole tape is didactic, narrative format. Mobile is a system; family is a system too.

1) Individual Butterflies
   family
   (family members)
   ages, value system
   -------------------------------
   harmony; balance

2) Strings & sticks which hold together
   (emotional investment)

Chemical dependency (CD) damages family the same as damaging mobile by removing a part
Emotional rejection is what all family members feel from CD person. CD family denies more than other dysfunctional families otherwise. Can apply this to all dysfunctional families.

Survival Roles:

a. **Chemically Dependent** person represses & medicates feelings/rigidly predictable blaming-withdrawing

b. **Prime Enabler** Person who loves them most: "the enabling illness"/feelings inside/secrets kept/afraid CD will leave them (already feels rejected) superworker/over responsible/self worth is low on the whole/believe the blame. Inside: pain/anger/physical illness.

c. Four behavior patterns of children: **Hero, Scapegoat, Lost Child, Mascot**

2. **Sharing/Discussion after Film**

What roles can you identify in your present family with your own children?

What roles can you identify in your family of origin? (Some may be [ACOA's or ACAP])

Those of you who have grandchildren, do you see any of these roles? (ACAG)

Reinforce idea of multigenerational projection of this family disease; maybe down through the ages

Reinforce idea that you did not cause this problem in your husband; that both of you are in some ways victims of victims

Clearly there are also genetic factors that interweave with these family dynamics
So there is nothing that you did or neglected to do that makes your husband drink (he might like you to think that it's your fault). It's not. You didn't cause it and you can't cure it. Neither did you cause your children's roles to be. Discuss.

GROUP SESSION # 3 FAMILY-SYSTEMS APPROACH

30” **Choices** Now we're going to try to get into perspective the fact that we have choices. I hear a lot of women say "I have no choice" or "What choice do I have?" a question form of the same expression that says "I'm powerless". Is this true?

**What are our choices:**

1. Keep doing exactly what we're doing
2. Detach (emotionally) a) Al-Anon; b) J-I intervention
3. Separate (physically) a) you leave; b) he leaves
   (Give examples) Anything else?

**Brainstorming:** how has this related to your life with your own spouse. Can anybody see where they are in relation to these choices?

GROUP SESSIONS #4 AND #5 FAMILY-SYSTEMS APPROACH

Start out as other Sessions

Catch up absentees of last week (if any)

Point out that this week I hope we can concentrate more on people who didn't get to say as much last week

Bring in family members: what would your parents say about these choices?

Come back to Milan as often as possible in the personal stories. What is the relationship between your husband and your daughter, son, parents,
his parents. Who of these people is most aware of the problem worries most, helps you the most in understanding the problem?

Also at group level who in the group is closest to Choice #3 today (may change from week to week)? furthest from?

As we said at the outset of these groups we hope that all of you along with us will try to help each other deal with feelings about their home situation and so we'll try to divide the air time to give everyone a chance to be the one being helped. This help will be offered in a gentle and caring way - no blaming or criticizing etc. Hopefully you'll all continue to be comfortable in sharing your stories with each other.

SESSION #6 FAMILY-SYSTEMS APPROACH

1. Summary from each group member as to where she is today with respect to: The Berenson Choices

2. Group Evaluation of the Sessions (put on Board)
   - What was particularly helpful to you (if anything)?
   - What could be improved?
     - first in open group discussion
     - then privately on paper ("If there's anything you want to say privately to me...")

3. Post Test
   - Survival scale: Same test only answer it now from the point of view of the past 6 weeks since we've started these meetings

4. Closing rituals - expression of appreciation to each one and to whole group. Invitation to keep in touch with each other and me. Exchange phone numbers if they wish
- saw some wonderful caring which was gratifying
- or other positive feedback to them as a group

Celebration with refreshments

- a little favor given to each member
FOLLOW-UP CALLS AT ONE MONTH AND TWO MONTHS FAMILY-SYSTEMS APPROACH

I'm calling as I said I would to say hello and to ask you a couple of general questions to get caught up on your situation since we last talked.

1) How are things going for you in the overall sense?

2) Has anything changed as far as how you are reacting to your husband (or how you and your husband are relating to each other) (or your relationship with your husband)
   a) If drinking is not mentioned: What about the drinking? same/better/worse
   b) How is that effecting you?

3) Have you gone to any Al-Anon meetings (get specific #s) or talked with any of the other women in the group? Any other supportive persons or groups?

4) Have you thought any more about doing anything differently (going to Al-Anon, doing an intervention, leaving)

5) Also ask individuals things that are specific to them; their kids, their jobs?

(any gaps in data can also be filled in - e.g. if I forgot any demographic data on intake)

6) Anything else you'd like to tell me?

