FAMILY THERAPY AND ALCOHOLISM

A Social Work Practicum Integrating Theory and Practice

by

BARBARA ELLEN BALL

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TABLE OF CONTENTS

Chapter

V. Cont'd

CHAPTER I

INTRODUCTION

Objectives of the Practicum

At the outset of the practicum, the objectives of the author were to:

1) develop knowledge of alcoholism and of family therapy;

2) develop skill in family therapy treatment from a structural perspective with families where a member (or members) abuse(s) alcohol;

3) explore the usefulness of family therapy theory and practice in working with these families.

The author planned to meet these objectives in two ways: by reviewing the relevant literature and by completing a supervised practicum. The following is a report of that endeavour.

Motivation to undertake a practicum in the area of families and alcoholism stems from contact with many former clients of alcoholism treatment programs. This client perspective, gained in the context of community organization work suggested gaps in knowledge on the part of social workers as well as other professionals. The author learned that families and individuals effect and are effected by alcoholism

yet often professionals, in the eyes of these clients, avoided dealing with it, thereby contributing to the problem. Thus, there appeared to be both a knowledge and a service gap.

These "client" viewpoints are borne out in the literature. Stanton and Todd (1982), Steinglass (1977) and Berenson (1976) assert the view that family therapists along with their mental health colleagues prefer not to treat alcohol problems. Kenward and Rissover (1980) also support this view. A variety of reasons are given for this. Alcoholism is noted by these authors as being one of the most difficult dysfunctions to treat. They also suggest that lack of knowledge about alcoholism, general discomfort with excessive drinking and prejudices against alcoholics are factors in professional avoidance.

Steinglass (1977) draws attention to the fact that professional stereotypes of the alcoholic are well documented. The alcoholic is viewed as distasteful, weak and self-indulgent. In perusing journals, the author found several studies on professional bias against alcoholics. Of note is the work of Peyton et al (1981) in which the significant negative bias of social workers against alcoholic clients was exceeded by that of psychologists and psychiatrists.

Bailey (1972) asserts the view that "helpers" who avoid pinpointing an alcohol problem become part of the denial system so widely associated with alcoholism. This view is also stressed by Davis (1980, 73). From this perspective, lack of professional knowledge of alcoholism becomes part of the problem.

The following literature survey will make the family problems associated with alcoholism evident. The dynamics of alcoholic families suggest a need to see the family as client. This appears to be an area of work particularly suited to social workers given the system's orientation of the generalist courses in social work.

Scope of the Literature Review

When faced with a topic of this size, there are obvious choices to be made with regard to what to include. The point has been made in the previous section that the application of family systems theory to families in which alcoholism is a problem is impeded by lack of knowledge of both alcoholism and family therapy on the part of professionals. Kenward and Rissover (1980), emphasize this viewpoint. They write that:

> While more professionals are beginning to conceptualize alcoholism as both a cause and a consequence of dysfunction in a family system, alcoholism workers generally lack training which enables them to recognise potential or existing problems which may impact on all family members as a consequence of the drinking behaviour, or which may contribute to the drinking behaviour. Alcoholism workers are frequently untrained in the theory of family systems and practice of family therapy. At the same time, workers who specialize in the treatment of family systems characteristically lack training in diagnosing alcohol problems in families and are deficient in both the knowledge base and skill necessary for the treatment of alcoholism. (102)

This perspective is one with which the author concurs. Thus, in that sense, "relevant literature" includes both alcoholism and family

therapy. In the interests of time and space, the author focused mainly on literature combining the two areas. General literature on alcoholism and family therapy is only touched upon briefly in order to put the combined literature in that larger context.

Literature detailing "multi family groups methods" is also excluded, the focus being on work with single families. A further restriction on the scope of the literature survey is that the primary emphasis is on adult alcoholism. The broader area of drug addiction is not covered in detail, nor is alcoholism at the young adolescent or leaving-home stages. This choice is related to the practical work which took place with families with an I.P. or "alcoholic" adult (parent or spouse role, as opposed to adolescent alcoholism). The bibliography includes references which provide detail of a broader nature related to different developmental stages and symptom development in the sibling subsystem.

With regard to the literature on alcoholism, the author notes a wealth of specialized areas of study such as the medical biological and pharmacological aspects of alcoholism. The topic has also been studied in the context of specific population groups such as the aged, youth, cultural, ethnic and religious minorities, as well as amongst the physically handicapped and homosexual populations. It has been studied relative to suicide, schizophrenia, sexual dysfunction, child abuse, family violence and crime and delinquency, to mention only a

few. A specific focus on any of these areas has been omitted from this report. The bibliography indicates several references which provide detail on these areas of study of alcoholism.

Alcoholism, Alcohol Use and Society

Canadian National Health and Welfare Statistics (1981) show that one in every twenty Canadian adult drinkers are alcohol addicted: 635,000 persons. These figures represent an increase of 7% since 1970. The population with alcohol related disabilities such as hepatitis, cirrosis, pancreatitis, alcoholic cardiomypathy, foetal alcohol syndrome and a host of other conditions is estimated by National Health and Welfare to involve 1.4 million Canadians (Special Report on Alcohol Statistics, 1981). The Alcoholism Foundation of Manitoba cites alcohol as a factor in:

- 40% of family breakdown resulting in family court appearance
- 35% of all homicides
- 29% of all rapes
- 50% of all highway traffic fatalities
- 40% of all hospital admissions
- 31% of all suicides. (Bull, 1983)

Faris (1978) finds that far too many studies concentrate on only clinically defined alcoholics, when in fact many people who never become alcoholics can have serious problems related to alcohol use. Many "alcoholics" also have had problems before they were so labelled.

He cites one study which shows that over a three-year survey period, 43% of male drinkers and 21% of female drinkers, had problems associated with drinking. The study, undertaken in the U.S.A., used eleven categories or problems in the following order of prevelance:

1) psychological dependence (alcohol use to alleviate depression, stress, or escape from problems);

2) frequent intoxication;

3) family relationship problems;

4) symptomatic drinking (the exhibition of signs attributed to physical dependence such as drinking to get rid of a hangover, inability to stop drinking and blackouts, etc.);

5) belligerence associated with drinking;

6) health problems related to drinking (involving physician's opinions);

7) financial problems;

8) problems with friends and neighbours;

9) job problems;

10) binge drinking;

11) problems with police or accidents. (Faris; 1978).

The relationship of alcohol use to violent crime is noted by Faris (1978), as being the strongest and most consistent in comparison to all drugs used both medically and non-medically. American studies show similar association with 64% of murders, 41% of assaults, and 34% of rapes being alcohol related (Faris; 1978).

As well, Faris (1978), points out that Health and Welfare Canada estimates place the economic costs of alcohol related problems at one million dollars per day. These estimates, which he terms "conservative", relate to lost production, health costs, motor vehicle accident costs, alcoholism treatment costs as well as research costs. Criminal justice system costs are also mentioned in this estimate, as are those of social welfare.

Krimmel (1971), notes estimates that show that 20% of applications to family service agencies involve a drinking problem that is related to physical abuse, debts, job loss and often to child welfare concerns. Personal, family and social disorganization related to alcohol use and abuse is also highlighted through Ontario studies of social work caseloads in which 20% of cases were related to alcohol abuse. Faris (1978), who notes these Ontario figures, also points to the Ontario Children's Aid Society figures relating 30% of its' cases involving severe alcohol problems.

Although it is acknowledged that statistics can vary widely, related often to vested interests and biased views, it is evident that alcohol problems are widespread. Alcohol problems clearly occur in conjunction with other serious social problems which impinge on family life. The existence of self-help groups such as Al-Anon and Alateen, in addition to Alcoholics Anonymous, adds weight to the view that alcoholism and alcohol problems effect all members of the family.

THE PRACTICUM: INTEGRATION OF FAMILY THERAPY WITH TRADITIONAL TREATMENT

In this practicum, the author does not see family therapy as the sole treatment method in working with alcoholic families. The interest of the author lay in exploring the value of a family therapy perspective as a way of conceptualizing alcoholism as well as clinically complementing and supplementing other treatment approaches.

A family therapy perspective emphasizes circular rather than linear hypothesizing and correspondingly shifts the focus from "cause and effect" to that of interactional patterns that serve to maintain symptoms in relationships. It has the capacity to encompass the view that families effect alcoholism and that alcoholism effects families, a view to which the author adheres.

Although some theorists and practitioners cite family therapy suitability as a unitary treatment modality, the majority of authors surveyed, including Berenson (1978), Stanton and Todd (1982) and Kaufman (1980), advocate use of family therapy in combination with traditional treatment and community support networks such as Alcoholics Anonymous and Al-Anon. The following comments are perhaps representative of this viewpoint:

> ...We suggest that to be effective, family therapists must work in conjunction with self help groups such as A.A., which we believe along with Kogan and Jackson and Berenson offers one of the few successful means of intervention in such a patient and use also other adjuncts such as disul-

> firam, sexual therapy or multiple couples groups depending on the needs of the family. Using marital and family therapy in addition to such other therapies would make us, like Steinglass more optimistic about efficacy...
>
> (Dinaburg, Glick and Feigenbaun; 1977, 1257).

Stanton and Todd have used structural family therapy with drug abusing families. They reinforce the views of the authors quoted previously with reference to treating alcoholic families (in comparison to those in which other drugs are used), stating their position as follows:

> ...whether or not a client agrees to abstinance as a treatment goal, however, the therapist usually aims toward halting an alcohol related interractional cycle within the couple or family much as he might with a heroin addict's family. On the other hand, in treating alcoholics and their families, we deviate in several ways from our standard treatment paradigm in that we...rely heavily on Alcoholics Anonymous and ALAnon as collaborative support and/or treatment systems.
>
> (Stanton and Todd; 1982, 389).

Davis (1980 - ;65) suggests that "the alcoholism field has had to overcome the effects of a number of psychotheraputic panaceas in the past", and cautions lest family therapy become one more substitute "for really coming to grips with the problems of drinking." He goes on to indicate that "memories are still strong" of psychotherapy techniques apparently causing long delays in getting help from A.A. to achieve abstinance. The delays in Davis' view are attributed to both ignorance about alcoholism and overzealous conviction about the power of the method used (Davis; 1980, 65).

The foregoing authors stress the importance of knowledge of

alcoholism on the part of the practitioner. Prior to illustrating the complexity of alcoholism, the author will provide a brief overview of historical developments as a background to the integration of the approach.

Historical Developments

> ...Whether a particular pathology is conceived to inhere in an individual or in a situation determines the locus and mode of the intended interventions.
>
> (Lennard and Berstein; 1969,3, as quoted in Meeks, 1976,835).

Meeks (1976) asserts the view that traditionally therapists have seen alcohol problems as residing physically, mentally or behaviourally in the drinker. Therapy has been directed towards the individual. Recently, social science concepts being applied to socio behavioural therapies have resulted in these assumptions being challenged. An enlightened perspective according to Meeks' (1976, 835) requires "consideration of interacting biological, interpersonal and social systems."

This multidimensional view has been slow to develop relative to other problem areas. Historically, family therapy and alcoholism treatment have developed as two very separate fields. In the alcoholism field, the priority issue has been the transformation of alcoholism from a moral to a medical problem. Illustrating the situation "around the turn of the century", Hanson and Estes (1977), write that:

> ...literature on the family with an alcoholic member was virtually non-existant. At that time, the alcoholic person was stereotyped as a marginal, under socialized member of society whose drinking was thought to be caused by moral depravity and weakness. The drunkard was seen as someone for the family to hide, the police to control and the clergy to reform. The family was to be pitied and shown charity...
>
> (Hanson and Estes; 1977, 67)

The conceptualization of alcoholism as a disease with an attendant set of symptoms and predictable course and prognosis was a necessary prerequisite for the transfer of responsibility for alcoholism treatment from the religious and judicial to the medical realm. The emphasis has thus, in Steinglass's view, been on the medical model designed primarily to describe a disease process as it effects the individual (Steinglass; 1977).

Steinglass, who provides an historical account of developments, notes that a family therapy perspective, which focuses on disturbed communication patterns and structural dissonances feels "strange and foreign". He further elaborates:

> ...although these phenomena are hardly absent in the family with an alcoholic member, the abusive consumption of alcohol and its' attendant behavioural and physical consequences appeared at first glance to be so overwhelming that it was hard to imagine successful treatment being achieved in any way other than by intensive work with the individual who was doing the drinking.
>
> (Steinglass; 1977, 267)

As Steinglass points out, curiousity about the role of the family factors in the etiology of alcoholism was shown as early as 1937. He

makes reference to the work of Robert Knight in 1937 which emphasized a dominant mother and passive father. These works led to the notion of an "alcoholic personality". Treatment thus remained individually oriented. As well, Steinglass (1977) points out that alcoholism professionals were seen as the "preferred treaters" rather than family experts.

Alcoholism therapists operating from these established orientations were unprepared to adopt the orientations developing in parallel fashion in the family therapy field.

Interest in the 1950's was directed to the "alcoholic marriage". Steinglass (1977) comments that concern crystallized on the wife's part in the initiation and perpetuation of the husband's drinking. Two factions emerged in this ongoing debate; one side viewing wives of alcoholics as persons with severe pathology prior to marriage, resulting in the choice of an alcoholic husband to satisfy and stabilize her intra psychic needs. The opposing faction explained the wife's behaviour as reactive to the stresses of the alcoholic marriage. Steinglass makes reference to a study by Edwards et al of 1973 that concluded that "no convincing evidence has emerged suggesting a single personality 'type' characteristic to wives of alcoholics or a theoretical explanation of their behaviour" 1977,269).

These studies, according to Steinglass (1977) were important in shifting the focus to the current situation in the alcoholic marriage. As he points out, this began the shift from viewing the alcoholic

individual in isolation and relating abusive drinking only to individual dynamics. Questions were being raised at this juncture about the extent to which an interactional relationship between a husband and wife may be causal or perpetuative of abusive drinking. This led to a spot being found for the spouse in treatment planning. Steinglass quotes Joan Jackson as pointing out that:

> ...once attention had been focused on the families of alcoholics, it became obvious that the relationship between the alcoholic and his family is not a one way relationship. The family also affects the alcoholic and his illness. The family can either help or interfere with the treatment process.
>
> (Jackson; 1962, in Steinglass, 1977, 269)

Joan Ablon (1976) cites a study undertaken by Bullock and Mudd in 1959 which took an interactive focus viewing the interelatedness of alcoholism and marital conflict. She notes also the related work of Ballard who in 1959 reported on M.M.P.I. results from experimental alcoholic families and control, non-alcoholic families. In her view, Ballard's work examplifies a pragmatic functional and interactionist approach to consideration of the marital unit. These findings, in Ablon's view, suggest that the conflicted alcoholic family is not unique when compared with the conflicted non-alcoholic family.

In the 1950's, Gleidman's project at the John Hopkins Hospital, which involved nine male alcoholics and their spouses, is noted by Steinglass as being the first of a series of projects to develop family techniques for alcoholism treatment. A concurrent group therapy modality was used. This work in Steinglass' view (1977), broke impor-

tant ground particularly in the area of outcome variables. Symptom reduction applied to the wife as much as to the husband. Steinglass indicates that the concurrent treatment of both partners led to an examination of marital satisfaction and marital interactional behaviour as targets for change.

As Steinglass (1977) notes, Gliedman's work was followed by several clinical papers describing group techniques for working with spouses. Thus a gradual shift was taking place as techniques developed for shifting the treatment focus from the alcoholic individual to the alcoholic in the marital context. These clinical papers were enthusiastic about concurrent group therapy although as Steinglass points out, the spouse treatment was still assigned an adjunctive role.

Steinglass (1977) cites Pattison et al, as being "pessimistic" concerning treatment with lower class families. In Pattison's view, alcoholism is present as just one of a wide range of social and psychological problems and alcohol abuse is often a socially acceptable norm. In such families, the disease concept is alien and the families therefore, resistant to treatment. Pattison advocated public health nurses and home visits as a way of intervening with alcoholic families (Steinglass, 1977).

During this same time period in the 1950's, according to Steinglass (1977), a body of clinical theory concerning pathology in families was

being developed based on general systems theory. Forerunners, mainly psychiatrists, focused attention towards new explanations for psychiatric conditions such as schizophrenia, psychosomatics and adolescent dysfunction. In this development, which had a strong clinical orientation and was built on communication theory, cybernetics and game theory, alcohol and drug abuse were ignored, both theoretically and clinically.

Boudreau (1982) notes that it has been well over a quarter of a century since Bateson, Jackson, Haley and Bowen began to apply "ecological thinking" to their work, especially in the area of schizophrenia. He states that it took an additional fifteen years before any serious work was done to apply this thinking to the field of alcohol abuse. He credits Berenson, Ewing, Steinglass and Meeks and Kelly for initiating development.

Steinglass credits the work of Ewing and Fox in 1968 as important in providing a bridge between the two fields. In their work, as Steinglass notes (1977), theoretical concepts associated with Bateson and Jackson (especially the concept of "homeostasis") were applied to view the alcoholic marriage. This led to the notion of alcoholism in a marriage in its context. In elaborating on Ewing and Fox's work, Steinglass (1977,278), notes they explain alcoholism in a marriage as a process in which two people strike an "implicit interpersonal bargain" in which the male alcoholic's passive dependency needs implicitly

encourage the wife's nurturing protective needs. This work also stresses the view that a sexual bargain is struck which engages an undemanding husband in a complementary pattern with an unresponsive wife. A cyclical pattern alternating between states of sobriety and states of intoxication play out these pacts by alternating between supression of impulses and direct expression of them (Steinglass, 1977).

Steinglass (1977, 278) notes that Ewing and Fox saw two advantages to family therapy; 1) it increases the potential for acknowledgment of a drinking problem by middle class gamma type alcoholics, who usually resist self labelling procedures and; 2) family therapy stimulates the alcoholic's motivation to change.

Steinglass himself, together with his co-workers Davis and Wolin, followed up on this work in the early 1970's. Their work was unique in that it involved clinical observations of family interaction during states of intoxication. An expansion of this work will be detailed in Chapter III.

To summarize and relate history to today, Steinglass' account shows two fields developing in an exceedingly isolated fashion. This is reinforced by Steinglass' observation made in 1977, that no articles on family therapy with alcoholics had appeared in journals or publications such as "Family Process" or "Journal of Marriage and the Family" which centre on family issues. He addds also (1977) that family agencies

often refuse to work with families containing an alcoholic member, referring them instead to the nearest "alcoholic centre." These observations reflect a continuing division between the two fields and this is corroborated by Kaufman and Pattison (1981). They note that while major developments have taken place in differential treatment methods of alcoholism and specialized techniques to match different patterns of family problems, the family therapy field has devoted little effort to the development of techniques for working with alcoholic families. They also state that in the alcoholism field, family therapy has been viewed as a generic treatment with scant awareness of major variations in methods.

Pearlman and Zweben (1981) make the additional point that while marital therapy has been increasingly used in the alcoholism field, there are virtually no well controlled studies of the efficacy of a marital systems approach to the treatment of alcohol abuse. They note the absence of guidelines generally for therapists seeking to apply a family systems approach, and assert the view that this issue is magnified with respect to the field of alcohol treatment, which they say lacks developed technical information. In these comments, they concur with Steinglass (1977).

Thus, current literature on marital and family treatment in alcoholism both stresses and illustrates the developmental delay relative to other areas of family treatment. It is characterized by divergent opinions on issues such as whether or not the therapist can

work with a system in which a member is still drinking; whether the focus of therapy should be on interactional behaviour alone or whether the drinking should be the focus and whether or not controlled or moderated drinking is a realistic goal. This latter issue is one of some longstanding in the alcoholism treatment field. It will be discussed in Chapers II and V of this report related to a system's perspective.

Corneil (1982), who reviews the political factors associated with choice of treatment programs, suggests that the medical model will likely remain dominant in the field of alcoholism treatment, citing the support of A.A. and the medical community as the factors. On the other hand, the author notes Berenson (1976), Davis (1980) and Stanton (1982) who stress the complementarity between family therapy and self help groups such as A.A. and Al-Anon. This suggests a stronger role for a family therapy approach as part of the treatment network for alcoholism and a related need for the development of theory and practice in what may be a broader and more holistic approach to treatment.

CHAPTER II

ALCOHOLISM: A MYRIAD OF THEORIES AND VIEWPOINTS

Alcoholism has been viewed from a number of perspectives and theories of causation have been advanced from the physiological, psychological and sociological viewpoints. Rankin (1978), who writes on the numerous etiological theories, notes that they can be grouped into four different models or frameworks which have been used to examine different types of information and to develop explanations of alcoholism. Of these, he comments that the "moral" model contributes little in terms of understanding, but is still used in judging alcoholic behaviour. The "biological, psychological and sociological" models, each encompassing a host of different theories, are inadequate in and of themselves.

Of particular relevance to family therapy is the transactional orientation which is noted by Rankin (1978) as spanning the psychological and sociological models; emphasizing the interaction between the individual and the environment.

Rankin (1978), suggests that the interactional theories are similar to social learning theory in that both propose the importance of reinforcement in the development of drinking behaviour. He notes the point of departure as being around the issue of the pharmacological effects of alcohol. As he says, Bandura's social learning theory finds

these effects to be important, whereas a transactional orientation does not.

The evidence on which these theories are based does, however in Rankin's (1978) view, contribute to the development of a model in which biological, psychological and sociological factors are interactive. It becomes obvious when surveying current literature on alcoholism that new information from these various approaches of study has increased awareness of the variability associated with alcohol use and abuse. Rossi (1978) suggests that in much of the literature the "allergy viewpoint" has given way to a more multi-dimensional one that takes account of the actions and reactions of others. It also becomes obvious that the alcoholism field is characterized by conflicts between the research community and the treatment community. The conflicts are related to the conceptualization of alcoholism, and they show up clearly in the issue of defining alcoholism. Conflict is possibly most heated around the subject of controlled drinking as a treatment goal.

This section will highlight these recent shifts in thinking and illustrate some of the issues.

Among authors who stress the importance of taking a multi-dimensional view, Beigel and Ghertner (1977) note that despite longstanding adherence to a biological or psychological model by many theorists, there have been no specific metabolic or psychic markers identified that have predictive value.

Doroff (1977) states that:

> ...even the most casual perusal of the literature on alcoholism makes it abundantly clear that no single theory of alcoholism exists. There is a range that encompasses views of alcoholism as a medical problem defining it as a disease entity as well as viewing it as a mere symptomatic expression of severe underlying psychopathology. (240)

Jacob et al (1978) comment that alcoholism and its associated problems present an enormous challenge to researchers, clinicians and theorists alike. They elaborate as follows:

> ...Because of the extensive disagreement about the etiology and nature of alcoholism, a number of experts have begun to view alcoholism as a "final common pathway" representing a multidimensional and multidetermined phenomenon. (1245)

Kissin and Begleiter (1977) in the preface to their fifth volume of series on alcoholism, suggest that alcoholism is:

> ...either a complex medical-social disease syndrome requiring a multi-pronged treatment approach, or a very simple illness for which we have not yet discovered a remedy. (vii)

Conceptualizations and Definitions: The Process of Defining

The complexities of alcoholism become apparent in the contentious issue of trying to define it. Krimmel (1971) asserts the view that:

> ...There is increasing agreement that alcoholism should be defined as a pattern of drinking that on a continuous basis interferes with adequate functioning in any significant areas of a person's life. (15)

The World Health Organization defines alcoholics as:

> ...Those excessive drinkers whose dependance on alcohol has attained such a degree that it shows a noticeable mental

> disturbance or an interference with their bodily and mental health, their interpersonal relations and their smooth social and economic functioning; or who show the prodromal signs of such development. (W.H.O. 1971 in Bell; 1978, p10).