I'll call you again in about one month.
SESSION #1 PERSON-CENTERED APPROACH

 Approx Time

15" 1. Introductions around room:
   
   Researcher: general intro to the project: Commitment to
   Confidentiality/Caring/Communicating
   
   Assistant/Demographer: Introduction by researcher
   explain her role (to help me keep on track and listen and take
   notes to understand my process)

45" Each participant asked to share, if they wished, a sentence or
two about themselves: FIRST NAME ONLY

   1) one thing they hoped they might get from sessions
   2) one fear or concern they had about these sessions
   3) show an item from purse or coat pocket or something
   on their person that has special meaning to them and gives us
   an idea about who they are.

30" 2. Overview of 6 sessions: what to expect

   Setting the tone: informality, sharing only what is
   comfortable; "no blame; no fault; just surviving." clarifying
   choices; family disease; family roles
   
   Brief, session-by-session overview (session # 2,3,4,5,6)
   Sollicit questions, comments, etc.

15" - Refreshment Break -

45" 3. Pretest administered: o.k. to ask questions to clarify etc

   Adjournment
SESSIONS #2, 3, 4, 5 & 6 PERSON-CENTERED APPROACH

Start each group session after the first one with:

What happened in your house this past week since we saw each other last? (not more than a minute or two each). Did any changes occur, that you noticed, either in yourself or our spouse or any other family member?

SESSION #2 SPECIFIC CONTENT

30" 1. Alcoholism as a Disease:
   a. Primary; b. Chronic; c. Progressive; d. Relapsing; e. Fatal
   Stages of progression: Early, Middle, Late (Signs and Symptoms)

30" 2. Levels of Denial:
   The basic function of denial is to buy time to find inner strengths and external supports. The actual mechanisms of denial are complex and multileveled. Simply stated, denial is first experienced as a unified buffer between the person and a grievous reality that she or he is not yet ready to experience. On closer examination, it becomes evident that denial consists of four distinct levels that serve to gradually ease the person into experiencing as much reality as the gradual accumulation of inner and outer strengths and resources permit. The four levels of denial, in order, are as follows:

   1. **Facts**: Denial of facts is bluntly evidenced through straightforward avoidance of reality, often accomplished through conscious distortion. Any occurrence, event, or intervention that confronts a person who experiences this level of denial, is discounted, deflected, ignored, or nullified, period.

   2. **Conclusions**: The person who is employing denial of conclusions acknowledges the fact that there is something amiss, but denies the cause, permanence and/or diagnosis.

   3. **Implications**: Denial of implications is a subtle and stressful process that often eludes all concerned and is seldom seen as denial. Basically, it is denial that alcoholism has changed one's entire life. It is manifest through
a passive or active resistance to doing anything that might imply that the impact of alcoholism might alter one's life. People who manifest this level of denial will promise anybody anything, don't deliver, are terribly apologetic and seemingly cooperative, but at all costs, they fight change.

4. **Feelings:** Lastly is denial of feelings. Actually, the main function of all the levels of denial is to keep the person from experiencing (feeling) the impact of the loss of a core level dream. Once the other three levels are peeled off, all that is left between the person and the awful reality that they face is the denial that what has happened does not have meaning on a feeling level. People at this level "feel" like they are fighting for their lives, and that if the feelings are acknowledged, they will go crazy, or worse.

**Homework:** Al-Anon Pamphlet "Alcoholism, the family disease"

**SESSION #3 PERSON-CENTERED APPROACH**

<table>
<thead>
<tr>
<th>Approx Time</th>
<th>Content</th>
</tr>
</thead>
</table>

Dramatization - Nancy, Don, Debbie & Ward Davis. Middle class white family in suburbs with nice house; he has good job; they love each other; he's a pretty loving Dad; social scene with cocktails - he gets into fight with the guys and so it goes.... Wife calls him in sick after Sun. night party. He explodes at kids; she makes excuses and compensates for him with kids (she enables, smokes a lot, enables more). Situation keeps getting worse: She says "If you loved me, you'd stop". She gets desperate and confides in divorced friend who says let's go to Al-Anon - "if you only knew how many other people were going through the same things. I'm one of them." They go to a meeting (small group); husband's boss is there!! Husband is not happy! He
tries to talk her out of next meeting but she goes. An older man is telling his story (Jane died, his wife) - why does he still go to meetings? (of course, we know why) She's speaker at next meeting we see and reports how she's not nagging him lately; meetings really work. Major ideas are learning not to suffer when he drinks and not to fix things he screwed up while drinking. Nancy thinks she's all "cured" now but she's "controlling" him in other ways. Don goes to jail and she puts up bond to get him out (DWI arrest). He goes "on-the-wagon" ... she finds where he's hid his bottle in workshop/. Al-Anon words flash back... she tells kids "Daddy needs help!" "Mommy too." Now she turns around: gives husband phone.. "it's for you" Won't lie for him anymore.