Cahn (1970) highlights the role that the reactions of others play in defining alcoholism by defining it as follows:

> ...Alcoholism is a label attached to a drinking pattern defined as deviant by the social control institutions. (25)

Concerning these definitions, several points can be made. Definitions referring to social and economic functioning are obviously dependent on the social surround and drinking norms and standards. Hence social variables are significant. That is, what might be considered problematic or alcoholic drinking in one context, may not been seen that way in another related to workplace standards, community norms, or norms of a social or cultural group. As well, defining alcoholism is obviously a process in a relationship between "definer" and "definee". Thus, alcoholism can be seen to exist as a function of relationship and entails judgments being made about drinking behaviour.

Rohan (1982; 32) writes that over a decade ago, efforts to define alcoholism had resulted in what was termed a "conceptual mess". His thesis is that alcoholism is a "conceptual construct". Expanding on this, he suggests that one of the major issues in understanding human behaviour is the relationship between observable behaviour and the unseen operations of the mind. One solution has been to name

an "innate unseen force of mind or body" to explain behaviour. Terming this a "ghost in the machine" explanation, he suggests that the construct of "alcoholism" is one such example. Rohan adds (1982, 32), that the destructiveness and persistance of some drinking schedules despite horrendous consequences, give the appearance of a "terrible victimizing power" and leads to a search for unseen forces. Thus, the difficulty in defining alcoholism is analagous to an attempt to describe the personality of a "ghost" that controls a person's behaviour.

Noting that the rational for the diagnosis of alcoholism includes social, political, legal and medical goals, each involving definitional differences, Kaufman and Pattison (1982) review the issues of definition and diasgnosis from the point of view of a multi-variate syndrome.

They point to the legal political perspective as being concerned with the moral or medical domain and suggest that the diagnostic assertion of a disease is a cultural diagnosis of behaviour as a non-moral deviance to be dealt with through health care institutions.

The social perspective focuses on how social process discriminates a person into a category of "alcoholic" and the attendant social consequences both positive and negative, that accrue. The treatment perspective is aimed at identifying persons for whom treatment is indicated. The research perspective aims to differentiate diagnostic criteria that will clarify etiology, prognosis, treatment prescription and prediction of response as well as evaluation of treatment effec-

tiveness.

Kaufman and Pattison (1982, 7) note that "alcoholics" do exist in the real world as a "consensual observed social reality", but that "alcoholism" is not a statement of social reality. In their view, it refers theoretically, conceptually and hypothetically to an assumed condition. They state that most scientific authorities concur in a construct of alcoholism as a multi-variate syndrome. They note syndrome to be a group or set of symptoms which together can be considered a "disease", and illustrate this by stating that medical practice in general deals with many syndromes that are not specific diseases (eg: senile dementia). They also note that signs and symptoms are not the same as diagnostic criteria and may be the same for diseases of different etiology. There are additionally, according to Kaufman and Pattison (1982), many diseases for which sign and symptom are the only diagnosis because etiology has not been determined.

Their article reveals the complexities of trying to define alcoholism. They conclude that there are multiple definitions and no system of diagnosis or classification that encompasses the widely different contexts in which a diagnosis must be used. Rohan (1982) agrees, portraying alcoholism as a label for events involving alcohol use and damage rather than the name of an entity. He suggests that hunting for a definition should be abandoned as should pursuit for an imagined animal. The author concurs with Rohan in this view.

Rossi (1978) concurs with Rohan, noting that in recent years, the assumption that some persons - alcoholics - suffer from a progressive disease - alcoholism - has been seriously questioned. He elaborates as follows:

> ...In light of accumulated evidence it appears that there is no separately definable entity which can be defined as alcoholism. Rather there appear to be multiple situations which have in common that some persons suffer adverse consequences as a result of using alcohol. (Rossi; 1978, 36).

He concludes that alcohol problems are best summarized as a variety of syndromes characterized by adverse physical, psychological and/or social consequences of drinking. As he elaborates, the concept that emerges suggests that all individuals who drink are at risk for the development of dependence and they can be seen as lying along a continuum.

Vocabulary changes reveal conceptual and definitional problems and shifts in thinking. Rossi (1978) notes "alcoholic people" and "alcohol problems". Bailey (1978) notes "alcoholism" also. Noting that the term was coined in 1849, he suggests that it is questionable in that it implies a tangible physical entity whereas it refers to a social and physical condition. He suggests further, that Jellenik had the courage to state simply that a "disease is what the medical profession recognizes as such." (Bell; 1978, 9).

Bell (1978, 9) cites Calahan as suggesting that for a number of reasons the concept of "problem drinking" accompanied by a statement of "what

kind of problem" is preferable to use of the term "alcoholism". In addition to pointing out that the term "problem drinking" is not, as yet so loaded with negative connotations, Bell (1978) also indicates that the reasoning behind this is that the requirement of specifying what kind or problem presents both encouragement and challenge, to investigate and help mitigate the range of actual and potential problems in which the alcohol may play a part.

Opposing arguments posed by Keller and McCormick are also noted by Bell (1978). These arguments suggest that terminology distinctions based on rationally different conceptualizations can be drawn. If one adheres to a physiological notion of causality, the term "addiction" should be used; whereas, for those who attribute the condition to a process in which sociopsychic response is significant, "dependency" is more appropriate. Finally, the term "alcoholism" is suggested for persons less ready to commit themselves to any one conceptualization.

The Treatment Field: Issues

As the foregoing section suggests, it is evident when surveying current literature on alcoholism that there are many issues related to definitions, concepts and terminology. These issues are emerging related to an increasing awareness of the variability of alcohol problems and also to the perceived need for new treatment programs.

Rossi (1978) who discusses these issues, notes that the bulk of treatment services have been, and continue to be, geared to "late stage" or chronic alcoholism; that is, to those who show the most extreme social and physical complications. He focuses on a doctrine of extremes in the alcoholism field, which in his view influences treatment approaches. This entails rigid classification of persons as either "alcoholic" or "non-alcoholic".

Rossi advances the opinion that this position may have developed and been reinforced by two factors. The first is rigid adherence to Jellinek's model of classification, even though Jellinek himself cautioned against this rigid use of his model. The second factor may have been A.A.'s availability as the principle way of providing service for extreme cases of alcoholism. Rossi summarizes that:

> ...The issue regarding extremes is not that that they don't exist - they clearly do and they probably represent the most visible aspects of problems with alcohol. However the assumption by many persons working in the field that extreme categorization is the only valid conceptualization of the problem becomes the stumbling block. They think that persons simply cannot have an alcohol problem; one either is or is not an alcoholic. Because all persons with alcohol problems are assumed to suffer from this extreme condition, therefore it follows...that only extreme remedies can be effectively used. (Rossi; 1978, 24)

Rossi elaborates further on implications for intervention. He states that studies and laboratory experimental situations have provided more support for the position that drinking behaviour is determined by social-psychological factors rather than physiological ones; thereby

leading to a view that controlled drinking is feasible for some alcoholics.

The importance of this, according to Rossi, is that some problem drinkers would go for help earlier if abstinence was not the only route open to them. He adds, however, that the findings that "loss of control" is environmentally determined does not mean that all alcoholics can become controlled drinkers, but simply that abstinence, while necessary as a goal for many, may not be for some.

Rossi (1978) suggests that some programs have been developed to attempt to match the uniqueness of individuals and circumstances. He classifies behavioural modification programs in this category. They are largely aimed at modification of drinking, and Rossi notes that outcomes in this area are "obscure". He suggests that behavioural approaches have yet to have their efficacy and applicability to be determined, and also that compliance with treatment planning is an issue in behavioural modification programs for alcohol problems.

In Rossi's view, A.A. is still the dominant philosophy in alcoholism treatment at this time.

The Issue of Controlled Drinking

Rossi raises the issue of the need for broader approaches to treatment of alcohol problems as do Kissin and Begleiter (1977).

The latter reach the conclusion that alcoholics are a heterogeneous population with widely disparate needs, for whom (given our present level of knowledge) a broad range of treatment methods is required.

At the time this practicum was being undertaken, the issue raised by Rossi (1978) that of controlled drinking as a feasible treatment goal for some "alcoholics", was gaining such prominance as to be the subject of at least two prime time television public affairs shows. The interest was generated around research undertaken in the early 1970's by Mark and Linda Sobell at the Patton State Hospital in California. The findings of the research, that "gamma" alcoholics could be trained as controlled drinkers, were challenged by Mary Pendery et al of the Veterans Administration Centre in San Diego. The matter came to public attention in the July 9th, 1982 issue of "Science."

Six years later, the study results were published. Pendery found that in all but one case (of the original twenty subjects), the experiment had been a failure. Pendery et al (1982) report that four of the twenty had died due to alcohol related problems; a fifth who had been certified disabled due to alcohol related problems had disappeared one year following the experiment, eight others had continued to drink excessively and six are abstinent.

Commenting on the controversy, Peele (1983) says that what the press reports have failed to show was that studies both before and after the Sobell's work, have found that the controversy represents a

larger dispute - between the disease theory exponents and those who favour a research approach that leads to a more complex view of the etiology of alcoholism.

He asserts further that the value of controlled drinking has been established yet policy (across the United States) ignores such treatment. In his view, the dichotomy lies between the clinical outlook, recognising what the client says as the reality and a more "objective" perspective which entails the acceptance of study results based on anonymous subjects. Those with a clinical outlook claim never to have encountered an alcoholic who could moderate his drinking. As Peele (1983) states, this view is difficult to contradict. As evidence he notes that Pendery et al, who recognise the one (now moderate) subject of the Sobell study, explain that "he never was an alcoholic".

Peele (1983) notes the dominance of the A.A. position in the field of treatment, in which the disease concept dominates. He stresses the view that research which counters the underlying principle; that of a biological allergy, is inevitably attacked. He continues his argument stating that research shows no biological basis for loss of control and additionally, that no alcoholism treatment centre in the United States is using controlled drinking as an official policy. In contrast, he points out that in the United Kingdom, most centres now accept the

principle of controlled drinking. Peele (1983) concludes his discussion by suggesting that political forces in America forbid a reasonable discussion of the issues.

Ogborne and Bornet (1982) note that alcoholic relapses now seem to be determined not simply by an action of alcohol upon a "diseased host organism", but by more complex processes involving beliefs, coping skills and relapse inducing situations. They suggest that A.A.'s insistance that members are "one drink away from a drunk" may be a self-fulfilling prophecy. Ball (1979) who discusses the issue, cites Larkin, who asserts the view that beliefs about loss of control may be partly responsible for its occurrence.

Ogborne et al (1982) cite two sets of data which suggest that exposure to A.A. may increase both the chances of sobriety and the chances of serious relapse. Referring to the Rand Report of Polich et al, 1980, and the data of Dr.M. Sanchez-Craig of the Addiction Research Foundation, they state that for subjects in both of these studies, A.A. attendance seems to have been associated with increased periods of sobriety and with increased adverse consequences during periods of drinking. Crediting these studies as "robust", Ogborne et al advocate further investigation of the effects of the beliefs of the "disease model" on alcoholic drinking behaviour.

Maltby (1983) details the profile of the subjects of the Sanchez-Craig research. The subjects are socially stable, working, having

income levels above the Canadian average, most have university education and in general they are noted as being highly functional, without apparent medical symptoms and with low dependance on alcohol. In addition, Maltby points out that they believed that moderate drinking was possible, were non-participants in A.A., had no periods of abstinence from alcohol in the past two years, had about five years of problem drinking and successfully maintained a job, and home or stable relationship.

From this profile, it is evident that the subjects of the Sanchez-Craig study are representative of a particular social class. They may represent persons who sought treatment for problem drinking or alcoholism somewhat earlier than most persons who approach alcoholism treatment centres for help.

Controlled Drinking: Related to This Practicum

It should be noted that few of the cases dealt with during the work of this practicum would have been candidates for such a study as they would not have fit these characteristics.

The author does acknowledge the need for a broader orientation to treatment for the reasons as stressed by the authors surveyed. It is evident also that research to develop new approaches and orientations will be on-going in the alcoholism field.

The Practicum was undertaken in a clinical setting which primarily

(in the adult programs section) deals with "later stage" alcoholics, who show both medical and social complications associated with heavy drinking for more than five years (considerably more in most instances). The family treatment work was undertaken in conjunction with other traditional forms of treatment based on the disease model of alcoholism. With these clinical realities in mind, discussion in this report will be largely confined to family therapy theory and intervention, in relation to and in integration with, traditional treatment which advocates abstinance as a goal for persons seen as "alcoholic."

This is, however, in the interests of the multi-dimensional viewpoint and the author stresses the view that the theories of alcoholism from a family therapy perspective based on a systems framework and focusing on interactive factors, have the capacity to add to the medical model view of alcoholism. It is an orientation which looks at interactive factors as determinants of behaviour thus, it focuses on the alcoholic in the environment and addresses the role of significant others.

Given that a need for a new orientation to treatment is necessary, one of the areas to be addressed is the position of family treatment writers on the issue of abstinence as well as the factor of A.A. as a resource. These issues will thus be dealt with further in Chapters III (Theory) and V (Approach to Treatment).

A related issue is that of the conceptualization of the author and of the conceptualization of alcoholism from a family therapy viewpoint.

Conceptualizations

As the orientation of the author is a multi-dimensional one and also for practical purposes, the terms "alcoholic" and "alcohol problem" will be used somewhat interchangeably throughout this report, both serving as labels for selected events involving alcohol use and damage.

In literature, the terms symptom, disease and syndrome (multi-faceted), are used as terms for alcoholism. It might be expected that family treatment writers would espouse the term "symptom" whereas writers who take a medical model approach would use the term "disease". In fact, this is not exclusively the case. An example can be noted in the work of Celia Dulfano, an M.S.W. who has written on family treatment from an interactional perspective. Her view of alcoholism incorporates both the "symptom" and "disease" conceptualizations as follows:

> ...During its' early stages, alcoholism is a symptom. The individual who is developing dependency on alcohol is drinking to relieve some underlying discomfort or to satisfy some underlying needs. The reasons for the drinking whatever they may be, are the disease; abuse of alcohol is a symptom of that disease... as drinking progresses over the year, however, alcoholism itself becomes the disease. Whatever may have driven the individual to drink in the first place, the cyclic phenomena (tolerance-physiological dependency-loss of control and craving) begin to take their toll. By now the individual is physically and psychologically addicted to alcohol. (1982, 13)

Dulfano's viewpoint stresses the variation in dynamics and the clinical picture of alcoholism depending on the individual and his circumstances

in the early stages. Her view of the later stages however, shift to those of the medical model and she portrays alcoholism as typical, more unified in persons with less individual variance. She adheres to a view of the "loss of control" phenomena as being biological.

Dulfano's (1982) views are typical of those of many authors who will be cited, suggesting that alcoholism should be seen as a multi-dimensional problem with multi-faceted causes. These views lead to a pragmatic conceptualization of alcoholism as both an illness (symptoms which form a syndrome as Kaufman suggests), and a social syndrome which develops over time. It is one in which family members are involved; both effecting the alcoholic and being effected by him/her in a continuous process of inter-relating feedback.

Integration of Concepts

Although a "pure" family therapy perspective sees alcoholism as a symptom (of system dysfunction), in taking a multi-dimensional perspective and in working in a setting that espouses the disease model, the author found it useful theoretically and for pragmatic reasons, to be able to relate the two concepts and apply either, depending on the situation clinically.

Although these concepts may appear to be opposing ones, a circular argument shows that they are not mutually exclusive. Alcoholism can be seen as a <u>disease</u> which arises from multiple and inter-related psychological, physiological and sociological factors (including family

system dysfunction). Having said this, there is no contradiction in also saying that alcoholism is therefore symptomatic of disturbances in the areas of physiology, psychology and sociology and inter-relationships between these areas. The disturbances are evident in the behaviour of alcohol abuse (again, these areas include family dysfunction).

The medical model perspective is clearly applicable at times such as serious medical emergencies related to alcohol and/or drug use. The user is clearly in the "sick" role and others must take over to facilitate treatment or prevent serious harm to the drinker or others. This perspective applies also during detoxication as well as in crisis.

Following this however, the focus is that of a family systems perspective employing concepts such as subsystems, roles, boundaries, feedback, power, homeostasis and hierarchy in assessment and treatment.

CHAPTER III

FAMILY THERAPY AND ALCOHOLISM: THEORIES AND CONCEPTS

The aim of this chapter is to orient the reader to family therapy theory in relation to alcoholism as well as integrating other viewpoints and approaches to maintain a multi-dimensional viewpoint. This will be done through a brief discussion of family therapy and a broad look at perspectives on alcoholism developed from family therapy theory and practice.

Family Therapy in Alcoholism Treatment

As Rossi (1978) indicates, the term "family therapy" can mean many things depending upon who is defining it. It can refer to a treatment technique, a way to conceptualize human problems, a systems approach or a psychiatric movement. He elaborates that there is no set way to practice family therapy and also that no one discipline has a monopoly on it. In the alcoholism field, Rossi notes that family therapy has been applied in a number of different treatment modalities including conjoint therapy, multiple couples therapy and multi-family group therapy.

Janzen (1977) also reviewed the application of family therapy in alcoholism treatment programs. He raises issues related to conceptualization, theoretical positions, effectiveness and the means and modes of treatment. He concludes that the present literature on family

treatment of alcoholism conveys no common understanding of the relationship between the drinking and the family problems. He also asserts the view that because alcoholism can be seen as both a "cause" and a "consequence" of family dysfunction, a systems viewpoint which emphasizes interactional patterns is applicable.

Brill (1981) who notes the variety of explanations with respect to "substance abusing" families, suggests that a common framework is present. Steinglass (1977) concurs as to a common framework, yet also reinforces Janzen's views (1977) through noting "haphazard application" in "novice" hands and conceptual and practice issues. This supports the statements of Rossi (1978) referred to in Chapter II that the alcoholism field lacks trained family therapists. Steinglass (1977) explains that frequently, alcohol specialists have simply extended group therapy approaches to include additional family members.

These views of the treatment field support this author's conclusions as stated in Chapter I, that the current picture of treatment reflects a continuing gap.

In this report, the author endeavours to narrow that gap through addressing conceptual integration of a family therapy perspective with the medical model of traditional alcoholism treatment. To do this, meaning and explanation must be given to the term family therapy. Key concepts that distinguish a family therapy perspective follow.

Family Therapy: A Perspective

To the author, the term "family therapy" indicates a perspective or point of view that is founded on general systems theory and developmental theory and the integration of the two. Okun and Rappaport (1980), illustrate this by asserting the opinion that:

> ...Even if only one member of the family is seen in treatment, the treatment can be considered family therapy as long as its' focus is on the family system. (37)

Freeman (1981) highlights the relevance of systems theory indicating its value in providing a conceptual framework for the numerous theories and concepts about human behaviour without locking the therapist into a particular behavioural theory base. As he suggests, systems theory used as a framework allows for the interconnection of ideas about how the three levels of systems - individual, family and community - function individually, and how they influence each other.

The second foundation of a family therapy perspective, developmental theory, conceptually combines the past with the present by giving an understanding of the family's position in its development.

Okun and Rappaport (1980) stress the importance of the integration of knowledge of developmental theory, which entails predictable stages of development of the family life cycle and the tasks associated with these stages. Successful transition from one stage to another is seen as necessary for healthy development with respect to both indivi-

duals and families. As Okun and Rappaport point out:

> ...transition from one stage to another inevitably transforms family structures and communications; transformations in family structures and communications are requisites for successful developmental stage negotiation. They are inseparable. (1980, 29)

Bowen (1978), who notes that family systems theory was developed from family research onemotional problems makes important points about the shift in emphasis associated with a family therapy perspective. As he suggests, the focus is on the functional facts of relationships, on what happened, how it happened, where it happened, as well as when. He differentiates systems theory from conventional theory noting that in the former, the emphasis on why is avoided. Noting that "why" thinking has been a part of cause-effect thinking since man began to look for causes to explain events, Bowen (1978) stresses the point that:

> An assumption behind systems theory is that man's cause-and-effect thinking is still a major problem in explaining his dysfunctions and behaviour. (261)

To elaborate, family therapy theory would emphasize the current what, who, how, where and when, not getting caught up in the causes through delving into past history. The focus is on the present, the identification of the dysfunctional aspects of the family system searching for strategies to ameliorate the dysfunction. Thus, the view is stressed that the researcher must lay aside his or her own why assumptions and "get beyond his own second nature cause and effect

thinking". (Bowen; 1978, 261)

It has been asserted in this report, that a multi-dimensional view of alcoholism entails seeing alcoholism as both a cause and a consequence of family dysfunction. It is a view of alcoholism as developing out of dysfunction as a disabling strategy, or as a solution which becomes a problem and adds to the other problems.

As evidence in support of this perspective, Kaufman and Pattison (1982) note that there:

> ...is now recognition of the effect of the family on alcoholism to supplement earlier findings on the effect of alcoholism on the family. (663)

Usher et al (1982) state this view succinctly:

> ...Although the chaotic and destructive qualities of the alcoholic's behaviour are apparent, the tragedy of the family is that it nevertheless relies on that behaviour...Nowhere is it suggested that such adaptive measures are desirable for meeting the family's needs. Just the opposite: by relying on those rigid and inadequate solutions, the family minimally satisfies the interpersonal needs of its members. (928)

Core Concepts

The six core concepts used in all family therapy approaches as outlined by Steinglass (1977) are:

(1) the family as a system - thus, any single piece of behaviour must be understood in terms of how each individual is contributing to or making the behaviour possible. Also, how the behaviour is affecting

each member;

(2) the concept of homeostasis - of which the feedback loop is the primary mechanism for the maintenance of homeostasis;

(3) the concept of the "identified patient" or scapegoat - who is seen not merely as a disturbed person in his own right, but as the member selected by the family system, to express the symptoms on behalf of the family;

(4) communication patterns - both verbal and non-verbal which reflect the basic structure and interactional patterns governing family behaviour. As such, they often become the target of intervention themselves. In alcoholism, interest in these patterns during intoxicated states and the contrast between sober and intoxicated patterns has been seen as critical to an understanding of family dynamics;

(5) behavioural context - that is, family therapy is interested in not only internal processes, but also in the relationship between individual behaviour and the interactional field in which it is occurring. Termed the "context" (the setting and the cast), it is believed to predetermine the behaviour of individuals by limiting the possible choices the individual can successfully or appropriately express. Thus, drinking behaviour described only in terms of quantity and frequency are inadequate, and a family therapist would want to know the contextual and relationship pattern factors that emerge when alcohol is present;

(6) "boundaries" - a family therapist is concerned about the nature

of the boundaries that separate individual members, also those of the boundaries between the family and the larger world. Alcoholic families are generally seen as characterized by rigid boundaries and a sense of isolation.

Unlike the medical model approach which conceptualizes alcoholism as a primary disease, a family therapy approach conceptualizes alcoholism as a "symptom". Thus, a family with alcoholism in a member is seen as a "dysfunctional" system which has given rise to the symptom of alcoholism as a stabilizing or adaptive mechanism. Steinglass (1977) notes that from this viewpoint, psychopathology is redefined. The "alcoholic" individual becomes the "alcoholic family". The symptomatic individual or "I.P." is portrayed as the patient selected by the family system. His or her needs and well being are viewed as being sacrificed in the interests of the larger system's functioning or integrity.

Steinglass (1977) elaborates suggesting that the alcoholic member may be protecting the family from overwhelming depression or intolerable levels of aggression. He notes that depression often occurs when the alcoholism is treated and the depression is often manifest in another member.

This view of alcoholism which portrays the drinking behaviour as adaptive or functional for the family, implies that the family system has a role in maintaining alcoholism in its' member(s). It also suggests that the family system is a powerful source of resistance to change.

The medical model counterpart to the dysfunctional family is the conceptualization of alcoholism as a "family disease". This viewpoint entails the notion that both a "sick" alcoholic and a sick "co-alcoholic", usually a spouse.

Some integration of these two perspectives can be provided through the concept of "blame". Deviant and destructive behaviours on the part of both the alcoholic and those around him/her are attributed to the "disease" of alcoholism which affects the total person, including behaviour.

Bowen (1978) notes "blame" as a central issue in alcoholism regardless of perspective. He suggests that blaming others for failure is present in all of us. He also notes that the higher the level of anxiety, the more the tendency to blame in a family situation. Alcoholic families are usually in a high degree of stress, therefore blaming is often a central feature of family interaction.

The notion of blame is done away with from a family therapy perspective through the attribution of contextual factors which are assumed to predetermine the behaviour of individuals by limiting choices. In practice, blame is negated through the focus on the functional facts and the avoidance of why. Integration in practice can be provided through the utilization of Berenson's (1976) suggestion that the therapist attribute blame to the disease if the family requires a "cause and effect" explanation. Thus, the disease concept

can be seen as a reframing technique when used from a systems approach. It is used to alter the "effect" in the context.

The Pharmacological Fallacy

As has been stated, a family therapy assumption about alcoholism is that contextual factors maintain and reinforce drug abuse. Basic to this viewpoint is the concept of the "pharmacological fallacy". The essence of the fallacy is that properties of the drug are insufficient to account for the re-inforcement of the continued abuse. Okun and Rappaport (1980), highlight the concept by asserting the view that the importance of context in drug induced experience is now an accepted phenomenon.

The concept of the pharmacological fallacy is both supported and stressed by Stanton (1982). He states that too often, drugs per se are seen as the problem or as "the agent that casts the user into the gutter". Stanton adds that many of the effects attributed to drugs are dependent upon expectations, the setting in which they occur, and the psychosocial needs or rewards being addressed or generated. This concept will be discussed further in this chapter and in Chapter V.

The emphasis on contextual factors in the maintenance of drug and alcohol abuse has developed from studies of family interaction.

Development of Interactional Models

The work of Steinglass and his co-workers of the early and mid-1970's in which clinical observations were undertaken of family interaction in intoxicated and sober states, was noted in the section on "Historical Developments". This work was the basis for the development of interactional models of alcoholism.

As Steinglass (1977) describes, interaction during intoxication is highly patterned and is very different from behaviour predicted during sobriety. As one example, he notes a family that claimed that drinking by the alcoholic caused depression, fighting and estrangement, actually showed more warmth, increased animation and increased care-taking behaviour.

Steinglass suggested that alcohol:

> ...by dint of its profound behavioural, cultural, societal and physical consequences might assume such a central position in the life of some families as to become an organizing principle for interactional life within these families. (1977,279)

Labelling these families "alcoholic systems", Steinglass suggests that alcohol (presence or absence) becomes the single most important variable determining the interactional behaviour between all members (drinking and non-drinking). As he notes, this implies a delicate balance existing between drinking and day to day functioning; also that alcohol might be unconsciously viewed as a stabilizing influence on interactional life by family members.

In intervention, the first task of the therapist is to appreciate the relationship between alcohol and family life.

Steinglass postulates two categories: the first, sees alcoholism as a signal or symptom of stress and strain. This calls for crisis intervention. If, on the other hand, it is part of the ongoing interactional pattern, then the traditional intervention aimed at abstinance is inadequate to the task.

Davis (1974) is credited by Steinglass (1977) as expanding on this theoretical model in two important ways. He incorporates behaviour theory and he highlights the importance of focusing on maintenance factors, rather than on etiological factors at this "primimtive stage of our understanding of chronic alcoholism".

Steinglass elaborates (1977) that Davis' work highlights the two major assumptions of theraputic approaches to alcoholism in that excessive drinking is maladaptive and that ultimately causes exist. Davis thus postulates adaptive consequences as the primary "maintenance" (not pharmacological factors). Steinglass suggests (1977) that these adaptive consequences or primary factors may differ for each individual and may be operating at a number of different levels such as the intrapsychic, intracouple or the family homeostatic level or even beyond in the larger system level. The "final common pathway" is the reinforced chronic alcohol abuse.

Interactive or systems theories of alcoholism have been advanced from both the "communications" and the "structural" schools.

Communication Theory of Alcoholism

Gorad et al (1971) suggest that communications or interactional approaches have received little attention relative to individual disease models concerning alcoholism. Interactional models focus on the function of drunkenness and other aspects of alcoholic communication styles to explain alcoholism. Noting that all observable behaviour can be seen as 'two level messages', with both a content and a 'meta' or relational aspect, they suggest that it is through the message sending that one person influences the other. In their theory, they are concerned with the functional effect of the 'relational' or 'meta' message on others in the context and concerning the defining of the relationship.

In discussing alcoholism, Gorad et al (1971) note that intoxicated behaviour is an indirect responsibility-avoiding behaviour. Drunkenness in our culture is accepted as evidence of "out of control" or "not really oneself", and therefore free of the usual responsibilities. It may entail an indirect message from husband to wife such as "mother me", but through the qualification provided by drunkenness, responsibility for sending of the request is avoided. Thus, Gorad et al (1971) note that to be able to act and thus communicate one's definition of the relationship, yet have all know that one is not responsible for one's actions,"puts one in a position of unusual control." (654)

They elaborate, suggesting that attempting to talk to someone who is drunk is an exasperating experience. "The usual response is to let the drunkard set the rules and follow his lead or to give up trying to communicate and withdraw." (Gorad; 1971, 654). These authors note other forms of communication as being responsibility-avoiding also, such as psychosomatic, psychotic and neurotic symptoms. In their view, alcoholism differs somewhat, in that in these other categories, the behaviour is accepted as involuntary, whereas in alcoholism, though the drunkennes is accepted as responsibility-free, the act of drinking is seen as willful and voluntary.

This entails some confusion on the part of the recipient as to how to take the message. They stress the point that the ability of drunkenness to create these confusions is critical to understanding alcoholic behaviour.

Gorad et al (1971) hypothesize that all alcoholics are alike in their style of communication, or share the use of certain communicational maneuvres which they use, drunk or sober. In addition to drunkenness, other techniques are shying away from decisive action and verbally stating positions when pressured, then not following through. They postulate externalization of responsibility, stressing the idea that these "relationship defining messages" indicate how the sender wishes to be viewed and treated. In the context, others do not know what the alcoholic wants and relatedly, his sense of possessing the power to influence is missing. As Gorad et al (1971)

suggest, this picture of self correlates intrapsychically with feelings of impotence, helplessness, enui and despair. They recall Bateson's (1972) view that the alcoholic may operate on the premise that the "self is a fiction".

These measures are employed with the greatest intensity in interaction with significant others. Gorad et al (1971) note that this is not merely due to the presence of the significant others. In their view, the defining of a relationship and deciding on permissible behaviour is a process involving two participants and interaction. Thus, they assume implicit collaboration in the form of permission and tacit encouragement. Postulating a selection procedure in pairing which involves an exchange of information and choice of styles that fit, Gorad et al (1971) suggest that otherwise the relationship would not endure. As the relationship continues, a steady state is established and a level of stability which includes drinking is maintained.

Gorad et al (1971) note the presence of chronic conflict over control as a contextual factor in the maintenance of drinking. They cite work of Bullock and Mudd (1959) and Mitchell (1959) which shows a high level of conflict in alcoholic marriages. They also suggest that to have one member of a relationship using indirect responsibility-avoiding maneuvres for controlling the setting of rules, implies a power struggle. The escalation of conflict over control combined with the perception of "losing" and being powerless to win frequently pre-

ceeds a drinking bout. The prime weapon therefore is drinking employed as a maneuvre to restabilize the system. Noting that wives of alcoholics seem to use more overt persuasion methods, Gorad et al (1971) highlight the "apparent" imbalance in the distribution of power (ie: the alcoholic appears less powerful).

Adding to this picture, Gorad et all suggest that the one area in which the husband has control is drinking. Thus, the wife is faced with behaviour that she cannot prevent. They suggest that this cannot be effective if the wife does not get upset or try to control it, however, the stress usually guarantees an opposite reaction. They add that the wife may prefer to see the alcoholic husband as the culprit than be confronted with a husband who openly states that he wants to be the "boss".

From this perspective, the Al-Anon program emphasizing in the first step the notion of the spouse being "powerless over alcohol" becomes significant. It is designed to break the cycle of the spouse attempting to control or effect the drinking behaviour of the other and therefore alter the interactional dynamics. This also lessens the "power" of the symptom in the context.

With reference to Gorad's work, McGrady (1982) notes that Rizzo[1] was unable to replicate these findings using similar methods.

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[1] This is cited as "personal communication" from Rizzo to McGrady.

McGrady also cites studies which have described verbal communication patterns. Billings et al (1979) found a high frequency of hostile and coercive communication. Moos et al (1979) and Orford (1977) found that couples who are highest on hostile interactions prior to treatment have the poorest treatment outcomes. Billings et al (1979) and Foy et al (1975) show that alcoholics increase the rate and amount of verbal output while drinking, and Cvitkovic (1979) found that assertive or aggressive responses increased while drinking. McGrady(1982) summarizes by noting that these studies suggest that alcoholic couples interact in dysfunctional ways, however, the pattern of interactions may not be unique to alcoholic couples. She also observes that the changes in patterns while drinking lend credence to the systems hypothesis of alcohol serving a positive function to the family system.

Support for a communications view of alcoholism is advanced by Okun and Rappaport (1980), who classify alcoholism as a "non-developmental crisis" of a "voluntary type", in which the alcoholic develops the symptom as a way of controlling the relationship and also as a form of tension resolution. They cite the work of Bowen and Haley on tension resolution and symptom formation which postulates three major ways that dysfunctional families use to manage tension. These are:

(1) open fighting between the spouses;

(2) triangulating or extending the tension to another member of the system (usually a child);

(3) submerging the tension through the development and maintenance of a symptom.

They expound on alcoholism as a "disabling strategy" (that of symptom development and maintenance) noting that some families are unable to diffuse tension through triangulation and open fighting. This may be due to the lack of a third member who is emotionally vulnerable to triangulation, or as they also suggest, one spouse may not take responsibility for continuing an open battle with the other (Okun and Rappaport; 1980).

In support of this conceptualization, it is noted by Okun and Rappaport (1980) that despite evidence of the "pharmacological fallacy" our culture continues to support the explanation that the alcohol was the cause of destructive and different behaviours. This allows the alcohol abuser a powerful tool for domination of relationships and avoidance of responsibility. Thus, alcoholism "fits" with Haley's definition of a symptom. It has an overwhelming effect on the individual and it is something for which the individual cannot be held responsible. Evidence for this is made in a 1976 study in which Rappaport noted that male alcoholics are more willing to engage in control battles with their wives than with their children. The same study (Rappaport; 1976) showed that they are more willing to choose strategies that avoid responsibility than to engage in open conflict and that wives were more willing also to choose such

strategies (Okun and Rappaport; 1980). Thus, avoidance of responsibility seems to be a characteristic choice of strategy in alcoholic couple systems. Okun and Rappaport (1980) emphasize the point that while family crises such as alcoholism are non-developmental ones, they usually grow out of developmental issues facing the family. They add that alcoholism complicates and delays the growth of individuals, subsystems and family systems.

As well as permanently arresting the development of some family members, alcoholism can add stress and strain to the family system and requires active supportive crisis intervention. In recovery phases, the need for recalibration of the system is stressed (Okun and Rappaport; 1980). This view portrays alcoholism as both a cause and a consequence of family dysfunction.

Okun and Rappaport, who use a communications perspective to explain alcoholism as a "voluntary family crisis" and a "disabling strategy", appear also to incorporate a structural perspective that is built on Bowen's theory. They suggest that when the behaviour of the alcoholic is assessed as being related to marital conflict, treatment would be focused on the couple relationship. The chronic alcohol abuse stems from and is symptomatic of, fusion of the poorly differentiated persons.

Bowen's Theory of Alcoholism: A Structural Approach

Bowen's theory of alcoholism is one that views families as not

having conscious choices about the selection of adaptive patterns. They are, in his view, programmed in their parental families. From this orientation, a person who becomes alcoholic is often the one who handles emotional attachments by denial and a "super independant posture". This is manifest in an exaggerated sense of responsibility and chronic overburdening. The harder he works, the more isolated he becomes. Relief found in alcohol initiates a drinking cycle. The denial of the need for others is in turn reinforced by spouse and children. The outcome is irresponsibility and broken promises related to the drinking behaviour (Bowen; 1978).

The other end of the spectrum according to Bowen (1978), is the person who becomes "de-selfed" in emotional fusion with a poorly differentiated mother. His denial mechanism permits him to distance himself from his need of his mother as well as others in subsequent relationships. This type of person can be seen as a "social outcast". His need for emotional closeness is great, yet he goes to extremes to deny it and often develops a drinking problem early in life. Bowen notes that most persons fall in between these two extremes:

> A high percentage of adult alcoholism is in people who are married and who have the same kind of emotional attachment in marriage as they had in their parental families. They are emotionally isolated from their spouses who play the reciprocal role in drinking dysfunction.
> (Bowen; 1978, 265)

Bowen relates the concept of "differentiation of self" to the concept of "maturity". The level of differentiation is determined by that of the parents, by the type of relationship the child has with the parents and also by the way one's emotional attachment to parents is handled and resolved or not resolved in young adulthood. Bowen (1978) suggests that it is common for people to get into marriages blaming parents for past unhappiness and expecting perfect marital harmony. As two "pseudo selfs" fuse into relationship, there is a high potential for impairment in the functioning of one spouse.

The discomfort of fusion is handled in one of several ways according to Bowen's theory: emotional distance in the marriage, conflictual marriages in which neither gives in (fluctuating between distance and closeness), one spouse becoming dominant and the other being subordinate. In this latter, and most frequent pattern, the adaptive spouse is programmed to support the more dominant one and becomes a functional "no-self". This pattern continued over time renders the adaptive one subject to chronic dysfunction such as physical or emotional illness or social dysfunction, such as abusive drinking or drug use (Bowen; 1978).

In applying his theory to alcoholism, Bowen notes that alcoholism has always been one of the most difficult dysfunctions to modify. He asserts the view (1978) that while systems theory offers "no magic", it does offer different ways to conceptualize and treat. The basic level of differentiation is seen by Bowen as more relevant as an

outcome predictor than is the intensity of the alcoholism.

Bowen suggests (1978) that in intervention, attention should be given to the overall level of anxiety. The nature of the problem is manifest in the fact that the family members who are most dependant on the drinker show more overt anxiety than the drinker. Family dynamics reveal that the more the family is threatened, the more anxious they get. The more they react by becoming critical, the greater the emotional isolation; drinking thus escalates in a somewhat spiralling fashion. He views the alcoholic person as operating on a margin between too much closeness and too much isolation.

A key principle to be drawn from Bowen is that in intervention it is often more productive to focus on assisting the overfunctioning person to tone down than to help the dysfunctional one increase in functioning. Bowen (1978) states that attending to the behaviour of others can effect a change in the drinking behaviour.

It should also be noted that Bowen does not dismiss the pharmacological effects of the alcohol as a re-inforcement in that he suggests that relief is found in alcohol. Bowen's statements are noted by Steinglass (1977) as presenting "the most undiluted justification for family therapy" currently in the literature. Bowen's position is that treatment that alters the behaviour of other family members will eliminate the alcoholism.

Steinglass also suggests that Bowen's views are "too extreme" for

most alcoholism therapists to accept. In Steinglass' opinion, a more integrative approach that takes account of the"behavioural consequences of alcohol consumption is likely more useful at this stage of our knowledge". (281)

It was suggested at the outset of this chapter, that a systems framework does not lock one into a particular orientation to behavioural problems and also that it allows for the interconnection of ideas about the individual, the family and the larger context. Bowen suggests (1978) that low levels of differentiation of the self and discomfort of fusion are factors in alcoholism. Joan Ablon (1980) brings in a sociological perspective in her research. As alcoholism shows cultural variances, she looks to the cultural surround for explanation and stresses the maintenance of cultural paradigms. In this, she seems to offer alternate explanations for "enmeshment" to those of Bowen.

A Socio-Cultural Perspective

Addressing a gap in research that she earlier identified, concerning socio-cultural factors as determinants, Ablon (1980) studied a population of middle class Catholic families of Irish, German and Italian origin among whom alcohol related problems are particularly frequent and severe. She suggests that in order to understand alcohol usage in this population, a knowledge of the historical and cultural roles of drinking in ethnic groups and a holistic view of contemporary family life are necessary. She suggests that cultural, social and

economic aspects of family life and role behaviour of family members related to living out cultural expectations are important. Her study illustrates the excessive use of alcohol fulfilling not only functions for the individual and family homeostasis, but also serving the maintenance of a cultural paradigm handed down through generations.

Two aspects of family life seemed to be related with reference to Ablon's work. Alcohol related problems were prevalent along with strong culturally patterned controls which encompassed almost all features of family life. The pattern of tradition could be seen as constituting a super structure for strong stable families in terms of no divorce or separation, normative career rituals and strong extended family relationships. Social patterns tended to direct both men and women into very rigid sex and work roles and to preclude new behaviours. Problematic drinking occurred with greatest severity in those groups that had the most rigid controls in terms of marital and sexual life and relationships with families of origin. (Ablon; 1980)

Irish Catholics exhibited the greatest amount of control and highest rates of problem drinking. In Ablon's view, religious strictures dealing with sexual behaviour was the single most important area of oppressive social control related to the problematic drinking among Irish Catholics.

The point is made that in assessment, it is important to look at the behaviour of each family member as they relate to one another in the complex of social and cultural expectations. Cultural prescriptions

and expectations regarding behaviour and attitudes related to drinking patterns can therefore contribute an important dimension to a systems model.

At a period in history where American society offers individual freedom options, most of the persons in Ablon's sample appeared to lead their lives "locked within a pattern of 'cradle to the grave' moral, social and economic expectations". (1980; 142)

> ...Excessive drinking (with all of its' adhering untoward consequences) is an effective and culturally sanctioned way of rattling the cage while not breaking out of it.
> (Ablon; 1980,142)

Basic intervention techniques focus on the establishment of spousal communication and also breaking the continuity of these culturally inherited role patterns are seen as an avenue of approach for the family practitioner (Ablon; 1980).

Brill (1981) notes that alcohol abusing families usually have problems in at least four areas: the provision of a normal growth and development environment, the establishment of clear consistant behavioural role models, the development of positive communication and relationship models, and the mastery of interpersonal relationships, especially intimate ones.

Citing Bowen's work in the 60's in which a paradigm of "schizophrenogenic" families was produced, Brill notes that this paradigm applied equally to families with a narcotic addict, alcoholic or

delinquent member as well as gastro-intestinal or colitis members. He notes that this raises the difficult issue of choice of neurosis and determinants of choice.

In a similar vein, McGrady (1982), suggests burying the "concept of the alcoholic marriage" along with viewing these couples as a "unitary group". She suggests that much of the general research on marital variables applies to this population. As illustration, she notes the literature on family roles assigned related to stress and the similar findings on alcoholic family role assignment. She suggests that these findings are not surprising. The choice of response, drinking, is different. The antecedents and dysfunctional communications are the same, across different types of distressed groups.

McGrady also notes that no one has studied the "organismic variables"[1] which play a role in the subsequent chain of events in which alcoholic couples engage consisting of the repetitiveness of interaction of drinking, marital consequences, more drinking, etc. She notes the promise of systems theory and social learning theory which assess, without providing a preset explanation of what patterns will be present.

The Issue of Controlled Drinking

In view of the current controversary on the issue of controlled drinking (as discussed in Chapter II), the author was interested in

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1. Organismic variables refers to internal responses to external stimuli - may include physiological responses, cognitions or emotional responses (McGrady; 1982, 680).

the opinion of family treatment writers, and the reasons postulated related to the use of different concepts and theories.

The author found that some variance in opinions were present and also that the issue is not discussed at great length by family treatment writers.

For example, Bowen's (1978) position is that treating other family members will cause a change in the drinking behaviour. There is no detail provided as to whether a change is a "moderation" or a "cessation". Kamback (1976) is quoted as stating knowledge of cases where the alcoholism simply disappears without specific treatment of the alcoholic member when the family functioning is improved (Barnard and Corrales; 1979).

Pearlman and Zweben (1983) note that many clients enter treatment with reduction in drinking as an aim. They cite "many" as poor candidates for this in view of a poor history of control over drinking. They advocate assisting these clients to assess the feasibility of temporary abstinance before considering non-problematic drinking. They do not expound apart from this.

Berenson (1976) is explicit in saying that he does not think that alcoholics can drink normally or in a controlled manner. He comments that an alcoholic drinking pattern has been established by physiological, psychological and family and social factors. He adds that it is unlikely that the system is modifiable to an extent that permits the resumption of social drinking. Berenson also notes the paradox which suggests that one can only become a social drinker when it is truly

unimportant to do so. If it is unimportant to drink, then there is no necessity to do so.

Usher et al (1982) are also specific in stating that abstinence is a goal in family therapy with alcoholic families. They give no rationale, but suggest that slips occur often and should not be viewed as a serious setback. They add that in cases where abstinence is not achieved, including those which show a reduction in drinking, the prognosis is poor. Reduction is usually followed by a gradual increase after termination of treatment and only modest improvements in family relations occur in their view.

An equally explicit statement is made by Okun and Rappaport (1980), Addressing the issue of "our culture supporting explanations that alcohol was the cause of different behaviour", they state that there are:

> ...two basic and now disproven assumptions; 1) alcoholics cannot help taking a drink and; 2) once drunk, alcoholics cannot control their behaviour. Alcoholics Anonymous has clearly shown not only that alcoholics can control their behaviour while drinking but even that they can control the actual amount they drink (Steinglass; 1976) and can learn to drink moderately. (260)

Reviewing the same source (Steinglass; 1976) the author notes references to "reduction in drinking" cited as "favourable outcome measure", thus the article does imply that control in drinking or at least reduction is possible. Acknowledging a bias, however, this author notes the additional point made by Steinglass that these clinical reports are unsubstantiated.

In discussing the studies, he reviewed as his basis, Steinglass (1976) also mentions the fact that only one of the clinical reports specifically identifies the therapists as "family specialists", rather than "alcoholic specialists", and notes that abstinence has been the traditional measure of success. Thus, it is unclear what biases were operant in these clinical studies reviewed by Steinglass. As well, the definition of "alcoholic" is not specified. The author does note that in his 1980 article, discussing the late resolution patterns of alcoholic families, Steinglass states that the "stable controlled drinking non-alcoholic" resolution type occurs very infrequently.

The concern of this author is that the Okun and Rappaport (1980) statements could be very misleading. Clinical experience with alcoholic families which is amassing, seems to increasingly support an abstinence goal orientation.

The majority of authors stress the use of A.A. and Al-Anon in treatment. This can be seen as a position which favours abstinence as the most realistic treatment goal. Thus, this author concludes that without advancing extensive rationales, the majority of family treatment writers take a multi-dimensional view assuming biological and/or psychological factors among others as significant in the maintenance of abusive drinking. Apart from Berenson, however, this is not specifically stated.

A Breadth of Viewpoints

Consistent with the prior discussion, this author concludes that writers who address alcoholism from a family therapy perspective, do not adhere solely to family therapy assumptions. For example, Kaufman (1980) warns against over-generalizing and suggests that genetic factors as well as social and cultural ones must be considered. He stresses the individual factors, which he sees as "interwoven" with family dynamics. Steinglass also appears to hold a dual conceptualization of alcoholism as that of a disease as well as of a symptom, as he raises the question, "How does the presence of this chronic disease alter the family life cycle?" (Steinglass; 1980,225). Steinglass also notes that the unique flavour of alcoholism "comes from the physiological effect of the drug on the individual and on the interactional behaviour (1980, 225). Thus, both of these authors appear to attribute some power to the pharmacological effects of the drug in multi-dimensional viewpoints, which espouse a broad theoretical perspective on alcoholism.

The addition of a family therapy view allows the practitioner a broader scope in both assessment and intervention. The importance of considering the family function of the drug abuse is stressed. Does it help maintain homeostasis? Does it assist in the labelling of a member as helpless and unable to leave home? Does it exist as a "unifying force" or problem to rally around and keep a family intact?