2. Discussion of videotaped drama "If you Loved me".

3. Discussion of homework pamphlet
"Alcoholism the Family Disease" (Al-Anon) 46 small pages

What comments, questions or issues came to mind as you were reading?

What was particularly helpful?

Was any thing particularly upsetting?

How did you come out on the maturity checklist? (pp. 30-31)

GROUP SESSION #4 PERSON-CENTERED

Approx. Time

1. Adjustment of Family to Alcoholism: Children

Treats children as an aggregate not in systemic way. Statistics: 12-15 million kids living in alcoholic homes; 15-18 million ACOA (no longer living there). Many will become alcoholic, marry one, or both (genetic "predisposition"). Isolation/Loneliness; problem identifying feelings & expressing them; depressed; relationship problems due to decreased trust; powerlessness, despair (emotionally, socially, psychologically).

Fear/anger/guilt - warns audience not to sit with these feelings. Three major roles:

**Don't talk**: ashamed of parent's behavior; sense of loyalty - scared of feelings; ambivalence; don't identify that the problem is alcohol; have been told not to talk (a rule and more, a law!); "if we don't talk about it, it might go away".

**Don't trust**: parents not consistently available to them; no honesty, no openness; Dad drunk/Mom preoccupied; too much else to worry about. Dad won't remember promises & Mom won't do anything about it.

1) perceptions not validated; 2) parents can't be open & honest; 3) people can't be predictable 4) can't be protected. Alcoholic & spouse make a pact of mutual denial. How can child trust if parents embarrass, humiliate, disappoint, physically jeopardize?

**Don't feel**: By 9 years old have well-developed denial (of feelings) deny own fear, sadness, anger, embarrassment, guilt (spends time on giving examples of each of the above feelings in relation to alcoholism: what things are feared, what's to be angry about, what's to be sad about etc.) stories about how she has worked with these kids. Need to feel psychologically safe to express. Needs understanding of alcoholism but also
to express feelings experienced being in an alcoholic home ("I know he's sick but it was still embarrassing"). Validate feelings: "normalize" o.k. to express anger. Don’t need to feel guilty. Skills in problem-solving. Again stories about clients of hers (a 74 year old ACOA still having trouble with feelings).

Poem: Daddy is gone... sad story.... now she understands he's alcoholic but it's too late... he's remarried and has a new little princess etc.

30" 2. Discussion of Videotape

15-20" 3. Discussion of Al-Anon Pamphlet (carry over from previous session)

SESSION #5 PERSON CENTERED APPROACH

<table>
<thead>
<tr>
<th>Approx.</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>20&quot;</td>
<td>1. Al-Anon Information</td>
</tr>
<tr>
<td></td>
<td>&quot;This is Al-Anon&quot;</td>
</tr>
</tbody>
</table>
|         | 2. Reading and discussion of brief Al-Anon Pamphlet: "Is Al-Anon For You?"

SESSION #6 PERSON-CENTERED APPROACH

1. Summary from each group member as to where she is today with respect to: The Al-Anon/Traditional Information

2. Group Evaluation of the Sessions (put on Board)

What was particularly helpful to you (if anything)?

What could be improved?

- first in open group discussion

- then privately on paper ("If there's anything you want to say privately to me...")
3. Post Test

Survival scale: Same test only answer it now from the point of view of the past 6 weeks since we’ve started these meetings

4. Closing rituals - expression of appreciation to each one and to whole group. Invitation to keep in touch with each other and me. Exchange phone numbers if they wish

- saw some wonderful caring which was gratifying
- other positive feedback to them as a group

Celebration with refreshments

- a little favor given to each member
FOLLOW-UP CALLS AT ONE MONTH AND TWO MONTHS-PERSON-CENTERED APPROACH

I’m calling as I said I would to say hello and to ask you a couple of general questions to get caught up on your situation since we last talked.

1) How are things going for you in the overall sense?

2) Has anything changed as far as how you are reacting to your husband (or how you and your husband are relating to each other) (or your relationship with your husband)

   a) If drinking is not mentioned: What about the drinking?

   same/better/worse

   b) How is that effecting you?

3) Have you gone to any Al-Anon meetings (get specific numbers) or talked with any of the other women in the group? Any other supportive persons or groups? Therapy of any kind?

4) Have you thought any more about doing anything differently (going to Al-Anon, doing an intervention, leaving)

5) Also ask individuals things that are specific to them; their kids, their jobs? (any gaps in data can also be filled in - e.g. if forgot any demographic data on intake)

6) Anything else you’d like to tell me?