Stanton (1982) in support of the "adaptive function" served by alcoholism notes that it is almost universally accepted that not only is compulsive drug taking overlooked in families, it is often covertly encouraged. Stanton notes also that families often sabotage treatment.

Alcoholism: Gaps in Knowledge

The author will not review research findings apart from those cited with reference to specific sections of this report. For an excellent summary the reader is referred to Stanton (1982), who encompasses research related to alcoholism with respect to family birth order, composition, factors in onset and studies detailing probabilities of alcoholism in the extended family. Findings on aspects of interaction patterns are also covered in Stanton's summary.

Despite extensive research, the author notes that gaps exist. The following section will give some picture of the state of knowledge and the gaps in research as they are identified by major authors in the field.

Jacob, Favorini et al (1978) comment on research findings thereby supporting Steinglass' position, that the state of knowledge is "primitive". They note, as do Dinaburg, Glick and Feigenbaum (1977) and Babcock and Connor (1981), that studies of families with male alcoholics predominate, and that studies of female alcoholism in families are scarce. The only consistent finding concerning the latter

is that husbands of female alcoholics tend to be problem drinkers or alcoholics also.

Jacob, Favorini et al (1978) reinforce other authors who note that critical information is missing on major domains of influence; the family being one such domain. Much of the literature on alcoholics and family interaction is, in their view, characterized by inadequate methodology and design. As well, they say that limited ideas about interpersonal relationships in general and alcoholism in particular, restrict the range of concepts and experimental strategies used to analyze the relationship between alcoholism and family interaction. They argue that specialized alcohol and marriage literature must be integrated with more general conceptual frameworks, in the interest of a more truly sociopsychological theory. They suggest that systems theory is a potentially useful direction to take (Jacob, Favorini et al; 1978).

These views are echoed by Ablon (1976; 236-7) who suggests that research is needed that is broader in scope. Her point is that personal pathology has been the overwhelming approach to research on alcoholism in families. She stresses the point that research that ties in the specific alcohol related crisis syndrome to the existing body of theory dealing with family and community behaviour in a variety of crisis situations, is grossly underdeveloped. In her view:

> ...Researchers on the alcoholic family consistently have been parochial in their conceptualizations, seldom turning to outstanding available and relevant literature....

She goes on to note that:

> ...Only a few authors such as Jackson (1958 and 1962), Steinglass et al (1971) and Bowen (1974) have pointed up the similarities of family system dysfunction in alcoholism to those reported by other researchers for families in other forms of crisis.
> (Ablon; 1976, 236)

Ablon values work which stresses disturbed role patterns related to the intra-family stressful event of alcoholism. She also stresses the point that the total family context should be kept in mind, suggesting that family characteristics that are indicative of good adjustment to crisis serve as assessment indicators of family strength and viability (Ablon; 1976).

Ablon notes that with few exceptions, the extra family dimension of sociocultural attitudes and the nature of available help are also ignored in research. She stresses these factors as playing a primary role in family attitude development and maintenance and shaping the options the family can see and take.

Ablon (1976) credits the work of Jackson (1962) which notes the lack of cultural guidelines for family response to this specific problem, other than the categorization of deviant behaviour and the labelling process. This invokes shame and stigma, thereby contributing to an already sensitive crisis situation. Her point is, that a history of the help seeking behaviour and community response is as important in

assessment as the history of the drinking behaviour of the alcoholic in affecting the progression of the problem. Ablon (1976) suggests that unsuccessful attempts in the spouses help seeking "career", are contributors to the anti-professional attitude often found among Al-Anon members and other spouses.

Kaufman (1980) comments that it is difficult to say how much substance abuse intensifies a "normally ethnically determined pattern" as there is no longitudinal research on which to base any conclusions.

Kaufman (1980) also challenges the "myth" that family structures observed at one point in time can be generalized to other time periods in the life cycle. He points out that families change structure and move through phases of enmeshment and disengagement after substance abuse develops. He also notes the fact that much disengagement is reactive to enmeshment. In support of this, he cites the alcoholic family vascillation noted by Olson in 1977 and also the work of Aponte in 1976, who uses the term "underorganized" and characterized by shifting boundaries. Kaufman suggests that we are not knowledgeable about family structures of substance abusers due to a poor research base. Kaufman's view is supported by Stanton (1980), who comments that in working with substance abusing families, he finds the concepts of "enmeshment" and "disengagement" to be less and less useful as a dimension. Stanton, in concurrence, cites Haley (1976) who observes that often the disengaged or distant member becomes extremely involved

and upset when change starts to occur. Thus, in his view, what may appear to be disengagement may actually be enmeshment. This supports Bowen's (1978) point on "fusion" and fluctuation between closeness and distance in discomfort.

Effectiveness

Janzen (1977) reviewed outcome literature concluding that while family treatment has advantages to both the alcoholic and other members that other treatment does not offer, effectiveness studies are lacking. He states further that few studies have a research design that permits the drawing of firm conclusions.

This author finds unanimity with Janzen's (1977) views on the part of other authors surveyed including Dinaburg, Glick and Feigenbaum (1977), Emrick (1982) and Stanton (1982).

Clearly, there is a need for more well-controlled studies that have the capacity to address the area of effectiveness.

Developmental View of Alcoholism

Joan Jackson (1954) can be seen as a pioneer in portraying alcoholism as a developemental process in the family. Her account of the stages of typical adjustment to alcoholism serves as a primer in understanding family dynamics. Jackson views alcoholism as a sequential seven stage process, commencing in the early marriage stage which is

characterized by attempts to deny the problem and subsequently moving through later stages of attempts to eliminate the problem, a disorganization stage (tension relieving), then a stage of attempting to re-organize (usually associated with a crisis). This is followed by stage five, which is efforts to escape; stage 6, which is re-organization of part of the family and finally; a recovery stage if sobriety is achieved.

Her model shows each stage as impacting on the next one, determining its form.

McGrady (1982) notes that Jackson introduced the field to a more humane view of the problems of living with an alcoholic. She is critical of Jackson's methodology however, and also finds ommissions. She points out the fact that the wives of Jackson's study were all members of Al-Anon and may not have been typical of other wives of alcoholics since they sought help, chose a self-help group and were open to group sharing. She also notes that there is not data to support findings as applying to alcoholic husbands. McGrady also finds that Jackson viewed alcoholism as a unitary problem and did not consider the continuum of alcohol abuse and problems.

Meeks (1976) suggests that Jackson's stages of family adjustment to alcoholism provide a sequential framework useful in the consideration of clinical implications at various stages in the problem progression. In the initial phase, the drinker may be joined by his wife and children in a denial conspiracy. This view is one of a "closed system", in terms of a lack of ability to observe and report reality or to accept

feedback. At this stage it is an effort to avoid the threat of family disintegration. Early intervention requires that persons intervene to change communication in the system as clues to the problem are detected. It is also noted that families seldom seek help at this stage.

Later on in the progression, a "marital schism" often results as the wife may be the first to abandon the denial, and differs from the husband in her perception of reality. Help can be given to the wife and children at this stage through focusing on objectifying the situation and assisting in the clarifying of options available for adjustment and for getting the drinker into treatment.

It is at the point at which the family has reorganized around the drinker that he/she is first cast into the "I.P." or scapegoat role. Once this point of new equilibriun is reached, resistance to changing it will often create problems which are clear at the point at which the recovering alcoholic attempts to resume his/her roles and status in the family. This is noted by Meeks (1976) as being a time where the equilibrium must shift to accomodate the alcoholic's re-entry, when trust must be restored, when other family members must relinquish roles against the hope that this time sobriety may be sustained. Patterns of meeting emotional needs have to be altered as the projection of all the family stress onto the drinker is no longer acceptable. Often too, family members expect that once the drinking

has stopped, all other problems will disappear. In fact, as Meeks (1976) states, relationships frequently get worse as other problems which can no longer be blamed on the drinking or drinker become more evident. He states that it is at this point, the "recovery stage", that family therapy may be most useful and critical.

Usher (1982) reinforces Meek's views concerning the recovery stage, noting that once the alcohol is removed, the family is in crisis, revealing characterisitics not readily apparent in the alcohol homeostasis. It is as if the alcohol abuse has disguised more basic problems. Emotional impoverishment, alienation, loneliness and emptiness are revealed. Individuals appear emotionally distant, needing support and closeness, but too empty and fearful to give or receive this. Feelings of depression and hopelessness accompany the emotional isolation, according to Usher.

Usher's discussion illustrates the adaptive function of the alcoholism. It may have been used to explain away their emptiness. Conflicts around alcohol may have distracted from or covered up alientation, and even offered some relief for the alienation allowing for some greater degree of interaction and emotional expression.

Four basic types of response to the crisis of giving up alcohol are noted by Usher (1982). The first is by re-introducing alcohol; that is, returning to old patterns and an alcoholismic homeostasis re-establishment. The second is to maintain sobriety, but split up

the family. The third is to begin the process of establishing a new pattern in which support from outside the family is relied on with little change in family patterns and still entails an emotional split. In other instances, the family may substitute other organizing principles such as excessive involvement in A.A.. A fourth response to the crisis phase is a basic change within the family and of the homeostasis. This allows for more effective interaction, closeness and improved ability to meet needs. (Usher; 1982)

Roles

The concept of roles is useful as is evident in the foregoing discussions of the development of alcoholism. Meeks and Kelly (1970) stress the importance of roles relative to family equilibrium. They point out that all members in the famiy are assigned and assume roles and relate to each other in characteristic ways. Each family has a set of rules that govern the roles and ways of relating. Roles and patterns constitute family equilibrium. Any attempt to shift this equilibrium (from within or without) may evoke resistance from the system. Thus, as they state it, no matter how "sick" to the outsider, the equilibrium established represents the family's attempt to minimize the threat of disruption and pain.

Usher (1982) states that from a family therapy perspective, alcoholism is neither a symptom to be alleviated or a cause of problems.

It is an integrated part of family life and should be understood as a component of survival.

Wegscheider (1976) has studied the alcoholic family in terms of the survival behaviours and family adaptive patterns and roles. She describes the adaptive roles as follows:

Chief enabler - who manifests super-responsible behaviour, a martyr stance, powerlessness, compliance, is often sickly or fragile and hides feelings of anger, guilt and tiredness;

Scapegoat - is sullen, defiant and acts out. He/she often uses chemicals and blames. Inner feelings of hurt and loneliness are present;

Lost child - the creative loner, is solitary and withdrawn. He uses fantasy to cope. The feelings within are those of loneliness and rage;

Mascot - is the hyperactive person who uses humour, likes being the centre of attention and is often cute or charming. He/she covers feelings of fear of not belonging and/or of breaking down.

Wegscheider (1976) stresses the need in working with families of facilitating awareness of these adaptive roles and also the need of creating a crisis to enable a confrontation of the alcoholic. She indicates that in the treatment phase, family members should be dealt with to enable an expression of feelings and also an acquisition of knowledge about alcoholism and it's effects upon families. She sees an "aftercare phase" as a time to focus on allowing members to experience their adaptive roles related to both past and present. Further

work on expression of feelings and communication within the family should be aimed at assisting all members to cope with the losses in roles and the restructuring of family relationships.

The Phenomenon of Denial in Alcoholics

A great deal has been written about the phenomenon of denial associated with alcoholics, especially in the literature which is written from an individual perspective. Jackson and Meeks illustrate denial in their developmental perspective showing it to be a family phenomenon. In this regard also, the author notes the popular Al-Anon pamphlet entitled "Alcoholism: A Merry Go Round Named Denial".

Herscovitch (1983) defines "denial" as "a psychological process which usually occurs at a level below awareness and which functions to isolate an individual from the implications of his behaviour."

As Herscovitch elaborates, persons in a state of denial truly believe that they do not have a problem with alcohol and they also believe that they can control their drinking behaviour. The state of denial is maintained by a process of minimization and selective perception which allows the individual to explain away the extent of both the consumption of the alcohol and the effects of it. When in denial alcoholics feel resentful about being involved in the counselling process.

In this author's view, an understanding of the phenomenon of denial

is essential to practice in the area of alcoholism.

Wolin et al (1979) studied alcoholism in families through viewing family rituals. Their work highlights one of the functions of denial in the family system. Wolin uses the term "subsumptive" for those families who incorporated the alcoholism into ritual life and the term "distinctive" with regard to families whose style was that of "warding off" the alcoholic behaviour, preventing it from invading cherished rituals.

The Wolin study shows that "distinctive" families are associated with an ability to prevent the emergence of alcoholism in subsequent generations. In these families, denial was seen as the means of keeping the alcoholism distinct. Thus, denial is functional in the prevention of alcoholism in succeeding generations.

On the other hand, Beletsis and Brown (1981), who discuss the effects of alcoholism on children, stress the phenomenon of denial noting the fact that the secret...the alcoholism, is maintained by the denial defense. They see this process as trapping the children in a situation in which all available energy goes into maintaining the denial and coping with reality.

In this atmosphere, the child learns to "manage" the actions of others, responding often to non-verbal cues. The child's feelings, behaviour and needs are dictated by the state of the alcoholic. A predominance of defensive coping strategies develops which is necessary to survival and becomes all encompassing. Beletsis and Brown (1981) relate the high rates of serious psychological problems in the adult children of alcoholics to the effects of alcoholism and the denial

defense in the family.

Kissin and Begleiter (1977) note that family disruption, either as a predisposing causitive factor or as a consequence is so commonly associated with alcoholism as to constitute "one of the major symptoms of the syndrome".

They say that many alcoholics come from homes where one or both parents are alcoholic, and suggest that in some instances an unhappy marriage may itself act to initiate or aggravate the problem. They make the point that once alcoholism has entered a severe phase, some form of family disruption is invariable. In their view, this may be due to the reaction of a perfectly "normal" individual to the self-destructive and other destructive behaviour of a spouse, or it may involve a level of interaction of psychopathologies of the husband and wife. The point stressed by Kissin and Begleiter is that once family disruption has taken place, a vital element necessary for social rehabilitation has been lost, ie: the family.

A Developmental Model

Steinglass (1980) also takes a developmental perspective applying the construct of the family life cycle stages to develop a model or framework of the life history of the alcoholic family. He notes the fact that a developmental perspective can help to alert the clinician to potential stress points along the life cycle and set priorities

for issues presented by families. He suggests that when the issue is a consequence of having to manage a "chronic condition", one can focus on potential distortions in the life cycle introduced by the chronic condition. Steinglass who thus sees alcoholism as both a cause and a consequence of dysfunction, suggests that it is important to learn what changes in the life cycle are associated with chronic alcoholism and what the clinical implications of these changes or distortions are on the developmental stages and associated tasks.

In Steinglass's life history model, the "alcoholic family system" is seen as one in which alcohol use plays "such a critical role in day to day behaviour as to become a central orgranizing principle around which patterns of interactional behaviour might be shaped". (Steinglass; 1980, 213).

Such families, in Steinglass's view, can be seen to cycle between two predictable states; one associated with sobriety, the other with intoxication. Thus, the view is afforded of the intoxicated interactional behaviour becoming as habitual as the alcohol consumption itself. He notes that chronic illnesses in their persistance over time tend to become associated with repetitive or stereotyped behaviour patterns which become part of a family's homeostatic mechanism (Steinglass; 1980)

Looking at family developmental phases, the "early marriage" phase is one of relative instability. Tasks include the working out of role

functions and rules for management. During this phase, the future role of alcohol use in family life is determined. Aspects of alcoholism such as unstable work patterns, heightened effect during intoxication, family violence and conflict related to alcohol use among both nuclear and extended family members, would increase difficulty for the task accomplishments that are associated with this phase. Alcoholism may contribute to marital breakdown at this period. If breakdown does not occur, efforts increase on the family's part to incorporate the alcoholism into the family in a way that it can be "lived with". This latter process is the conversion of the family into an "alcoholic family". Alcohol use has been made a factor in the homeostatic mechanism. Overall stability is achieved despite what is on the face of it, a destructive force in family life.

The "mid-life" phase sees the family in a stable wet phase cycling between two interactional states, one corresponding with sobriety, the other with intoxication (Steinglass; 1980). It must be understood that in conceptualizing these "family alcohol phases" Steinglass is taking a macroscopic or longitudinal dimension. Characterizing phases as wet or dry is not related to the microscopic or day to day use, but rather lengthier and more clearly demarked time periods associated with profoundly different life experiences and patterns of behaviour. He identifies three such family level alcohol life phases; a dry phase, a wet phase, and a transitional phase.

For most families in a mid-life, stable wet phase, this is not a smooth or level plateau, in that stresses from both within and without interrupt the steady state. (Stresses would include birth, death, illness, job change, economic factors, etc.). Family coping mechanisms can be overwhelmed. The response can be an increase in alcohol consumption or the conversion to a dry state. It is noted that:

> ...This initial conversion of the wet alcoholic family to dry alcoholic family especially when the alcohol history predates the marriage has long been associated in the clinical literature with an increased rate of divorce.
> (Steinglass; 1980, 217)

It is also suggested that the absence of the alcoholic behaviour leaves a psychological void that may be reflected in efforts to encourage the alcoholic to return to drinking. Divorce often occurs as a culmination of unsuccessful efforts.

For some families, the transition from "wet" to "dry", stable states occurs only once. However, for many, the mid-life phase is characterized by recurring cycling in periods of months or even years. This pattern may be a macroscopic counterpart to the microscopic cycling between sober and intoxicated states of the stable, wet phase.

Finally, Steinglass postulates a "late resolution period". Four late resolution patterns are noted as follows:

(1) Stable Wet - entails a continuation of the steady state established during the mid-life period;

(2) Stable Dry - in which family life is organized to maximize the prevention of "slippage back to a wet state". The family's life to a remarkable degree continues to be organized around alcohol. Family members are usually active participants in A.A. and Al-Anon and family discussion is frequently centred on alcoholism. The solutions of these families can vary from highly rigid ones to flexible ones, but alcohol remains a central force;

(3) Stable dry, Non-Alcoholic - alcohol in these families is eliminated in an emotional and subjective sense as well as in a physical sense. Little residue remains beyond curiousity about the early life experience with alcohol;

(4) Stable controlled drinking, Non-Alcoholic Family - this is noted by Steinglass as occuring infrequently (Steinglass; 1980).

Steinglass suggests that clinically, it is important to distinguish between families that have introduced alcohol use as a central organizing principle and those that treat the drinking of a member as an isolated symptom. In each of these types of families, the alcoholism constitutes a problem, but in the first, the family incorporates the condition whereas in the second type, it tries to ward it off. Steinglass (1980) asserts the view that styles of families that attempt to confront or ward off alcoholic behaviour are more successful in long term recovery.

In discussing families where alcohol's role is part of the homeostatic mechanism, Steinglass makes the point that obvious resistance

would occur if the clinician did not understand the role that the symptom played in family homeostasis. Efforts on the family's part to develop alternative stabilizing mechanisms should be a major focus of intervention in Steinglas' opinion. He sounds a pessimistic note, however, suggesting that such families place such a high value on stability that long term growth is often traded for short term stability (Steinglass; 1980)

This model suggests that the development of the "alcoholic family" is organized in cyclical fashion rather than in progressive stages. In this respect it differs from the model outlined by Jackson (1954). In Steinglass' view, the family repeatedly returns to stages already experienced. This is compared to developmental patterns related to chronic illness. Family developmental events have their impact blunted and coloured by the current "alcoholic life phase" and its attendant behaviour patterns.

The author, noting Steinglass' comparison of alcoholism and chronic illness in family patterns and behaviours, suggests that the alternate conceptualization of alcoholism as a disease is supportable.

Conclusion

In this chapter, the author has developed a conceptual framework for family systems intervention. Theories used to explain alcoholism

from both the communications (strategic) "schools" and the "structural" schools have been explored. Unique issues in intervention with alcoholism will be examined in the following chapter.

CHAPTER IV

ISSUES IN INTERVENTION

The Issues of Wet and Dry Systems

The therapist working with alcoholic families must confront theoretical and clinical issues related to wet and dry systems. One major issue is whether or not being "dry" should be a precondition of treatment. In this regard, Brill (1981) notes that many therapists refuse to work with wet systems.

This position is based upon the assumption that meaningful change cannot take place while drinking continues. Not all therapists agree that this is the case. Dulfano (1982) notes that some therapists would focus on the presenting problem assuming that the alcoholism would clear up as a result. This view is one of alcohol as a "symptom".

Krimmel (1971) also comments on this issue, stating the view that therapies aimed at uncovering underlying causes of the 'symptom' of alcoholism have been largely unsuccessful in treating alcoholism because they fail to deal directly with the symptom. Sometimes they unintentionally permit the alcoholic to continue drinking. With a therapist engaged, the alcoholic can continue to drink being provided with the rationale that the "basic" cause or problem has not yet been solved.

Dr. Harry M. Tiebout is credited by Krimmel as being one of the first professionals to urge therapists and counsellors of all professions to attack drinking as the primary problem. He is quoted as saying:

> The mistake we made...was our failure to recognize that the task was twofold. In rather doctrinaire fashion, we persisted in treating the alcoholism as a symptom which would be cured or arrested if its causes could be favourably altered. The drinking was something to be put up with as best one could while more fundamental matters were being studied. The result of this procedure was that very few alcoholics were helped. The drinking continued and the symptoms remained untouched.
> (Krimmel; 1971, 143-4)

Krimmel thus highlights the point that in practice, the therapist, in not addressing the alcoholism directly, is colluding in "denial" and perpetuating the drinking. In a position alligned with Krimmel (1971), Bernson (1976), Dulfano (1982), Davis (1980) and Usher et al (1982), Kaufman and Pattison (1981), state that it is "critical" that the therapist not maintain the illusion that problems are being resolved because the family is in therapy, when in fact the problems are still being reinforced.

Dulfano highlights denial, noting that in some families the alcoholism is hidden and that other problems bring the family to therapy. In her view, the therapist's task is to "uncover and confront" the family's alcoholism (1982).

Pearlman and Zweben (1981) highlight this controversy as "current" among practitioners, revolving around the appropriate balance in therapy between "alcohol abuse", when it is the presenting problem, and the underlying system dynamics. Their point is that there should not be an "either-or" choice. They note the clear trend in family therapy in recent years towards focusing more directly on the initial concerns or presenting problem, and suggest that the marital dynamics constitute a leverage point in the task of effecting change in the abusive drinking. They also state that effecting change in the drinking is the primary theraputic task. The difference they see in a family therapy perspective is that the problem is dealt with from a collaborative interactional perspective.

Davis (1980) cautions that shifting the focus from problem drinking to other problems should not be done without a clear understanding that eliminating the drinking remains a top priority. Stressing referral to self help groups as a means of addressing the drinking, Davis sees as a matter of delicate "timing". He adds however, that it is best to err on the side of being too "early", risking losing the family. Erring too late according to Davis, confirms the family's denial.

Dulfano (1982) takes a similar position to that of Davis. She states that unless alcoholism is part of the theraputic contract, little

can be accomplished, especially when the alcoholism is chronic in an executive member of the family. She highlights timing also, noting that in some such families, the therapist must work with the presenting problem until a relationship of trust and hope is established.

Usher et al (1982) concur with Dulfano, suggesting that the therapist's first task after engaging the family, is to remove the alcohol. In their view leverage comes from addressing the relationship of alcoholism to the family homeostasis. Noting that motivation comes from the system, they suggest that the therapist capitalizes on this by addressing the family's problems and relating them directly to the alcoholism.

They stress that labelling, eliciting negative feelings, refusing to excuse the alcoholic and insisting that the family take responsibility are ways of stressing the system so as to increase awareness, cut through denial and increase motivation to change. In this way, the therapist takes a position which does not connive with the maintenance of drinking. They add that the fear that additional stressing of the system may drive the family away, may interfere with the willingness to confront the alcoholism. This is noted by Usher et al (1982) as unwittingly helping to maintain the homeostasis and impedes change.

The dry state, according to Brill (1981) may be unachievable especially at the outset of treatment. Brill advocates measures to

achieve a dry state being suggested early - and for some families made a precondition.

Kaufman and Pattison (1981) concur with the foregoing authors, who stress the importance of early action to achieve a dry system. If this fails, the next step is to disengage the family to enable a clear definition of responsibility. In this, the family is disengaged from the perpetuation of a wet system. They see Berenson's (1976) methods as useful in this regard.

As Kaufman and Pattison (1981) elaborate, in this approach, the family are presented with three choices all of which seem impossible. The problem is resolved by choosing one of them, following through or experiencing powerlessness and helplessness. This takes time, and immediate action should not be expected. The point of despair forces the realization that they must be responsible for themselves rather than continuing to change the alcoholic.

These options open the door to consideration of new family adaptations, whether the alcoholic is drinking or not. In this author's view, dealing with "wet" systems entails a number of clinical difficulties. These will be highlighted in the approach to treatment in the following chapter.

Family Types and Intervention

Kaufman and Pattison (1981) detail different family situations

matched with suggested intervention techniques. They postulate four family types for consideration.

(1) The functional family system, (or family with an alcoholic member). This type of family is stable, with parents who have a good marital and sexual relationship, and children who have good relationships with each other and their peers. Drinking, seen as a response to social strains or personal neurotic conflict occurs in binges, usually outside of the home or at bedtime. These families usually contain an "early stage alcoholic" and such a system may deteriorate with time. Such families show little overt conflict. They are responsive to external change and resistant to internal change.

The focus is likely to be on the alcoholic with a strong desire to retain and rehabilitate him/her. In intervention, the initial use of family education is suggested (Kaufman and Pattison; 1981), including an explanation of the medical effects of alcoholism as a joining maneuvre. Achievement of a dry system is often possible, though short term hospitalization may be required. Disulfiram is also useful provided the alcoholic is given responsibility for self-administration. Short term therapy aimed at rule definition and role re-structuring may be sufficient for such families (Kaufman and Pattison; 1981);

(2) Neurotic enmeshed family systems are those in which drinking

behaviour interrupts normal family tasks, causes conflict, shifts roles and demands adjustive and adaptive responses from family members. Physical problems including sexual dysfunction are present and feed marital conflict and role re-alignment. Marital and family rules, styles and conflicts evoke, support and maintain alcoholism as a coping mechanism to deal with anxiety. The cycle of anxiety, drinking, anxiety, intensifies behaviour and presents a spiralling crisis. Triangulation patterns and projected conflicts are evident. All members feel guilty and responsible for each other, particularly for the alcoholic and his/her drinking (Kaufman and Pattison; 1981).

Passive dependent techniques are often used by the alcoholic to control and the spouse tries to control by forceful active and dominating means or alternately by suffering. Neither ever clearly becomes dominant, and marriage is competitive.

Kaufman and Pattison note that in these enmeshed systems, blame is high and this dual projection blinds each to their respective roles in creating problems. They may duplicate this position in therapy, setting the therapist up as judge. Roles are abandoned with that of "breadwinner" as last to go. At this stage, treatment may be sought; the alcoholic relegated to a "child" role. Frequent coalitions with the non-alcoholic spouse and children or in-laws are seen, and children are often neglected.

Therapy is difficult and prolonged with the "neurotic enmeshed family". Educational and behavioural methods may provide some initial relief, but are unlikely to impact on the enmeshed relationships. The therapist is often faced with working with a wet system. Re-enactment of or actualization of conflicts is very important due to resistance and recounting of the past to avoid the present. Work on marking boundaries and defining roles in intervention is stressed by Kaufman and Pattison (1981) and they add that frequent joining maneuvres are necessary to keep such families involved and tensions down. The therapist must be active in defining roles, setting rules and tasks until enmeshment is lessened. A.A., Al-Anon and other supports assist in the disengaging process. Relapse is frequent and longer term therapy for family re-structuring is necessary (Kaufman and Pattison; 1981);

(3) The disintegrated family system. This is the alcoholic who has lost his family and has no recent contact with them. The history includes progressive deterioration, job loss, family instability, loss of self-respect and separation. The family may have been destitute. Family intervention is related to the factor of "pseudo-individuation" of the alcoholic from family ties. Kaufman and Pattison (1981) suggest a focus on the individual initially, with an exploration of potential ties. When abstinence and stability have been established, but without assuming full reconstitution, substantive explorations

of the family can be initiated to re-establish parental roles and kinship relationships. With or without re-constitution, the family can re-negotiate new roles on the basis of his identity as a "rehabilitated alcoholic".

Unlike the "here and now" approach used with the enmeshed family, the focus with the disintegrated family is one of a reviewing of the past and planning for the future. Prior behaviours are re-assessed as new rules and roles are set. The goal is to stabilize roles in reconciliation and stop continual victimization and conflict, as well as establish mutual respect in a separation resolution;

(4) The absent family system or long term isolated alcoholic, has usually suffered early loss of family of origin, rarely has close friendships and frequently shows a history of brief fleeting relationships. He/she has never acquired coping skills and has little ability to form social relationships. This type does best in institutionalized social support systems, as Kaufman and Pattison (1981) note.

Two major family interventions are suitable. The first is the revitalization of any existing support networks and the second, especially with young persons is the fostering of intense socialization in peer groups. A.A., church and recreational groups draw these alcoholics into relationships in a context of potential skill acquisition and increase ability to engage in meaningful, long term relationships, in the views of Kaufman and Pattison (1981).

In the foregoing discussion, this author notes that the use of A.A. and other support groups is an important aspect of intervention in

several family "types". Other authors also emphasize the role of these fellowship and support groups as the following section illustrates.

The Role of Self Help Groups

Davis (1980) stresses complementarity between family therapy and self help groups such as A.A. Both de-emphasize will power as an essential motivation for change, and both recognize that all members are suffering related to the alcoholism. Both also use contact with significant others to facilitate change in the drinking behaviour as well as implicitly assuming that family can be a source of resistance to change.

Davis supports Kaufman and Pattison (1981) suggesting that families who seek counselling tend towards enmeshment. He advocates using support groups to counter enmeshment. Stressing that participation in Al-Anon and Al-Ateen is just as important as A.A., Davis states that it does not matter which members attend groups first. In his view, major changes take place in individual rights, responsibilities and boundaries as well as role expectations when non-alcoholic members are helped to take a clear stand on the issue of alcoholism. Participation in these groups exemplifies this stand.

Noting that there is no direct work with relationships in A.A. or Al-Anon, Davis (1980) stresses the potential for a different range of problem identification and evaluation, and solution for family

therapy when used in a complementary manner. Davis advocates an active role by the therapist concerning attendance and participation in self help. Suggesting the therapist may need to monitor, encourage and reinforce continued attendance, Davis leaves no doubt about his views on self help groups when he asserts the view that too few therapists accompany their clients to an initial meeting of A.A. He also suggests (1980) that therapists need good contact with a few A.A. members.

Stanton (1981) notes that Berenson (1976), "who developed the most promising treatment approach" to alcoholism, advocates a combination of family therapy and A.A. and Al-Anon in a specific series of phases and techniques (141). Stanton (1981) supports Davis in suggesting that many of the Al-Anon principles are similar to those used in family therapy though the overall philosophy differs. He makes the point that the Al-Anon principle of "detachment with love" makes change on the part of the non-alcoholic member necessary. He also suggests that the group sharing is somewhat similar to multiple family therapy. Stanton (1981) states that these self help groups compose the single largest family treatment program in existence and suggests that it is unfortunate that specifics about their techniques and effectiveness are not more widely known. (141)

In accordance with this view, the author notes Davis' (1980) statement that ten to twenty years ago, the development of Al-Anon

and Al-Ateen were probably at a more advance stage than the corresponding development of other theraputic approaches to the families of the alcoholic.

These viewpoints which stress the importance of self help groups clearly imply that the therapist must be positive about self help groups in order to be able to advocate attendance and participation on the part of clients. The author also believes that a good working knowledge of these groups is essential to be able to "sell" clients on their value and to make effective linkages in referral.

CHAPTER V

SETTING AND APPROACH TO TREATMENT

Description of Setting and Procedures

The author undertook the practicum at the Alcoholism Foundation of Manitoba(A.F.M.), located at Christie Centre, 586 River Avenue, and initially linked to the Non-Residential Treatment Program which is part of the Winnipeg Region of the Treatment Directorate of the organization. As the practicum progressed, the author connected with the Intake Unit, River House (the women's Residential Program), and with other treatment personnel. Thus, referrals came from a variety of sources.

Work with clients commenced in late March, 1982, and was still being completed in several instances in late spring of 1983. No new referrals for the practicum were accepted past mid-November, 1982.

The Alcoholism Foundation of Manitoba provides treatment, education and research services for the Province of Manitoba. As well as the Winnipeg Region, the A.F.M. also has Northern Western and Central Regions. The agency also has a Human Resources Centre from which books, films and tapes are available. Public education programs, training programs and preventative services concerning chemical dependency are provided through community services workers located in

the Provincial Health Regions.

The A.F.M. has its own Board of Directors, is funded by the Provincial Government and reports to the Minister of Health.

Treatment services offered by the A.F.M. in Winnipeg include both residential and non-residential programs. Alcoholism is conceptualized as a disease and treatment is based on initial recognition of that on an intellectual level, leading to an emotional acceptance of the disease through an identification process. An abstinence goal orientation is stressed. The organization also has a Youth Program which seeks to involve those "at risk".

The main modality of treatment is group therapy. An emphasis is placed on didactic teaching about alcoholism as a disease involving both "thinking states" and "feeling states". Individual counselling is also used. Clients are encouraged to look at their lifestyle and adjust it to eliminate alcohol and develop new coping mechanisms.

Medical service and assessment is provided by a medical doctor. A clinical psychologist provides psychological services on referral and he serves as consultant to all treatment staff.

During the practicum period, a number of changes took place in the organization related to the opening of the new "Primary Care Unit" and Men's Residential Treatment facility at 1041 Portage Avenue. This is next door to the Administration Offices, which were also re-

located recently to 1031 Portage Avenue. These changes had little impact on the practicum work apart from the freeing up of space which had been at a premium for the first half-year.

The author received referrals from a variety of sources within the A.F.M., including the Intake Department, River House, the Clinical Psychologist, the consulting Psychiatrist, the Non-Residential Program, the Aftercare Program and directly from the switchboard. Referrals were also made by City Welfare, and in addition, the author's name was given to several people by former clients seen early in the work. These persons shared A.A. or Al-Anon affiliation with each other.

The majority of clients were referred at or near the completion of a three week alcoholism treatment program. Others were referred some weeks later while the alcoholic was in "after-care". A "slip", occurring after several sober years, precipated a referral in still other instances, and with some drinking, was not seen as a problem at all by the client. Of this latter group, some had stopped drinking in the past and others presented with difficulties related to drinking, but denied a problem with alcohol. An example of the latter type is a referral following the apprehension of children from circumstances of drinking and neglect. In another case, the family wanted reconciliation work after a child sought refuge from a drunken father.

In the majority of instances, the alcoholic took an individual

treatment program and the author worked with the family following that. The goal in these instances is structural change to enable the family to live without alcohol. In a minority of instances, the clients were in "denial". The initial goal was then to convert the system to a dry state.

Supervision

The bulk of supervision was provided by Professor Ruth Rachlis of the School of Social Work. The author also availed herself of much consultation with Dr. A. Herscovitch, Clinical Psychologist, and with other A.F.M. staff members.

Most client sessions were audio taped and were used to monitor and evaluate the author's learning and clinical practices. On one occasion, live supervision was provided using a one-way mirror. Supervision mainly took place through weekly meetings between the author and the supervisor at which time specific cases were discussed, and audio tapes reviewed.

Comments on the Practicum Setting and Supervision

The Alcoholism Foundation as a setting for a practicum on alcoholism has many advantages. Staff are knowledgeable about alcoholism, having had extensive training in alcoholism treatment and

having had personal experience of alcoholism also.

Consultation opportunities present with the treatment teams and with both the Clinical Psychologist and consulting Psychiatrist, provided valuable learning.

As the disease concept is used exclusively at A.F.M., the author did not share a common language with other staff and operated from a different orientation. Despite this, the author found staff members generally interested in the work being undertaken. It was possible to involve several staff who had an interest in family work in a "co-therapy" role. This was useful in generating ideas, sharing knowledge and sometimes reducing emotional fatigue. It also diminished the "working in isolation syndrome" felt occasionally by the author.

In retrospect, the author believes that family therapy skills are likely best learned in a setting geared specifically to family therapy. Live supervision is a definite advantage in this type of learning. The absence of a team all operating from the same vantage point was also felt as a definite lack during this experience. A setting geared to both family therapy and alcoholism treatment would of course, be the ideal.

Description of Clients: An Overview

In undertaking the practicum, the author saw a total of nineteen

clients (couples, individuals and families) for more than one session each. In addition, the possibility of family work was explored with at least eight other persons attending treatment programs. In these cases, the alcoholic was unwilling to involve family. Two of the nineteen cases involved work with an individual. The first of these could be described as an "absent family system" according to Kaufman and Pattison's typology outlined in Chapter IV. In the second instance, after seeing the family system in its entirety for two sessions, the author chose to proceed by seeing just the "alcoholic". (This decision was related to unrelenting scapegoating and active blocking of the "alcoholic's" attendance at A.A.).

The following section gives an overview of clientele:

Family Composition and Relationship to Alcohol

1 family consisting of mother, father and 19 year old daughter.
Both parents diagnosed as alcoholic

1 family consisting of father and 14 year old daughter.
Father with a history of "alcoholism" (recently treated)

2 couples where both spouses were diagnosed alcoholic.
Referred when children were in care

2 families with two children in each.
Father alcoholic

1 family consisting of a mother (alcoholic) and three adult daughters all living at home.
Father had left home one year previous and resides in another province

2 childless couples both married approximately one and one-half years.
Both contained an alcoholic male

6 couples with pre-school children, ages under five.
Father alcoholic in all instances. Mother also alcoholic in one

3 couples with children ranging from pre-school to young teenage. Male parent alcoholic in all instances

1 family consisting of a single parent mother (alcoholic) and four teenage children in the home, plus a boyfriend (alcoholic) who sporadically resides in the home.

Socio-economic Status of Clients

The majority of these clients were in a low income bracket (thirteen of nineteen families). Of these thirteen, six were on welfare, possessed few marketable skills and had no immediate prospects of work. The remaining seven had low wage work and little opportunity for advancement. These families particularly those on welfare, could be described as economically stressed. Five of the remaining families can be described as being in the lower-middle to middle income bracket. One family had been in a higher income bracket, however, they had suffered serious business reversals. In a number of instances, work records had been very sporadic with jobs lost related to drinking and in two instances, jobs were lost due to plant layoffs while the couple was in therapy. In one situation, the male of the couple was living at a "half-way" house, having been recently released from jail. He found work and then resumed heavy drinking again and lost his job.

Marital Infidelity and Violence

In nine instances, the couple had a recent history of infidelity on the part of one or both parties in the relationship. In five instances, there had been violence in the relationship. In at least one case, a loaded gun had been involved. In at least three cases, one

partner in the couple had recently been suicidal.

Multi-Generational Alcoholism

In at least fifteen of the nineteen families seen, alcoholism was reported in the extended family network, usually in the parent generation and in several instances also in a sibling. In the other four instances, it is not known whether alcoholism was part of the family history. Of the fifteen cases which reported family alcoholism it was present in the parent generation in eleven families, sometimes on both sides (of the spousal relationship), sometimes in just one. Several of these families also reported third generational alcoholism (grandparents).

Marital and Blended Families

In ten of the nineteen cases, either one or both members of the spousal system had been previously married. In many of the families, one of the couple was a step-parent.

Alcoholism: Male-Female Distribution

The nineteen families included alcoholism in seventeen males and five females.

Alcoholism: Both Adults of Executive Subsystem

In five of the nineteen cases, alcoholism was a symptom in both spouses. In two of these five families presented "dry", (Berenson; 1976, notes when both spouses are drinking, the therapist's difficulty increases "geometrically").

Wet Systems Presenting

Of the nineteen families, ten began family work with a member or members actively drinking. Of those ten, three had two drinking adults. Of the remaining nine dry families, the "alcoholic" was abusing marijuana daily and the spouse abusing coedene.

"Poly Addiction"

In at least five of the nineteen cases, the alcoholic concurrently abused drugs and alcohol. Three were actively abusing when family work began.

From this overview, the wide diversity of client situations is apparent. In many of these families severe dysfunction was manifest in not only alcohol and "poly drug addiction", but also in repetitive patterns involving physical abuse and violence. Several of the families presented issues related to past relationships that were impacting on their current life. In many situations, "blending" was recent and the families required boundary work to assist in that process. In other words, boundary work to reconstitute or "regroup" was needed.

Over half the cases entailed issues related to "wet systems". In the author's view, the vast majority of families "fit" the typology of "neurotic enmeshed systems" (as detailed in Chapter IV of this report). Of the dry systems, most were newly dry, thus in a "crisis" or "transition" stage. (The "alcoholic" - or alcoholics - in cases of both

spouses being symptomatic) were usually still in phase 2 of treatment (after-care) individually. In some instances, spouses were involved in prior Al-Anon groups. The majority were not.

A major issue encountered relates to the larger social milieu and the fact that the practicum was undertaken in a time of severe economic recession with high unemployment. Most of the clients were in a position of little "choice" in relation to the job market. Thus, external stress factors complicated life severely for many of these families who had instrumental as well as emotional problems to resolve.

Development of Treatment Approach: Background and Principles

The author's approach to family treatment was developed from and influenced by factors from several sources as follows:

(1) Conclusions reached through undertaking the literature survey ie: the development of and use of a knowledge base;

(2) Contextual factors - including the nature of the supervision, the nature of the clientelle and severity of the problems, and the factor of the disease concept being used in the agency setting;

(3) An awareness of self as a beginning clinician with a determination to utilize a knowledge base, take full advantage of the learning opportunities and develop practice skill accordingly.

The following discussion will synthesize these factors to illustrate the background to the treatment approach and identify some of the governing principles applied in practice.

In the initial chapter, the author illustrated alcoholism as a complex and multi-causal phenomenon. This view assumed specific, individual variation in initial causal factors. The relevance of theory which highlights biological, psychological and sociological factors pointed to the appropriateness of a multi-dimensional perspective and the use of a systems framework. The principle of breadth in assessment is, thus, relevant.

Related to this, the systems emphasis on current maintaining factors was established as opposed to a focus on "causes".

The "pharmacological fallacy" was discussed previously. The author sees validity in this concept in that it serves to emphasize contextual and interactional factors rather than "disease processes". The author believes, however, that the pharmacological effects of the drug also serve as reinforcers (a multi-dimensional view consistent with the assumption of individual variation in alcohol problems).

In the author's opinion, to apply the "pharmacological fallacy" to the extent that it negates a role for the effects of the drug in the maintenance of the behaviour is inconsistent with a systems' viewpoint and with a holistic perspective, ie: psychological and biological system. Therefore, the author's position, while one of emphasizing

interactional factors in the context, does not negate drug effects as well. This position is reinforced by Bowen (1978), Steinglass (1977), and Stanton and Todd (1982).

Alcoholism is noted as a difficult problem to treat. In this respect, the majority of authors have emphasized the concurrent use of individual treatment and self help groups such as A.A. and Al-Anon. Theoretically, alcoholism can be treated using the context of the family as the sole medium, however, after reviewing the literature the author concluded that for a "beginning level" therapist, not working within a "family therapy team situation", that making appropriate use of the individual treatment resources and A.A. and Al-Anon would be the most feasible. This position was considerably strengthened by the opinion of Berenson (1976), Bowen (1978), Stanton and Todd (1982) and also by the detail on late resolution patterns provided by Steinglass (1977).

The author's conclusions based on the literature survey, were that despite the late arrival of family therapy to the alcoholism field, the application of its perspective and orientation has wide ranging implications in terms of increasing the treatment options. Choices abound as to modalities of treatment. The perspective can be used in "multi-family group therapy", in single family group therapy, concurrent spouse groups, and in conjoint approaches. In addition, it can be used in work with alcoholics alone, or with the non-alcoholic in

accordance with Bowen's theory.

The spouse subsystem can be the medium, and this can be undertaken through conjoint or concurrent sessions. The approach can involve the nuclear family and/or the extended family. Others in the social surround can be involved and therapy can involve any combinations of the above.

Kaufman and Pattison's (1981) discussion as presented in Chapter IV, illustrates the range of situations in which a family systems approach is applicable. Even with single and alienated individuals (the absent family system), the perspective is applied in a network building strategy utilizing A.A. and other supports. (Their illustration shows the compatibility of a family systems framework with the followship aspect of A.A.).

Another principle in the approach is related to the assessment principle of breadth. The approach to intervention should be able to provide for the inclusion of any persons in the context deemed significant to the goals and process. The author saw the main limitation to this being related to the degree of development in her own skill level. Basic to this principle of breadth in assessing and intervention, is the point that the author's framework with reference to context includes other "helpers" involved with the client. This point is emphasized by Freeman (1981).

Integration of the Medical Model and Systems Perspective

Prior to contact with the author, clients were generally in contact with the agency for assessment of the alcohol problem or for other problematic situations involving excessive use of alcohol. The majority of clients had been socialized to the medical model concept of alcoholism as a "disease" or "illness" through either an individual treatment program or through participation in A.A. or Al-Anon. Thus, the "pre-set" frame of reference for understanding alcoholism and for understanding what was happening in their family life was based on this.

In those instances where a "wet system" presented, an assumption in nearly all cases was that at some point in the course of work with a family, a referral to a self help resource or a treatment program would likely take place. In fact, this was an intermediate goal in most situations, related to achieving a "dry" system.[2]

In Chapter II, a discussion of the conceptual level of integration was undertaken and the two concepts (disease and symptom) were shown to be related through assumptions. Thus, in this practicum, alcoholism in a family was seen as both an illness which impacts on the family

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[2] The reader is reminded that the majority of clients seen in the practicum did not fit the characteristics of "early stage" or less extreme alcoholism. They had already experienced serious social, familial and in some cases, medical problems related to chronic abuse of alcohol and/or other drugs.

system and as a social syndrome in which the behaviours are maintained through family interactional dynamics.

From this perspective, alcoholism has the impact of a chronic disease, but can also be seen as symptomatic of a dysfunctional system.

The assumption of each viewpoint can be further related through the notion of "will". The disease model assumes that the behaviour is beyond the will of the drinker due to the presence of the disease which is seen as chronic and progressive. The systems concept which employs the notion of maintenance of behaviours through reciprocal behaviours in the context, also implies factors other than will. From each perspective, however, the destructive cycle can be broken through the exercise of "choice". Berenson (1976) notes this as a paradox which the therapist must resolve for himself.

From this author's viewpoint, choice is made possible through the creation and maintenance of a theraputic system through which the family system is strengthened and supported so as to make the use of will a possibility. This view suggests that the essence of therapy is around the issue of motivation and the creation of a system in which the capacity for motivation is increased. In practice, one can integrate the medical model through the notion of motivation to effect "recovery" and also to prevent or deal with a "relapse". In other words, in the context of alcoholism as a "disease", being healthy involves a choice.

The use of resources which espouse the "disease" concept also

provided integration. However, the reasons for the use were related structurally to the family system through the concepts of "boundary", "enmeshment" and the concept of "differentiation of the self". These concepts belong to a family systems perspective on alcoholism.

The Issue of Controlled Drinking

This issue must be looked at conclusively with respect to the integration of a systems perspective with that of the medical model. This author's bias was reinforced by the views of family treatment authors as reviewed in Chapter III. That is, that controlled drinking as an outcome in cases of chronic alcoholism is an unlikely possibility. The author notes further however, the practice of classifying drinking into two categories (as noted in Chapter III, with reference to Steinglass (1980)). "Stress response" drinking is generally encountered in general service agencies; whereas drinking seen as a homeostatic and integral component of family functioning is more often encountered in specialized settings such as that of the practicum.