I’ll call you again in about one month.
INTAKE INFORMATION FORM

CLIENT:
1. First Name: __________________  2. Age: ___  3. Phone: ______________
4. Referred by: ____________________ ____________________
   (person) (agency)
5. Ethnicity: ______________  6. Religion: raised in________________________
   __________________________  present __________________________
7. Relationship status: M____ L.T.____ Other* ______ How long?_____
8. Marital History: M (no. of times)____ D (# times)____ S (#times)____
9. Children: (number) ___ Ages ___ ___ ___ ___ ___ ___ ___ ___
   (circle those living home)
10. Education: Highest grade completed ______________
12. Previous work summary: _______________________________________
   ___________________________________________________________
   ___________________________________________________________
   ___________________________________________________________

PARTNER:
18. Present Drinking Status* : ________________________
19. Longest Sobriety: _________ AA/Treatment History________
   years/months __________________________
   ___________________________________________________________
   ___________________________________________________________
CLIENT'S FAMILY OF ORIGIN:

   (M or F; circle client)

22. Alcohol/Drug Problems: A= Alcohol  D= Drugs circle if recovered

<table>
<thead>
<tr>
<th>Paternal</th>
<th>Paternal</th>
<th>Maternal</th>
<th>Maternal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandfather</td>
<td>Grandmother</td>
<td>Grandfather</td>
<td>Grandmother</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Father</th>
<th>Father's Brothers</th>
<th>Mother</th>
<th>Mother's Brothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father's Sisters</td>
<td>Mother's Sisters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client's Brothers: their children
Client's Sisters: their children

Client herself*: Rationale for not screening out

or grandchildren

GENOGRAM: (on back; Data includes husband and his family history of drugs, alcohol treatment and recovery)

23. Knowledge of Al-Anon*:
   Word of Mouth
   Reading
   Meeting attendance

24. Contact with other wives of alcoholics:
   This study
   Other

---

* Besides three specific screening tests, exposure to Al-Anon could screen out some prospective clients. Not living in same household; partner presently sober; or client herself currently experiencing active alcohol and/or drug problem would also be reason to eliminate a prospective client.
<table>
<thead>
<tr>
<th>First Name</th>
<th>Group / ID#</th>
<th>D.I.</th>
<th>DTC</th>
<th>Phone #</th>
<th>Age</th>
<th>R.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F.H.A.</th>
<th>B.O.#</th>
<th>of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A-A</th>
<th>Pre</th>
<th>TIPR</th>
<th>SSBS - Pre</th>
<th>SSBS Post</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A-A 1 mo</td>
<td>Sub. 1</td>
<td>Sub. 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A-A 2 mo</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A-A 3 mo</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Screening: Date
5 | 5 |

FCEA
6 | 6 |

SHS

RMAS

<table>
<thead>
<tr>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

KEY:
- DTC - Date of Telephone Contact
- DI - Date of Intake
- ID - Based on last 4 digits of phone
  - *01- lowest phone number
  - *02- next lowest

FHA Family History of Alcoholism
- A-A - Al-Anon Attendance

TIPR - Time in Present Relationship

SHS - Spouse Hardship Scale

FCEA - Family Center on Education for Alcoholism

(SpouseScale)

RMAS - Revised Marital Adjustment Scale

SSBS - Spouse Survivor Behavior Scale

1. Coddling/Rescuing
2. Avoiding/Withdrawing
3. Controlling/Thwarting
4. Pleading/Threatening
5. Blaming/Punishing
6. Quarreling/Attacking
<table>
<thead>
<tr>
<th>Hand Data Card</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Name</strong></td>
</tr>
<tr>
<td><strong>D.I.</strong></td>
</tr>
<tr>
<td><strong>Phone #</strong></td>
</tr>
<tr>
<td><strong>F.H.A.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A-A Pre</th>
<th>TIPR</th>
<th>SSBS - Pre / 88</th>
<th>SSBS Post / 88</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-A 1 mo</td>
<td>Sub. 1</td>
<td>Sub. 1</td>
<td></td>
</tr>
<tr>
<td>A-A 2 mo</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>A-A 3 mo</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening: Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FCEA</th>
<th>6</th>
<th>6</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SHS</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RMAS</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
</table>

**Key:**
- DTC - Date of Telephone Contact
- DI - Date of Intake

**FHA** - Family History of Alcoholism
**A-A** - AI-Anon Attendance
**TIPR** - Time in Present Relationship

**SSBS** - Spouse Survivor Behavior Scale
1. Coddling/Rescuing
2. Avoiding/Withdrawing
3. Controlling/Thwarting
4. Pleading/Thwarting
5. Blaming/Punishing
6. Quarreling/Attacking

**ID** - Based on last 4 digits of phone 
- *01 - lowest phone number
- *02 - next lowest

**SHS** - Spouse Hardship Scale
**FCEA** - Family Center on Education for Alcoholism (Spouse Scale)
**RMAS** - Revised Marital Adjustment Scale
REFERENCES


Berenson, D. (1986, June). Berenson workshop. The master therapists. Univ. of Conn. School of Medicine, Farmington, CT.