What must be emphasized is careful assessment, not "pre-set" assumptions. Theoretically, as noted in Chapters II and III, the medical model assumes a cyclical process with biological origins. A multi-dimensional systems view assumes cyclical and repetitive predetermined patterns of behaviour in a spiralling crisis. Thus, the focus is on the context. The individual (biological and psychological)

system in interaction with the drug can be seen as part of the repetitive cycle of the subsystem, both effecting and maintaining the larger system functioning.

Wet Systems

A final principle was that of inclusion of wet systems. This is related to the author's belief that "wet" families need help; and also to the skill development objectives of the practicum. Wet families present unique clinical difficulty to the practitioner, thus to exclude them would have been counter to the aims and goals of the practicum.

In this respect, however, the author notes the "trap" of the "student role" present in the requirement of cases to complete the practicum and the clinical need to terminate in instances where to continue therapy would be colluding in denial and thus counter-productive to system change.

Conclusion

The approach to treatment was predicated on factors related to the viewpoints of authors, factors in the context and the author's objectives and perception of herself as a beginning level practitioner.

The degree of difficulty presented in most instances called for operating principles of flexibility and pragmatism. The need for these principles was stressed repeatedly in the supervision and consultation

periods.

In the succeeding section, the author will detail the approach taken related to the assessment of the alcoholism, and also to both wet and dry systems. This will be preceeded by a delineation of the principles of structural and strategic approaches which formed the basis of the author's perspective and by a brief review of main techniques.

The Treatment Approach: Introduction

The approach to family treatment was based on a combination of principles and techniques from both the structural and strategic "schools" of family therapy. To elaborate the author drew most heavily on the work of David Berenson (1976 & 1979). Berenson is classified as a "strategic therapist" by Stanton (1981) who also provides detail of Berenson's work. Berenson however, developed his approach from the work of Bowen (1978), who is classified by Okun and Rappaport (180) as a "structuralist".

In all cases a structural analysis was undertaken and the author used concepts such as "boundary", "power" and "allignment", as well as those of Bowen (1978) of "anxiety", "integration of self" and "differentiation".

Principles derived from Stanton and Todd's (1982) work with "addicted" families using a structural and strategic approach served

as an influence, however their strategies are geared more to symptoms in the younger (adolescent and "leaving home" stages) generation. Berenson's approach specifically gears to adult alcoholism and incorporates the use of A.A. and Al-Anon, thus was most applicable in terms of strategies.

The major tenents of structural and strategic therapy are presented in the following section.

Structural Therapy

The theoretical and operational facets are derived from the following views of the family as noted by Stanton and Todd (1982).

People are seen as interacting within a context, both affecting it and being effected by it. Alcoholism is thus affected by and effects the context.

The family developmental stage is important both in the assessment and in the defining of strategy. The assumption is that the family is "stuck" at a stage.

Symptoms are both system maintained and symptom maintaining. This incorporates the author's view of alcoholism as serving an adaptive function in the system.

The system can change; new behaviours can emerge if the context is change. Individual change is inhibited by an absence of change in the context. This view emphasized the role of the family in alcoholism, especially in the recovery stage, implying that resistance

to individual recovery lies in the context.

Treatment should be pragmatic and the emphasis should be on the present. Repetitive behavioural sequences need to be changed. The emphasis on pragmatism in alcoholism has been noted.

A focus on the symptom is important. This point is consistent with the views presented in the literature which emphasize that significant change cannot occur while the I.P. is continuing to drink. It is essential that the therapist not convey to the family that because they are in therapy that change will occur while the drinking continues.

Process is emphasized more than content. This includes interventions that are non-verbal and non-cognitive.

The therapist should direct the therapy and take responsibility for change. This is not meant to imply that the therapist should take credit for change. The responsibility is in the devising of a change strategy.

The assessment process is part of the therapy. It involves hypothesizing, intervening and examining feedback.

Contracts (relating to the problem and goals) are negotiated with clients.

The major purpose of interpretation is as a re-labelling technique, not the production of insight.

Homework tasks are assigned.

Joining is emphasized as is the reduction of guilt and defensiveness. In the author's view, this is extremely important in work with addiction due to the factor of blaming and related also to the issue of "unfinished business" which is a factor in addicted families.

Therapy involves intermediate stages between the initial dysfunctional state and the desired end state. For example, with alcoholic couples who desire a closer relationship, they must often be assisted to emotionally disengage prior to being assisted to become closer.

Therapy tends to be brief. (The author notes an exception to this which is related to the strategy used with families in which the I.P. is still drinking and in which the structural task is to increase distance and lessen the reactivity of the spouse. Berenson's methods are related to longer term work with intervals between sessions rather than brief and concentrated engagement within a short time period.)

The Goals of Structural Therapy

In structural family therapy, the main or overall goals are to solve problems AND to change the underlying systems structure. The theoretical foundation of structural family therapy rests on the belief "that the whole and the parts can be properly explained only in terms of the relations that exist between the parts." (Aponte and Van Duesen; 1981). Thus, the link (boundary) that connects one part to another

in a social system is the point of focus. As well, a judgment about what is functional or dysfunctional in a family rests upon understanding the family in its social context.

Family Structure and Function: Assumptions

From a structural perspective, the ability of a family to function well depends on the degree to which the family structures are well defined, cohesive and flexible. Where the structure is not adequate (underorganized) the system has the capacity to generate new structures. A structural therapist sees the symptom as maintained by the current structure and eco-system. The dynamics that maintain the problem are manifest in the transactional sequences. For example, in the case of an alcoholic spouse system, the goal structurally might be to decrease the enmeshed behaviour and work towards a more clearly defined boundary between the individuals so as to increase the degree of differentiation of each part of the spouse subsystem. This can be done related to the alcoholism as well as other problems involved through the contracting process.

Process and Use of Self

A key point from a structural perspective is that the therapist is never in a structurally neutral position. For example, in choosing to address a family member, the therapist is both aligning with

that member structurally and also elevating his or her status in the system, by virtue of the power vested in the therapist role.

The process can be conjoint, concurrent or sequential. However, all work is conducted in the light of treatment for the whole family. The therapist can choose to facilitate direct engagement of members or can choose to centralize engagement using him/her self as a "switchboard". In alcoholism, the latter position is useful at the beginning of therapy when the tension level is high and when "unfinished business" is impacting on the emotional aspects of the system. Use of self in a central position helps to diffuse the tension.

Key Concepts

The major concerns are those of "boundary" (the rules and regulations that govern transactions; who participates and how) alignment (the joining or opposition of one member of a system to another in carrying out an operation), co-alition (a process of joint action against a third person), and power (the relative influence of each member on the outcome of an activity), (Aponte and Van Deusen; 1981).

To elaborate further on the central concept of "boundary", boundary types can be described using the terms "enmeshed", "clear" and "disengaged". The extremes of either end of this continuum indicate the potential for symptom formation if they are extreme related to the family developmental stage. It is noted (Minuchin; 1974) that an

enmeshed system responds to any change with excessive speed and intensity whereas a disengaged system tends not to respond when a response is necessary.

With alcoholism, the family boundary frequently is seen as closed and rigid; the family turning in on itself. One of the tasks is the provision of support from outside of the system to open the boundary. Thus, this model fits well with the integration of outside resources such as A.A.

Clarity of boundary is determined by how well the lines of responsibility have been thought out and the designation of authority delineated. Thus, the concept of "roles" is also related to that of boundary as roles are defined by the rules vis-a-vis each subsystem of the system.

Another common dysfunctional structure related to the concept of boundary is the "violation of function boundary". Aponte and Van Deusen (1981) note this as being the intrusion of family members into functions that are the domain of other members. They give the "parental child" as an example. In alcoholism, the drinking can be seen as the drinker's domain in a "chronic conflict" context.

The concept of "alignment" is clarified also using the terms "stable coalition" (rigid joining to form an inflexible characteristic relationship), "detouring" (a form of stable coalition which is formed

to diffuse stress between two members by designating another party as the source of their problem and assuming either an attacking or a solicitious attitude towards the third party), and "triangulation" (each of two parties in opposition seeking to join a third party against the opponent and the third party co-operating alternatively with each). In alcoholism, the tension level is frequently high and therapists can be vulnerable to triangulation.

The dimension of power is related to who has the power relative to whom and concerning what aspect or function. Thus, the term power relates to functional power. It is used frequently with respect to a weak executive subsystem in which parents lack the leverage to perform their function. It also relates to the inhibition of developmental potential when an individual cannot act in an age-appropriate way, because of the family organization.

Major Techniques of Structural Therapy

Minuchin (1974) relates the major techniques of structural therapy to three areas of purpose: 1) creating the transaction; 2) joining the transaction and; 3) restructuring the transaction.

The creation of the transaction can be done by "structuralization", which is related to the therapist's part in the sequences. For example, with a couple in which the alcoholic is clearly cast in an inferior and incompetent role, the therapist may relate to him/her

with an attitude of deference designed to elevate status. "Enactment inducement" is the promotion within session of specific patterns. (For example, directing a couple to refight a fight they commonly have). "Task setting" is an assigned activity to be carried out within specific parameters in session or at home.

Joining with the transaction can be done by "tracking" (adopting symbols of the family's life) to communicate and build relationships. The therapist joins and as Minuchin (1974) says, "leads by following". Other joining maneuvres are those of "accommodation" (behaviour congruent with the family rules) and "mimesis" (joining in manner and content including body posture, content, tempo language, etc.). Frequent "joining" must be used in working with addicted families.

Restructuring techniques exist primarily to change the structure of the family's transaction. They are employed chiefly to overcome system conflict and structural inadequacy as is noted by Aponte and Van Deusen (1981). System conflicts or competing needs are addressed by means such as "exaggerating the symptom", "blocking" and "developing implicit conflict". They are generally designed to break down or re-organize structures through the use of confrontive means.

Structural inadequacy is generally addressed through resource provision and the provision of new learning. The use of A.A. can be seen in this light.

Three types of tasks are used for both conflict and structural

inadequacy problems. They are "system recomposition", "symptom focusing" and "structural modification." "System recomposition" is the adding to or taking away of a component. A couple might be instructed to exclude children from a fight for example. Symptom focusing techniques are those of exaggerating or prescribing the symptom (eg: fight more often, or be "ten percent" more anxious). De-emphasizing the symptom can also be used.

In cases of severe scapegoating, the need is sometimes to diffuse a focus, and emphasize another symptom such as the spouse's "anxiety behaviour". De-emphasizing has the effect of "opening a new door" in the words of Aponte and Van Deusen (1981). "Re-labelling" is a modification of the de-emphasizing technique. This has the effect of altering the meaning of the symptom in the context. Terming alcoholism a "disease" is in effect a re-labelling process. Use of these techniques is carried out with an understanding of the function of the symptom in mind and in accordance with a plan of structural change. The therapist can use "choreography," "disassembling techniques" "reinforcing techniques" and direct means such as "coaching" or "instructing". "History-taking" and "genograms" can be employed in boundary work for the development of new structure; adequate to the functional needs of the family system.

STRATEGIC THERAPY: GENERAL TENENTS

The strategic approach to therapy differs from the structural one in that it relies more on theories of change than on theories of the family. It stems from the communications school in that a symptom is regarded as a communicative act which has a function within the interpersonal network. With alcoholism, Gorad's theory was developed on strategic principles (discussed in Chapter III).

As Stanton and Todd (1982) note, a basic tenent of a strategic approach is that change comes about through the interactional processes triggered when active intervention is accomplished in the system. The goal is therefore to change the dysfunctional sequences of behaviour.

Major techniques from the strategic approach as noted by Stanton and Todd (1981) are: tasks and directives, putting the problem in solvable form such that it can be agreed upon, counted or measured, using extra-session tasks thereby placing heavy emphasis on extrasession change, avoiding power struggles by taking the path of least resistance and also the use of paradoxical directives. The latter category includes prescribing the symptom, restraining, denying the possibility of change, and exaggerating the family's position (or turning the resistance back on the family by becoming more homeostatic than they are).

The technique of ascribing noble ascriptions is stressed by Stanton and Todd (1982) as particularly useful in countering the defensiveness which is common in addicted families and in lessening

resistance. This is a form of both re-labelling and joining.

THE APPROACH: GENERAL CONSIDERATIONS, WET SYSTEMS PRESENTING

With adult alcoholism, the author assumed two categories:[3] 1) drinking as a stress or crisis response; 2) drinking as a central mechanism (the "alcoholic family system" - organized or triangled around alcoholism). These categories are derived from Steinglass (1977) as discussed in Chapter III. The initial task is to determine which of these categories seems most applicable.

Assessment

Factors such as variable patterns of drinking, family agreement that alcohol is not a problem, a spouse relationship that appears symetrical as opposed to fluctuating (complementary and overt conflict patterns) and also little behavioural change when drinking, are used to suggest the first category (Berenson; 1976).

In the assessment process, a careful history is taken including an exploration of the drinking. Drinking is not labelled "a problem". The factor of denial is taken into account in assessing, for often the extent of drinking is minimized by the family and/or the alcoholic. The family affect is carefully observed especially related to alcohol.

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[3]Berenson (1976) emphasized the point that these categories are not invariable and that many systems may present as one category, yet actually end up as the other or as a mixture of the two. The first type are more generally seen in a general family agency as opposed to a specialized alcoholism treatment setting such as the context of the Practicum. Only one case was seen that belonged to the first category during the Practicum.

Intense disagreement around use of alcohol or the amount consumed suggests denial and also it may suggest alcohol as an organizing principle (and hence the second category). Incongruent affect also indicates denial.

Factors relating to the development of alcoholism are also looked for in assessment.[4] These are heavy consumption, and a family history of alcoholism. Workplace and social context factors related to alcohol abuse can also relate to the development of alcoholic drinking, and these factors were looked for in assessment.

Drinking as a Stress or Crisis Response

If the family is assessed as belonging more to the first category than the second, contracting takes place around the agreed upon problem and treatment is based on resolution of the problem using structural and strategic methods. If there is no change in the drinking with the resolution of other issues, the option to change course and re-define the primary problem is taken. The second category is seen as that of drinking as a central organizing mechanism.

Approach(s) to the Alcoholic Family System

Factors that distinguish this category in assessment are:

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[4] Assessment of these factors is emphasized by Berenson (1976). Heavy drinking leads to addiction biologically; alcoholism is more likely to develop in offspring of alcoholic parents. Heavy workplace and social drinking increase the risk factor in the development of alcoholism.

agreement that alcohol is the problem or intense conflict about alcohol, an impact or relationship between drinking and other family problems, intense behavioural change when drinking, fluctuating spouse interaction. As well, the factors mentioned previously related to the development of alcoholism are looked for in assessment as relevant.

With families of this category, the initial goal is to get the drinking stopped. This is based on the assumption that meaningful change cannot occur while drinking continues.

If the family is in crisis and all agree, the drinker can enter a treatment program. The rationale for this can be to learn about his/her relationship with alcohol and how to handle it. This can be done sometimes even if the drinker is making a distinction between "problem drinking" and "alcoholism". In practice, it is unwise to join in a debate about drinking (as Berenson (1976) warns). Thus, the author took the position that looking into the nature of the drinking problem was strictly the "research task" of the drinker.

At crisis points, the crisis can be utilized to get the drinker into treatment. Family member's responses can be utilized in this regard provided that the anxiety level is not too high with interaction characterized by blaming and scapegoating. This requires the therapist to conduct the session in such a way that anxiety does not govern the session.

If there is not agreement about the need to stop the drinking, different strategies must be used. This is where the therapist must decide where maximum leverage exists. In general, the author took the position that conjoint work especially at the outset, was useful in that it revealed the interaction patterns and gave the opportunity to make the patterns evident to all members.

As the alcoholism exists in a context of spiralling anxiety, the goal is to diminish the anxiety and accompanying enmeshed behaviour, blaming and defensiveness. This is to create a climate in which motivation can be encouraged. Using a centralized position is useful in this regard. The focus is one of widening the perspective and process one of differentiating the members so as to increase the range of potential targets for change. The emphasis is on "thinking" rather than on "feelings" (attempts to encourage expression of feelings only increases anxiety, guilt, blaming and defensiveness). The goal is to enable a clearer perception and a different perspective. The therapist must be careful to develop and keep maximum leverage and this cannot be done if coalitions develop. The focus should not be on the alcoholic, for this is a duplication of the family pattern.

Work With the Non-Alcoholic Spouse

The option to work with the non-alcoholic spouse can be utilized if this is the best leverage point. It can also be used

if the alcoholic is inaccessible. The spouse is often the most over-anxious and over-functioning member. He/she if often more motivated to change due to the most suffering. The goal is to enable him/her to become more responsible for self. Structurally, the goal is disengagement in the interest of lessening anxiety and breaking the cyclical behaviours.

The strategies used are those of Berenson (1976 and 1979). In summary, the approach is to give the spouse three options:

1) keep doing what you are doing;

2) detach emotionally; and

3) separate or physically distance yourself.

These strategies are presented as the only options. The rationale is based on offering three choices all of which seem impossible, the spouse following through, experiencing powerlessness and "hitting bottom". The aim is to enable the taking of an "I position" (a self-determining position). This disengages the spouse from the perpetuation of a wet system. This approach is long term, for an "I" position is slow to develop. Powerlessness must precede it.

If family members (spouse) choose(s) not to change, the decision is overt and can be labelled as such. With option 2, the choice is to accept the alcoholism and be responsible for self. In this option, Al-Anon assists in the reaching of a powerless state,

regarding changing the drinking.

Option 3 is separation and the spouse must be prepared for the drinking to get worse (this is based conceptually on alcoholism as a homeostatic mechanism - and as a communication strategy). In choosing this option, the spouse is taking responsibility for self, and is disengaged.

If the spouse decides against options 2 and 3, he/she is in effect choosing 1, and this should be made overt.

This approach is long term. In systems of extreme enmeshment and high anxiety the spouse may become very depressed. In working with a spouse in this approach, the therapist must be careful to point out the possible immediate and longer term consequences of separation. A stance that neither pushes her/him away from the alcoholic, nor keeps her/him locked in, must be taken. A point to stress is that this must facilitate a true 1 position. Therefore, it should <u>not</u> be presented as a strategy to "get" the alcoholic to stop. This would obviously negate the entire rationale for the strategy.

General Clinical Considerations

In order to affect change in any system, the therapist requires "leverage" and must be able to avoid being sucked in and replicate the system by becoming part of it. The general principle then is to avoid replicating the system behaviours and patterns.

In work with the spouse alone, it is easy to replicate the spouse-alcoholic roles in the spouse-therapist relationship if the therapist falls into the trap of asking the spouse to change for her or him (as the spouse has been doing with the alcoholic). He must allow the spouse time to choose for "self". As well, others in the family have been playing complementary roles to those of victim and martyr (often played by the spouse). In this respect, as Berenson (1979) outlines, a consultant role is the best one for the therapist to take.

With the spouse alone "option", it is easy also to create a triangle isolating the alcoholic as the family has. Berenson (1979) suggests avoiding this by including the alcoholic, by extending an invitation to attend sessions, keeping him/her informed by phone, or overtly telling him/her that you are plotting against him.

With the couple - conjoint model - a focus on the alcoholic is a replication of the family pattern. Another trap noted by Berenson (1979) is for the therapist to replicate the spouse's pattern of "pursuer-saviour" roles, matched by the "distancer" part of the alcoholic. The therapist who permits any extreme behaviours of the alcoholic then (frustrated) abandons the saviour stance and impatiently tells him to go to A.A. and sober up is again replicating the family fluctuations which are part of the alcoholic family interaction.

Chief ways of avoiding this lie in taking the stance that the problem belongs to the couple (family) system. Using ground rules helps the therapist keep control of the therapy session. Not getting involved in handling disruptive behaviours is also useful. A detached stance, pointing out the interaction should be used. The taking of an "I" position is also useful.

With the spouse alone, the therapist can avoid reinforcing the victim role by ensuring that he/she does not have to be in a corresponding saviour position. The spouse should be encouraged to develop a network, and the role of an Al-Anon sponsor should be stressed. This helps reduce the tension that is funelled into the therapy sessions and in addition, fosters self-determination and the development of personal resources. This point is emphasized by the author in view of the crises which frequently occur in alcoholic families.

The option to terminate is extremely important. It is essential to be able to set conditions for treatment so as not to be perpetuating a dysfunctional situation of no change. Thus, the therapist must be free to say that being dry (to continue with therapy) is a condition. In cases with the spouse alone, the therapist, after a reasonable time, must be able to insist that Al-Anon as a resource should be explored. If it is not followed through with, the option to terminate, "leaving the door open" should be exercised if, in the therapist's judgment, it would be anti-theraputic not to. Termination should be conveyed in

terms of self on the part of the therapist, for it should not be to convey "failure" or to ease frustration (of the therapist).

In this regard, the author notes Berenson's (1976) warning about the trap of "help me, but I won't let you". This cannot be played without the therapist playing "why don't you let me help you like I do all my other clients". The author became somewhat vulnerable to this trap related to the "student role" which required cases to complete the practicum.

The reader is referred to Berenson (1976 and 1979) for a full discussion of other pitfalls in work with alcoholic families. One that has been noted is the "Debate" trap. The author was particularly careful to avoid labelling anyone "alcoholic". This requires taking the position that the problem belongs to the client. From this stance, it is the drinker's responsibility to "research the nature of his or her alcohol problem". The author did not become engaged in the "sidetracking maneuvre" of debating about "alcohol problems" versus "alcoholism".

Work with Dry Systems

The author generally sees two phases of work with dry systems, depending upon the degree of detachment prior to the alcoholic taking treatment. The first phase is geared to assisting the system in a "crisis" state to stabilize into a "stable dry state". In systems

organized or triangled around alcohol, the cessation of drinking is a crisis and the stabilizing tendancy is to revert to a wet state. (Recividism is high in alcoholism as Herscovitch (1983) notes).

In assessment, the factor looked for is the extent of enmeshment and the function served by the drinking. The patterns are generally readily apparent. In some systems there is a high level of conflict with triangulation around alcohol related to the treatment program of the alcoholic. In some instances, overt attempts to sabotage can be seen. (For example, the spouse arranging for something the alcoholic "needs" to do on a night he attends treatment, such as babysit, or be present at some function). In other instances, denial is manifest in the spouse ("He's not that bad"). In other systems, conflict related to unfinished business is heightened. This usually portrays the alcoholic in the scapegoat or persecutor roles.

These patterns are not as evident in systems where previous work had involved the wife and enmeshment was lessened prior to treatment, ie: if the spouse has managed a true "I" position.

A key principle in conjoint work is to keep the anxiety level down. This can be done through taking a centralized position and directing communication through the therapist. The option to see first the spouse can be exercised if conflict is very high. Often he/she is trying to control the alcoholic and must be assisted to disengage. If this does not take place, the chances of the resumption of drinking

is very high.

At this stage, the spouse can be encouraged to get in touch with her "emptiness" and assisted to "hit bottom" in a disengaging process.

In conjoint work, the unfinished business impacting on the current context can be worked with. Educational resources can be used and the spouse can be linked with Al-Anon for support (this assists in the disengagement and provides for less dependency on the alcoholic).

Generally, with "newly dry" systems, the spatial conception is one of increasing distance, to lessen reactivity and anxiety. Often in a non-defensive atmosphere the spouse can get in touch with her own feelings, "own" them and acknowledge her role and behaviour in the family patterns.

In some systems, the spouse has developed expectations related to the cessation of drinking that are unrealisitic. In these instances, she can be assisted to examine these either conjointly or concurrently. In general the author sees this "early" dry phase as a time when the system requires support. A general rule is to deal with only those issues which require dealing with and not to raise others until the system is more stable without alcohol. Individual issues can be looked at related to "recovery" and these are consistent with a goal of increasing self-differentiation. Blaming and attacking patterns can be noted

and each member helped to take responsibility for self.

The second phase is evident in issues related to intimacy. This generally is aimed at decreasing distance. Often at this stage, the alcoholic is using A.A. and the "sick role" as a way of avoiding responsibility and this can be countered. The isolation of the alcoholic from the rest of the family can be the focus of work. Tasks that build and increase the clarity of the spouse subsystem boundary can be used at this stage. Couples can be asked to do some things together that are "non-threatening" and enjoyable, thus permitting them to experience new ways of relating.

They can be assisted to explore extended family issues and given tasks that relate to increasing differentiation from family of origin. Sexual concerns often surface at this stage and they can be given Masters & Johnson type tasks. Sexual problems are common with alcoholism. Parenting concerns often present a vehicle to encourage contracting and co-operating behaviours. Assessment takes into account developmental stages which have not been successfully completed and tasks given that assist in the completion. In the light of prior dysfunctional patterns families can be given tasks to assist in the establishment of new, more functional ways of relating. Sometimes the issue of resumption of drinking occurs at this stage and generally Berenson's (1976) "paradox" can be used to deal with it (see p.128-130).

Process and Procedures: General Considerations

Pre-Session: Prior to face to face engagements the author attempts to gain prior information to decide whom to include in the initial session and to be able to form some hypothesis for the first session. This information includes details about family composition, social and cultural factors, ages and any other factors related to "family developmental stage" and external pressures. When the referral is made by a third party, the author endeavours to learn their emotional response to the family and their involvement in the situation.

In general, clients were asked to call as opposed to the author calling . This served to gauge both motivation and anxiety. When there was reluctance involved, the author took an outreach approach to engage the family. As well, information about prior "help" was taken. (This is seen as influencing client's expectations and attitudes and also as a way of being aware of process traps in advance). The author endeavoured to keep control over who attended, seeing this as an intervention in terms of the implicit message about who is involved in the problem.

Initial Session: This was generally structured according to Haleys (1976) process, (social - problem - interaction - defining the change) as a four phase process. The process was tempered by clinical considerations presenting in the session, especially pertaining to phase 4,

related to "wet" systems.

Conclusion

The approach and basic principles and procedures have been described in this chapter and the context of work, setting, supervision and clientele described.

The succeeding chapter will illustrate the application of the approach through case discussion and will also focus on evaluation.

CHAPTER VI

CASE NARRATIVES

As the practicum cases varied in "wet" and "dry" systems, family composition and issues for resolution, clinical issues and choices of strategy also varied. Rather than review a single case from the beginning to end, the author chooses to use excerpts and summaries to give broader illustration.

Situation 1: Assessment and Intervention

A principle of a systems approach is to include all persons in the view of the"context". The following situation illustrates this in a case for which no "therapy" was contracted. The case is, therefore, not among the 19 summarized in the case overview sections. A systems intervention was used however, despite the fact of no ongoing involvement.

The referral of a young couple with a long history of alcohol abuse was made by a welfare worker. Both individuals were newly dry and the welfare worker felt that they needed marital counselling.

In the initial and only session, the couple, instead of disclos-

ing any marital issues, focused on their situation with social agencies. Six agencies and a hospital were actively involved with the pair related to child welfare concerns, welfare and health matters. They wanted to talk about this and how difficult it was to stay sober. As they related details, they showed triangulation patterns, blaming and externalization of responsibility. They described the frustration of being caught in competing agency demands and powerlessness they experienced. For example, they were often late for their appointment to see the children at the Children's Aid Society as they had to wait to see their welfare worker to get their cheques. They were then confronted on being irresponsible and uncaring. Any attempt to focus on their relationship was resisted. The therapist noted their frustration and depression. Their pattern had been to "give up" and go back to drinking. They both wanted to stop drinking.

As detail was gathered, the author saw that this couple added to their own frustration by the strategies they used to cope with social agencies. Apart from drinking (as a strategy) their only other method was to involve a third party agency to deal with the conflict between themselves and the other one. This was a trap that the author did not want to fall into and thereby reinforce the pattern and replicate the system. Their strategy contributed to their feeling of powerlessness and sense of "no control" over their lives. This in turn led to drinking when resentment increased. Drinking and consequences

increased the difficulties and the agency power. The couples' major activities consisted of a series of appointments with agencies and the hospital (where one child was). They were kept very busy with scheduled appointments.

Rather than adding to this overload of what appeared to be a highly stressed system with diffuse boundaries (underorganized) and lacking power, the author felt that the only valid intervention was to assist the couple to resolve some of their issues with agencies in a way that contributed to better functioning of all. The goal was to alleviate the pressure which threatened to return the system to a wet state, but also to use a strategy that would stop the triangulation patterns and enable the couple to take responsibility for themselves and establish some sense of control and self-respect.

The author proposed a meeting to be attended by the couple and the other agencies which would allow each participant to see the processes that were posing difficulties and enable contracting concerning new procedures. Thus, the author joined the transaction, with the next step being re-structuring.

At the subsequent meeting, all participants including the couple contracted around goals, roles and responsibilities which were clearly delineated. The couple as well as the agencies, agreed to some new operating rules.

In summary, rather than attempting to counter the resistance,

the author chose to go with it and engage the couple in a process related to an issue that was relevant to them and to the issue of drinking. The subsequent intervention entailed a change in a dysfunctional structure by serving to block the pattern of blaming and triangulation, but also allowed agency representatives to see their part in the pressures being experienced by the clients. The conflicting demands were changed, through changing some of the procedures. The locus of the problem in structural terms was the boundary between the couple and the eco-system, and that boundary served as the point of intervention.

The following situation illustrates features of beginning with a newly dry system. Concepts and theories will be noted and clinical issues highlighted.

Situation 2 (Alan and Alice) - Newly Dry System

This family consisted of a childless couple in their mid-twenties who had been married just over one year. They were separated at the time of referral. The husband had just completed a three-week, non-residential program for alcoholism treatment and was newly abstinant. The therapist met the couple during the end of his treatment course and the decision to engage in relationship counselling was made at that time. Although they were living separately, they saw each other almost daily and were involved in many joint financial matters.

This couple was seen for approximately ten sessions which were scheduled weekly for the first while, then less often towards termination.

The initial session which was conducted along Haley's four staged process, entailed the issue of a request for relationship counselling made by a "separated couple". The assessment which took into account the family developmental stage, was conducted primarily in a way to keep tensions down. This was due to the factor of a "newly dry" system. Some history-taking and use of a centralized position were employed for this purpose. "Joining" was accomplished through a discussion of the "family evening" that had been attended by the couple and at which the counselling services had been offered. As well, the therapist took some time to find out about the respective jobs of the couple.

The "work" phase was initiated through a focus on their expectations of counselling and enquiry about the events preceding Alan's decision to seek alcoholism treatment. Several factors were noted by the therapist. This couple had no experience of stable life together. Excessive drinking and irresponsible behaviour on the husband's part had been a constant feature of their courtship and early life stages.

Their history was one of spiralling crises, including psychiatric hospitalization of Alan shortly before treatment was sought. The

hospitalization had been preceded by threats of suicide. At the time of the hospitalization, Alice had been advised by the psychiatrist that Alan was a "hopeless case", and she had been strongly advised to begin legal separation proceedings. She had done so, and a lawyer was currently involved. The history included several incidents of violence where Alice had been held hostage with a loaded gun for several hours at a time.

The author assumed that this system had not undertaken completion of tasks of the "courtship" and early marriage stages. This implied that couple boundary work was needed. As well, the worker noted "unfinished business".

Taking a decentralized position to see transactional patterns, the author noted the rigid roles in the system. These roles were "helper" wife and "helpee" husband alternating with "victim and martyr" (wife) and "persecutor" (husband).

As the therapist directed enactment of patterns in the session, the individuals attempted to triangle the author by putting her in a "judge" or "referee" position. Conflict was most evident in the interaction stage related to the definition of the problem and contracting around goals for work. The issue was the future of the relationship.

Each stated the problem in terms of the other's feelings, eg: "Alice doesn't believe I've quit drinking and won't return home". The interaction was characterized by blaming and accusations.

Bowen's theory was used, as the therapist noted that neither was able to take an "I" position (clearly neither was able to differentiate between thinking and feelings). Thus, this couple appeared to reflect the fusion of two poorly differentiated individuals.

A clinical dilemna of this first interview was to avoid being triangled on the issue of the resumption of the relationship. To avoid this, the therapist focussed on the process that was occurring in the interaction, noting that when Alan demanded Alice return, Alice (figuratively) went in the opposite direction. This was re-framed as "pushing her away", in order not to hurt her. It was also tentatively suggested that Alan, in view of the year of crisis, was also showing some ambivalence about the relationship which he was reluctant to give voice to. The re-framing and interpretation of ambivalence were accepted.

The goal of the author was to gain entry in a way that kept options for work open and to "buy time" by bringing other issues into focus. The concern was to avoid a coalition with the wife whose agenda was also to resist resuming the relationship. This was accomplished through the re-framing about the process and relabelling of the "demanding" as "protecting".

After noting the blaming pattern particularly around the past and drinking, and finding issues of unfinished business, the therapist took control feeling that further direct engagement was counter-productive. An effort was made to focus on the interaction occurring

in the session through the laying down of some ground rules. Bowen's technique of directing communication through the therapist was useful in reducing the anxiety level.

Early in the first session in a joining strategy, the strengths of this couple were noted. Both individuals were supported; the wife in choosing to interrupt the crisis cycle and the husband for his decision to seek treatment and work on his problems. This was the beginning of a process of strategies to assist in lessening the enmeshment of the couple and foster a higher level of self-differentiation. The therapist, in this initial session and for the balance of sessions, stressed this process through asserting ground rules of speaking for oneself and also by noting differences and framing them positively. Early in the session, the therapist began to expand the focus moving from "unfinished business" related to drinking, to the interaction in the session. This was to highlight areas for work and to diminish blaming.

Berenson (1976) suggests that power is not a useful dimension in families where alcoholism is involved. Other theorists take the view that the alcoholic individual controls the relationship and therefore has the power. Madanes (1981) uses the concept of incongruent hierarcy with regard to marriages with a symptomatic spouse, noting that the symptomatic person is in an inferior position to the other who is in the "helper" role, yet also in a superior position in terms

of refusing to change. "The couple are caught in an interaction that defines simultaneously their power and their weakness in relation to each other. The concept of a position that is simultaneously inferior and superior is important here" (30-31). This appeared to be an important aspect of this couple's situation immediately preceding treatment and therefore pointed to the importance of assisting them to look at their roles as part of the process of therapy in later sessions.

The first session was terminated with a contract being reached around a series of six sessions with an option to re-negotiate around that and extend it to a few more. The contract was to assist them to resolve "unfinished business". The author saw her role as being to assist this couple to improve their current functioning through re-structuring and boundary work. Many effective and instrumental issues were identified as "problems" in the initial session. It was agreed that these issues would be worked on for the balance of sessions in order that a mutual decision concerning the relationship could be made by the two parties.

As well as effective problems, this young couple had serious economic problems related to debts incurred during the first year (largely, though not exclusively related to Alan's drinking). Both were employed in low wage work. The wife's earnings were highest.

The wage discrepancy reinforced the roles of "helper" and "helpee". Some sorting out of debts took place during the second session, with areas of responsibility being explicitly agreed upon. In much of this process, coaching and enactment were used.

Relationships with extended family also reinforced the roles. Alan was seen as the "sick" one; Alice, as the caretaker and victim, in the extended family member's eyes. This became particularly apparent during the second and third sessions when families of origin were considered and family chronologies taken to assist in differentiation. Alice was explicit about her expectation when the first met that she could help Alan and that she had felt "more capable" with him than with other men. The "helper" role was thus the basis of early relating.

Alcoholism was present in both extended families. Both had fathers who were active alcoholics, and this extended also to several brothers and brothers-in-law on Alice's side especially. Drinking was a focus of family socializing and most of the socializing of this couple took place within the confines of the extended family. Alan's father had beaten him brutally as a child and communicated his worthlessness to him even to the extent of predicting to Alice that their marriage would fail. Both sets of parents had been opposed to the marriage. (Stanton and Todd, 1982, note that parental opposition is a frequent factor in marriage failure). The parental opposition was brought out and both parties were helped to get a clear perception of

this as a factor.

Information taken about extended family showed the roles of this couple as clearly patterned on roles in families of origin. The couple had no shared friendships with others. Alan's friends were heavy drinkers and Alice was loathe to associate with them. The importance of developing friendships was stressed and A.A. was encouraged (to maintain sobriety and for network potential). Al Anon was also suggested early in the session. However, the timing was premature. Her reaction showed her rigidity in the "helper" role, as well as keeping Alan in that of "helpee". The suggestion was reintroduced later when it could be clearly related to Alice's need to find resources to resolve her feelings about the past and the fears she continued to re-experience.

As sessions progressed, Alan was encouraged to acknowledge his ambivalence about resuming the relationship. This freed Alice from her defensive stance and shifted the power in the system.

Family chronology material was useful in enabling an explanation of roles and diagrams assisted in clarifying or marking boundaries with families of origin. Their differences were accentuated in light of their past. This was a means of further marking individual boundaries and to facilitate increased understanding and acceptance. The therapist modelled "I behaviour" and did some coaching in this regard,

blocking patterns and re-directing interaction.

The couple were given the task of "each" planning an enjoyable low-cost evening together. The task had several purposes:

1. To increase differentiation by giving each individual a task to do separately;

2. To begin to lessen the triangulation of extended family members (with whom they spent time to excess);

3. To address issues related to courtship stage work. Their courtship had never been adult to adult, but entailed only "helper", "helpee" roles. Thus, the author wanted to bring out the issues related to intimacy;

4. To provide a new experience where each had to think of what the other would enjoy.

They completed the task and the experience assisted them to develop a "current perspective of their relationship".

Financial management was a major issue of dissention. It was a focus in the fourth session. The task assigned was that of doing an individual budget. This was designed to be used to assist in differentiation or lessening of the enmeshment, also to introduce new roles. Alan had completed the task quite thoroughly, where Alice had done it in very sketchy fashion. She was visibly shaken by his task completion and proceeded to put him down suggesting that he had "probably gotten someone else to do it for him". This clearly indicated that his symptom

and irresponsible behaviour were tied up in her complementary role as the "capable" one, and also showed the rigidity of roles. The therapist, noting her reaction, suggested that his skills still needed some developing and drew Alice in putting her in a teacher or expert role in the session. This was to lessen her resistance and elevate her status.

During the next session however, Alice attempted to sabotage the gains made in the process of Alan becoming competant and responsible. She insisted that she had received a phone call from one of the creditors whom Alan was paying back. She indicated that the creditor had called because Alan (although he had told her he was paying), was behind in his payments. The creditor was holding Alice responsible for the debt. This was one of several crisis points in these counselling sessions. The therapist suggested that as this particular debt had been agreed on as being Alan's responsibility, the matter should be left to Alan to resolve with the creditor, and that Alice, if called again, should direct the caller to her husband. Between sessions, Alan called the therapist to advise that Alice had lied in the last session, and that she had confessed to having called the creditor herself. The therapist, wanting to avoid a triangle stated to Alan that this should be talked about in the next session. This incident itself is a good example of an attempt on the part of family members to

sabotage treatment success. The incident was upsetting to Alan, and is the type of situation that can often lead to the drinking beginning again. In Alan's case, this did not occur.

In the next session a confrontation took place. Alice admitted her fabrication. To alleviate guilt and defensiveness, the therapist related this to Alice's role in her family of origin. She revealed how tied up her sense of herself was with her ability to "look after" people. This interpretation thus removed blame. Her tiredness with the role was brought out, and as well, the helplessness she had felt prior to separation when she could not cope with Alan's suicidal and threatening behaviour, which was an escalation of the symptom. Her openness gave Alan a new role in the session in which he was encouraged to give support and understanding to her. This seemed to be the point at which Alice "hit bottom". She resolved to stop trying to run Alan's life and to allow him to run it.

The concept of "letting go" was related to Al Anon as the therapist wanted to use Al Anon to maintain some work on self-differentiation after the sessions were finished.

In summary, work with this newly dry couple extended to ten sessions. The system stayed dry and they decided to resume their marriage. The outcomes were positive in terms of the goals that were negotiated in progress and their overall issue of the future of the relationship.

The author notes that marital therapists frequently take the position that a marital relationship cannot be worked on unless the couple is living together. In this case, because of the issues of alcoholism and fusion and the need to keep anxiety down in this stage, the author saw the separation as functional and necessary. If anything, the aim was to "slow down" the system and facilitate detachment initially so as to enable the resolution of emotional issues and gaining of perspective.

The major structural techniques used were relabelling, structuralization, modelling "I" behaviour tasks, enactment, tracking, system re-composition, relabelling the symptom, escallating the symptom and moving to a new symptom.

Situation 3 - Of Termination and Triangle

The following excerpt highlights a termination issue, the concept of "triangle" and the use of strategic principles. The case involved a young couple who had seen the author for approximately eight sessions related to staying "dry" (both) and reducing conflicts that escalated into violence. The goals had been reached and the author saw the couple as functioning well and capable of dealing with other issues on their own. The author was concerned about their view of themselves (as unable to manage, and "sick"). When the issue of termination was broached, they appeared to be almost manufacturing issues to prolong the therapy. The author became increasingly

uncomfortable with the "expert" role that she was increasingly being cast in. In checking with other staff in the "aftercare program", the same patterns were occurring there.

In consultation with the Clinical Psychologist, the following strategy was devised. The therapist was to instruct the couple to have a serious discussion about sex, with one standing at the top of the basement stairs and the other at the bottom, shouting to each other. The strategy was based on going with the resistance, taking on the "expert role" and being disqualified (de-triangled).

The rationale given to the couple was "to help them get at the power issues in their relationship". The first step of the task was to get a decision made as to who would stand at the top and who at the bottom. The task would firm up the couple boundary and push the therapist to the outside. In giving the task, the author was quite certain that the couple would endeavour to do it as they looked everywhere but to their own resources, unable to see that they had any. They did attempt the task and after several tries became very frustrated. The therapist, through exploring what happened when they did the task, was able to explore their own solutions. The task illustrated how much more expert they had become than an outsider. They had given up finally and sat together on the chesterfield (at equal levels). Both agreed that being either at the top or the bottom was not comfortable. The experience fostered increased intimacy in the relationship and

termination was agreed upon with no resistance. The couple continued to function well.

Situation 4 - The V. Family

This case was chosen for expansion because it represents a family system in which an alcohol problem had developed seemingly related to stress. This family were beginning to organize around the problem.

The V. Family, consisting of parents, Mr. V. age 50 and Mrs. V. aged 48, daughters Joan age 20, and Janet age 17. The family was referred by both the Intake Department and the Non-Residential Treatment Team. The father was being labelled "alcoholic" and had been attending A.A. for several months. He was unable to "identify" with other A.A. members concerning his drinking. When he took a treatment program in the Non-Residential Department, he was unable, in that context, to identify with group members. Thus, he was advised by the group leader that family counselling might be more relevant.

This family was seen twice, for sessions of two hours each. In the first session, joining was accomplished by enabling the family members to disclose their obvious anxiety about being there. The mother was clearly the most anxious and indicated that she almost turned and ran at the front door.

The closed family boundary was evident in the mother's "rule"

statement that "We are a happy family and can solve our own problems". The eldest daughter's tears were noted as the therapist remarked on the sadness she sensed in this family.

The interaction patterns, as the members each outlined their view of the problem, showed father in a scapegoat role, and younger daughter in coalition. Mother indicated coalition also with older daughter, stating that she discussed everything with Joan - and that Joan was "more like a sister".

The worker, wishing to learn more about the drinking and the family interaction, sought to widen the focus. She inquired about when the problems began. The family recounted some history of the problems which had begun three years previously. As they expanded in response to questions, the author noted that the issue of drinking to excess was very recent. It had begun after a series of stressful events, including two bereavements, serious illness of Mr. V., related to business failures and bankruptcy. The family had been forced to sell their home and move to rented accommodation. Mr. V. had become depressed the subsequent year and was under a doctor's care and on anti-depressants. He was again unable to work and as he recounted this, Mrs. V. broke in saying how frightened she was upon seeing him crying.

She took over, adding that this had been hard on the children. She implicitly blamed her husband for her fear, Joan's tears and also cast Janet in the victim role. The author also learned that Joan had

moved out briefly, suffered a broken romance, and moved back in. During this troubled time, both sons had left home to get married. Joan had taken on the family "helper" role. She had attached the label "alcoholic" to father, relating the family roles to alcoholism as she had learned in a course.

The drinking was enquired about during the history taking, but it was not reinforced as the "main problem". It was learned that Mr. V. recently had been drinking in excess of two drinks twice to three times weekly, at which point he became a "different person, acting angry and saying things to Mrs. V. that he would not have normally said." He had also had a bottle in the car at one point. Drinking and fighting were inter-related.

The worker hypothesized several things related to the function of the drinking in the system. Mr. V. showed no anger at points in the dialogue when it would have been appropriate to do so. Alcohol allowed him to get angry, yet not be held responsible for his anger. He was using alcohol to deal with stress. The family rules prohibited anger. It also allowed Mrs. V.to blame something for the sexual problems. It served to keep the family together, as Janet had returned home to help her mother and younger sister (the latter had been cast into a victim role by both mother and Joan). It also provided Joan with a means of not dealing with her own personal issues. This was a very frightened, anxious family. All members felt a good deal of pain and embarassment. There had been no problem with alcohol until very recently in the history. The younger daughter, who was very silent and withdrawn, had been seeking help from a friend's mother

(a counsellor). This was being actively discouraged as the family rule was not to talk to outsiders about "our private business".

The picture that emerged was of a highly stressed system, with stress impacting from developmental issues not being dealt with as well as other outside issues. Mrs. V. was in a very traditional role and had made no moves to establish roles for herself outside of those of wife and mother. She felt inadequate and frightened, and showed jealousy of the young daughter who was closer to her husband than she (the wife) was.

In Minuchin's view, the family structure must be able to adapt as circumstances change and a family's adaptability depends on a sufficient range of patterns and alternative patterns of transaction, coupled with the flexibility to mobilize them (Minuchin, 1974).

Two types of constraints can occur relating to family development; generic and idiosyncratic. The former relates to universal rules governing family organization; the latter to unique expectations and intentions of a family member and also to the particular values expectations, etc. of a given family (Okun and Rappaport, 1980).

Minuchin (1974) portrays some families as "turning on themselves with a consequent increase of communication and concern decreasing distance and blurring of boundaries"(p. 54).This appeared to be the case with the V. family. They clearly showed diffused inner boundaries, cross-generational coalitions and high anxiety related to stress. Their roles prohibited the seeking of outside help. None of the feelings related

to these events had been dealt with. The worker wanted to know more about their functioning and explored this focusing on the pain that they all showed, thereby expanding from the drinking and uniting them around the common emotion all felt.

The worker encouraged the expression of feelings with a theme of "unresolved pain" and "unfinished grieving". Ways of dealing with feelings were explored and the members were able to see how they needed to be able to give permission to each other for this, ie: mutual support function. Mr. V. was encouraged to express his anger towards both his wife and eldest daughter. He did so. Relief was felt as all cried. They cried also when they spoke of the loss of their sons.

Mrs. V. was supported and was able to express her fears and feelings of inadequacy. The family myths were brought out in the open, as they were prohibiting the resolution of issues and maintaining dysfunctional structures and functioning.

Mr. V. had been abstaining from alcohol and attending A.A. He was encouraged to keep on exploring the matter of his relationship to alcohol. Mrs. V. was asked to attend a series of informational sessions on alcoholism in families as a homework assignment. This was done for two reasons. The first was to enable her to have some outside contact which was non-threatening. The second was to give her the opportunity to decide for herself whether alcoholism was the problem in the family.

The third was to lessen the enmeshment with Jane.

She refused to do so without the eldest daughter accompanying her. Thus, in giving the task, the assessment of the extent of the mother's dependent coalition with daughter was confirmed, but the task did not accomplish that purpose.

They did report at the next session that they had not been able to identify with other families who attended the session and Mrs. V. did benefit from the experience. She began to experience her own strengths through being supportive of others at the educational group. She decided that she might like to get involved in some "volunteer work".

The younger daughter was assigned a "peer related" task, and related to in a manner that lessened the assignment of the "victim" role in the family and showed her capability. This was to alter the family's perspective.

The feelings of loss and anger about the son leaving home had been acknowledged and shared by the family for the first time. They were given the task of making contact with the son and his family and to work at establishing a family to family relationship. This was to enable the further resolving of the issues and also to close the boundary by accepting the son as a person with his own family.

Mr. and Mrs. V. were given a task to do together to establish an inter-generational boundary. In the session, remarks were directed to the couple to clearly mark that boundary. The daughters were

related to as individuals and asked about their plans for the future. This was to increase their individuation relative to the developmental stage.

Mrs. V. was re-inforced in her strengths and ability to be supportive, especially to her husband.

The family at this point were about to take holidays. After holidays, two other extended family members became seriously ill, one terminally, thus sessions were terminated. The "alcoholism" had appeared to the author to be a response to stress and was dealt with in that manner. Mr. V. did not want to permanently abstain and did not do so. The family was followed up for a year. In this period, there have been only two occasions of excessive drinking.

The issue of sexual impotance of Mr. V. had not been mentioned in therapy or focused on in treatment. (The author had been told of this problem on the phone prior to the session). This ceased to be a problem shortly after the sessions, and seemed to reflect improvement in the couple relationship.

The basic focus of work had been centered on stress and responses to stress, the need to talk about <u>all</u> feelings (not just "happy" feelings) and modelling and enactment to give permission for this. Rigid sex roles had been made explicit, examined and questions raised in a process which challenged the family rules and norms. It was suggested that for a male to be able to "cry" was a sign of strength. The theme of

"overprotecting" was used in a positive framing in relation to members not being open with each other.

This family has experienced further stress yet according to feedback in follow up, have functioned well. There is less tension. The oldest daughter has resumed her plans for a career which had been put aside. Mrs. V. is not pursuing any goals for herself, however, she is content with her role at present. She is now more supportive of Mr. V. and the couple have developed more of a friendship network.

There is of course a question still, around the matter of Mr. V. being able to sustain a moderate level of drinking. Should his drinking become problematic at a future point, this family is knowledgable about alcoholism and resources for help.

Situation 5 - Wayne and Wanda

This case has been included for several reasons. In the author's view, the situation highlights the value of a family therapy perspective in addition to and complementary with, self-help groups. It entails a family system which appeared to have achieved a "stable dry state" through the use of self-help groups, yet because a "slip" was involved after a lengthy period of sobriety, the dynamics of the family had not been sufficiently altered to maintain the stable dry state. In this case, although drinking was occurring, this was not presented by the couple as the problem, nor was it the focus of the intervention.

Wanda and Wayne, a couple in their mid-thirties, were referred by Wayne's sponsor in A.A. The couple had two children who were not involved in the therapy. Both Wayne and Wanda had been previously married. Wayne's previous marriage, which had been precipitated by a pregnancy, was characterized by heavy drinking on his part. It was a relationship in which he felt trapped and lacked committment. Wanda's previous marriage was characterized by physical abuse in which she was a frequent victim. The couple had been married to each other for ten years. Their children were both under eight years of age.

The presenting problem was that of adultery. Wayne had commenced drinking again after three years of sobriety and regular attendance at A.A. The affair had been brief, had been terminated by Wayne, and had entailed his becoming emotionally involved with a female with whom he had a sponsor role through A.A. (They had been involved respectively in A.A. and Al Anon for three years.)

In the first session, the therapist gathered information about the problem which Wanda identified as "the affair" and her inability to resolve her feelings about it. She was highly emotional and the more she talked, the more incongruent Wayne's affect became.

When the worker directed them to talk to each other about the problem, they showed pursuer--distancer patterns. The worker, noting how verbally dominant Wanda was, hypothesized drinking as a stabilizing mechanism and way of gaining power and avoiding direct conflict resolution.

This couple showed enmeshment in some respects and disengagement in others, and the case is illustrative of the point that much disengagement can be seen as a reaction to enmeshments. Their lifestyle was mainly "disengaged". They had virtually no family life and Wayne clearly had no role apart from "bread winner". Their involvement for the past three years in A.A. and Al Anon had reinforced this. On the other hand, the extent of responsibility each took for the other's feelings and the lack of expression of "self" (especially on Wayne's part) indicated fusion or enmeshment.

The therapist used structuralization as an assessment tool, elevating Wayne's status by tone and manner as well as frequency of addressing. This evoked resistance from Wanda, who began to take over from Wayne in response. This was blocked successfully, the therapist stressing the need to hear both viewpoints.

The decision early in the first session was not to address the issue of drinking, due to both a lack of leverage and the assessment of the power dimension. Thus, the only reference to drinking was to label it as Wayne's "own issue" which he had "experience with and knowledge of." Wanda was expected to go along with this because of her Al Anon background and she did. The decision was consistent with elevation of his status.

The goal was to resolve the emotional issues related to the affair in several sessions as required. The therapist planned to give tasks outside of session and to use in-session time to restructure.

The focus was on the individual boundaries (clarifying and building) and also on the couple boundary in the family system. Tasks given were of the "individual plan - couple carry out" type, designed to individuate and foster meaningful couple time.

As the affair was gradually put behind them, they were assisted in discovering how they dealt with anger. They were taught different ways of expressing anger in the session - more directly and openly. By the fourth session, Wayne was able to disclose the depression he had been feeling for some time and his thoughts of suicide.

As he spoke, Wanda cried. She said how relieved she felt when he talked about it. His depression had immobilized him to the extent that he had not been able to gain the energy to tackle the issue of drinking. He had not wanted Wanda to know because he had not wanted her to feel the way he had felt when in prior years, she had overdosed. During this time, the worker simply stimulated the process and encouraged direct engagement.

Wanda's relief was a welcome surprise to Wayne. She encouraged him to talk and said how inadequate she had felt, and how shut out. She knew "something was wrong" and felt that Wayne "distrusted" her.

This couple terminated, each resuming A.A. and Al Anon, but not excessively as before. This case never was focused on drinking yet drinking was stopped as a result of increased ability to function effectively, and as a natural outcome of restructuring.

To conclude this narrative chapter, the author has illustrated a few of the clinical issues with "wet" and "newly dry" systems and shown the combination of structural and strategic methods and principles applied in practice.

The following chapter will focus on an evaulation in the practicum and as part of that, will overview all cases seen and attempt an analysis of work.

CHAPTER VII

EVALUATION AND CONCLUSION

Evaluation: The Framework

Evaluation was not a major focus of this practicum. In choosing to undertake a practicum rather than a thesis, the author's primary goal was to develop skill in the application of knowledge. The practicum was not intended to be a research project, nor set up to fulfill research criteria. There was no intention to compare family therapy treatment with traditional treatment. Instead, the family work was undertaken as a component of traditional treatment; to add a dimension from a different perspective which saw the family as client (as opposed to the individual) and which provided a focus on family dynamics.

Evaluative concerns will be related therefore to the author's objectives as outlined in Chapter I, and evaluation discussed within that framework.

Objective One - to gain knowledge of both alcoholism and family therapy: was partially met through undertaking the extensive literature review which comprised the first section of this report. The application of knowledge is related to the practicum work; and

Objective Two - the process of skill development.

Skill Development: Process Evaluation

Process monitoring and evaluation of skill development was an ongoing componant of the practicum and carried out in several ways. The major context was the weekly supervision period. Audio tapes were used as a tool to reduce subjectivity, and reviewing of tapes was a regular aspect of supervision.

Live supervision: this form of monitoring and evaluating the therapy process was used once during the learning period.

Case Discussion: supervision time included a focus on case discussion. Tomm and Wright's (1979) categorization of skills (conceptual, perceptual and executive levels) was used to partialize skills of the process. Structural maps and diagrams were submitted and reviewed to monitor skill in the use of family therapy concepts such as boundary, coalition, alignment, detouring, etc.

Consultation: the consultation with the Clinical Psychologist provided a context for ongoing issues related to process. A focus of consultation was on use of "self" in therapy.

Self-Evaluation: the author used the audio tapes to monitor process and identify areas for further discussion in supervision.

Collateral Feedback and Peer Consultations: the author sought feedback from other "helpers" involved with the clients and also from

staff who were directly involved (in a few instances) in co-therapy. Post session discussion time focused on reviewing the process.

Client Feedback: on-going feedback was sought during the work and used to monitor the process. In some instances, feedback was solicited through use of a questionnaire which was mailed out after termination (Appendix 1).

Questionnaire (see Appendix)

The questionnaire had several purposes, one of which was to provide feedback on the process. While the author was interested in getting responses to specific questions, the over-riding interest was in the rate of response itself, as this was seen as providing more meaningful feedback. This was based on the hypothesis that clients would return the questionnaire only if they were either very satisfied or very dissatisfied.

Distribution

The questionnaire was developed part way through the practicum period. Distribution was restricted to the clients who, 1) could be located; 2) who could read and write English well enough to fill in the questionnaire; and 3) with whom an agreed upon termination had taken place. The reason for this third restriction was that in a few instances, the author wanted to "leave the door open" for further contact and not give a message to the contrary.

Of the nineteen clients seen in the practicum, one instance entailed the client moving out of town following termination and prior to development of the questionnaire. Two other families lacked skill in reading and writing in English. (The author judged the questionnaire as inappropriate for them). In two other instances, there had been no mutual termination decision and these clients could not be located. In three instances, work was not considered completed.

As is apparent, the questionnaire distribution was somewhat skewed or loaded towards those cases in which there had been no drop out, and whose situations were stable enough that they could be located.

The questionnaire was distributed to eleven families. In one of these eleven, the husband and wife had separated and only the wife could be located. This entailed a possible response total of 26 questionnaires (corresponding to total number of family members available to fill in responses). Responses in the several instances of families with young children, were only sought from adults. In most of those cases, the spouse sub-system had been seen in therapy, not the total family.

Comment

Questions 5, 9, 11 and 13 were designed to provide response to the process. Question 5 was related to empathy and joining skill, and the others to gauge general satisfaction.

Responses

As expected, the majority of responses were favourable, indicating that members were "very satisfied" and "would seek similar counselling again and recommend it to a friend or relative".

In one situation, where a separation had taken place after the initial session, the husband saw the author as being "on side" with his wife. In this case, the author had erred by not challenging the couple sufficiently around their expressed goal of staying together prior to contracting. When faced with the separation, the author saw no option but to accept it. Doing so was in allignment with the wife who had initiated separation.

In one other situation, a child saw the author as being more on side with parents. This perception was accurate in that the author had chosen to reinforce the executive sub-system. One other wife, who indicated satisfaction, said she would choose "Christian counselling" another time. She had been very resistant to Al Anon. One respondent who had resumed drinking and had been returned to jail, asked for more counselling in the future. In this case, the author had "predicted" accurately.

What is more significant as feedback is the high response rate. Generally, mail out questionnaires do not yield a high rate of return. The detail provided indicated effort being put into the responses. This too, gave the author a good indication that the process had been

both engaging and of value to the clients, as they saw it

In summary, monitoring and evaluation of process was carried on in supervision and consultation, using audio tapes, structural diagrams and live supervision. Feedback from clients and peers was solicited to assist in self-evaluation, and a questionnaire was used to gather feedback with client, where possible.

Outcome Evaluation

In addition to developing skill in application of family therapy, the author wanted also to provide some evaluative comment concerning the method itself, as indicated through Objective 3 (to assess the usefulness of family therapy theory and methods with alcoholic families). There are limitations to which conclusions drawn from this practicum could be generalized, however the project has value in terms of highlighting some areas for further work, using controlled research designs. The following discussion will highlight the major limitations.

Limitations

As Pearlman and Zweben (1983)note, there are many issues with respect to evaluation of alcoholism treatment and also with marital and family system therapy. They point to the fact that there are few well-controlled studies of systems-based methods, adding that a treatment outcome study must ensure that treatments are being delivered consis-

tently and with a description of treatment.

In the case of this practicum, apart from the approach as set out, and Tomm and Wright's (1979) categorization, little further attempt was made to delineate discrete process elements. A principle of pragmatism over-rode any adherence to a strict model and this was related to both the diversity of situations and issues, and also to concerns about maximizing "theraputic leverage" or maneuverability.

Pearlman and Zweben (1983) also note that a limit to generalizing concerning outcome, may result from the issue of therapist inexperience and competence. In the case of the practicum, the auhor must be regarded as a beginning level clinician. (Harvey, 1980, sees the process of development of skills in terms of five stages and suggests that three years is a period of beginning skill development).

Comment on process related to outcome is thus limited by both therapist inexperience and by the lack of a clearly delineated treatment that was followed universally in each case.

A further limitation can be seen in the fact that the author's work took place as a component piece of a larger or total treatment "package". Related to this, the "package" itself varied in each case. For example, some clients had residential treatment, some had non-residential. Some had aftercare along with treatment, some had just aftercare, and some had no aftercare. Some had psychological counselling, others did not. Some were attending A.A., others were not. Several were seeing others for individual counselling as for example, a daughter

in one family who was linked up with Children's Aid. Thus, the clients did not represent a standardized group who received a standardized form of treatment. Additionally, no control group was set up to provide comparison.

Moos et al (1982) note that treatment outcome in alcoholism programs is effected by six sets of factors which are: 1) socio-demographic date; 2) pre-treatment symptoms and functioning levels; 3) treatment experience; 4) life stressors; 5) coping responses to stressors; and 6) environmental resources such as family and work settings.

They add that issues can emerge related to treatment selection and assignment. Extra treatment factors can account for variation in length of stay in treatment (they cite a "drop out rate of 25% for in-patient programs and of 60% for non-residential out out-patient programs").

In the practicum, variances in sociodemographic data, pre-treatment symptoms and functioning levels, life stressors and coping responses as well as environmental resources (family and work situations) are somewhat evident through the description of clients (Chapter V).

The "selection" of practicum clients was also influenced by the bias of other treatment staff; with reference to the referral process. To elaborate, the process of referral varied. In some instances, clients sought help directly, getting the author's name from a friend or from the switchboard. These clients were often highly

motivated and ready to work. They would be classified as "voluntary" and "self selecting".

In most instances however, clients were referred by other parties, most within the A.F.M., some from external agencies. Staff who were positive about family work were instrumental in "selling" the idea to clients to the point that in a few instances, clients were persuaded to see the author when there were no clear family issues to be worked on, or when the need for family work was not present at that time (for example, in early sobriety when both partners were linked with A.A. and Al Anon and this was sufficient given their situation at that point in the process of alcoholism treatment).

Some clients who had been referred by external agencies were clearly "involuntary". Others had taken individual treatment and continued to drink during treatment. In still other situations, there was a clear rationale for family work to maintain a dry state and referral decisions had involved mutuality between the client and the referring person. Finally, a minority of staff were opposed to family work, seeing alcoholism as an individual problem. They referred no clients. Thus, staff bias operated to exclude some families, the extent of which is not known.

Despite these limitations, the author provides an overview of practicum clientelle in the section following an expansion on the term outcomes.

Outcomes in this Practicum

As Berenson (1976) suggests, in most therapy, the goals are very hazy, with terms such as "growth", "better communication", and "increased self-differentiation", being used. He states that in working with alcohol problems, one has a very simple measure of effectiveness: "Is the problem-drinker drinking or not and is his (her) behaviour disruptive?"

He illustrates this point, stating that if arrests for drunk driving, job losses, or repeated hospitalization, continue to occur, treatment cannot be seen as successful. He adds however, that cessation of drinking represents only "partial" success of treatment and therefore should not serve as a sole outcome measure.

With regard to outcome, Steinglass (1977) suggests that family treatment approaches widen the view so that "symptom reduction" applies to the spouse as much as to the alcoholic.

In structural family the goals are to effect change in the sumptom and in the family structure. In this practicum, no instrument was used that enabled the measurement of "structural change", thus, clear evidence of structural change cannot be provided as an outcome measurement.

The purpose of enabling structural change is to enable increased functional capability. Therefore the author sees detail on lifestyle changes and improvements in functioning such as being able to negotiate,

discipline and manage children more effectively, and reduction in fighting, etc. as relevant to the measurement of outcome. As well, the author notes that in several instances, some indication of structural change can be seen in the questionnaire responses.

The following sections on use of the questionnaire will illustrate this point.

Follow-Up Questionnaire

As noted in the section on process evaluation, questionnaires were used as well as follow-up phone calls in eleven cases with nine families (23 individuals) responding. A second purpose of the questionaire was to provide follow-up concerning change (outcome).

Question 4 is related to specific changed relative to goals of therapy.

Questions 7 and 8 provide for information about A.A., Al Anon or other supports, both pre and post treatment.

Question 10 asks for major lifestyle and relationship changes post counselling.

Question 12 was designed to provide some indication of self-differentiation and also increase or decrease in self-esteem.

The questionnaire ends with space for feedback as well.

Illustration of Questionnaire Responses Related to Outcomes

The responses to questionnaires have been integrated into the charts (see pages 182-200)

which are used as an overview and in some instances, into the summary comments on cases. This section is simply intended to give some illustration of the kinds of answers given by clients.

One respondent replied that he had accepted his separation, was now able to co-operate with and communicate with his wife about the children and "felt better" about himself. His wife replied similarly and said the counselling enabled her to make the separation decision (case 8). One other (case 1) replied that counselling helped him "find where he stood in life." The most important changes for him were: being able now to "manage his temper," and "get over the feeling that everyone looked down on him." His wife and he both replied (separate questionnaires) that for the first time they could "talk without fighting." The wife also replied that she can now "be herself - not what everyone else wanted her to be" (this comment is seen by the author as indicative of a higher degree of integration of self and differentiation). She also said she could speak freely and be open with husband and others, and that she does not "let her feelings run her life." (Bowen, 1978, notes that the self-differentiationed person governs with intellect).

A third set of respondents (case 2)(both) detailed the family activities, giving evidence of major lifestyle change. Both noted that they can now talk about their feelings to each other, "rather than guessing" as they used to. The wife noted her new ability to

"stand up for herself" and the absence of the feeling of "walking on eggshells", so as not to upset her husband. The husband said he "felt much closer" to his wife, and was "giving" more to her and the children. (This person had been drinking and also prior to the "slip", was attending A.A. three and four times weekly during a "dry" period). He replied that he was "more honest" and for the "first time" like himself.

Respondents in case 3, indicated that the counselling helped them "learn how to share feelings as a family." The wife indicated that they had put all the onus on the husband. She also indicated feeling "more confident about herself and appreciative of her family." The husband indicated that now "instead of talking about him" to the two daughters, "his wife talks to him." (The author sees clear evidence of the attainment of restructuring goals in this statement).

The foregoing illustrations show the kinds of answers in response and the ways in which outcome data was gained.

A.A. or Al Anon Attendance

In many instances, directly related to the assessment of some families as insufficient in resources (structural insufficiency), also as "enmeshed" (turning in on themselves and showing rigid boundary around the system), the provision of resources such as A.A. and Al Anon, as well as other supports (church groups, etc.), was a goal of intervention.

In this respect, a change related to use of support groups is

seen as relevant outcome in this practicum, in that it indicates structural change related to a more permeable boundary.

In other instances, a reduction in A.A. attendance was also seen as a favourable outcome indicator. Several individuals were using A.A. as they had previously used drinking (as a stabilization of power in conflict and also as a means of avoiding conflict). In these instances the goal was to mark or clarify the family system boundary.

As well as using the questionnaire, evaluation of change was carried out in other ways as follows.

Ongoing Evaluation and Follow Up

Goals were regularly set and reviewed during the therapy process. In most instances, assessment detail about problems (frequency, etc.) enabled on going evaluation and measurement of change. The termination session included evaluation also.

In the vast majority of cases, follow up was undertaken by phone both shortly after the termination of therapy and also in later months. Because over a year was spent in work, follow up in several cases is long term, and provides indication of lasting change or no change in both symptom reduction and functioning ability.

In a few instances, the client was not available for follow up. These will be delineated in the following summary charts. Telephone

follow up in as many instances as possible was conducted with most or all family members, not just one. This was seen as necessary in order that one member's subjective assessment was not relied on.

Overview of Practicum Work

The following section provides an overview of the nineteen cases seen in the practicum. The charts indicate the cases by number, family composition, number of sessions, symptoms and status (wet, dry), at outset and at termination. Follow up data is included and information about use of support groups both pre and post therapy. The final column indicates outcome information related to goals and lifestyle changes and gives an outline of the major techniques used. Discussion of these cases and some analysis is provided in the section on evaluation which follows these charts.

CASE 1

FAMILY COMPOSITION: AGES - STATUS
Couple; mid-20's; childless; separated at outset.

UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:
Couple - 10
Individual - 2
Total: 12

SYMPTOM & STATUS AT OUTSET AND TREATMENT DETAIL:
Alcoholic - newly dry - in individual treatment.
Spouse - fear, refusing to live with husband.
Violence: including threats with loaded gun. Suicide Attempts: alcoholic.
Frequent Arguments: 3 - 7 times weekly. Irresponsible Spending - both.

POST THERAPY (TERMINATION):
Dry (Alcoholic). Fear reduced (spouse) and marriage resumed. Violence eliminated. Suicide threats eliminated. Arguments reduced in frequency and severity. Budget followed.

AT FOLLOW UP AND LENGTH OF FOLLOW UP:
Dry - one year. Marriage on-going - one year. All other patterns and changes stable one year later.

SUPPORT GROUP -
Pre:
A.A. attended during therapy.
Al Anon not attended.

Post:
A.A. very infrequently.
Occasional Al Anon.

COMMENT: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGES:

Major goals were: 1) to resolve issues of unfinished business and enable a mutual decision concerning relationship;
2) eliminate symptoms as noted.

Structural goals were: 1) enable increased self-differentiation (clarify individual boundaries;
2) decrease enmeshment;
3) build spouse subsystem boundary.

Major techniques were: joining, I message (modelling), tracking, resource provision, reframing, structuralization, de-emphasizing the symptom and symptom focusing.

Lifestyle: stable; plan family; improved extended family relationships.

FAMILY COMPOSITION: AGES - STATUS

Family of four; couple mid-thirty's; both previously married; two children.

UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:

Couple - 4
Total - 4.

SYMPTOM & STATUS AT OUTSET AND TREATMENT DETAIL:

Alcoholic - drinking.
Alcoholic and spouse - depression. Alcoholic suicide ideation. Spouse anxiety.
Ceased attending Al Anon related to this.

POST THERAPY (TERMINATION):

Cessation of drinking.
Reduction in anxiety and depression/elimination of suicidal ideation.

AT FOLLOW UP AND LENGTH OF FOLLOW UP:

Stable, dry - one year. Changes maintained - one year.

SUPPORT GROUP - Pre:

A.A. stopped.
Al Anon stopped.

Post:

A.A. attended.
Al Anon attended.

COMMENT: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGES:

Major goals were:
1) eliminate drinking;
2) eliminate depression and anxiety;
3) resolve unfinished business related to an extra-marital affair;
4) enable resumption of use of support network.

Structured goals were:
1) clarify individual boundaries and lessen enmeshment;
2) clarify spouse subsystem boundary (father underinvolved).

Lifestyle: Couple report improved communication, more time spent together. Father more involved in parenting areas - more responsible. Improved family life and activities including father and children.
Family Treatment (restructuring) was only form of treatment. Al Anon and A.A. were resumed at termination.

CASE 3

FAMILY COMPOSITION: AGES - STATUS:	Couple (age 50's); two children ages 20 and 17.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Nuclear family of four - 2. Total: 2.
SYMPTOM & STATUS AT OUTSET AND TREATMENT DETAIL:	Father drinking excessively three times weekly. Mother highly anxious. Frequent (two times weekly) quarrelling between spouses. Father depressed. Daughters unhappy, crying frequently.
POST THERAPY (TERMINATION):	Drinking - ceased. Mother reports less anxious and nagging less - father confirms. Less quarrelling - two times monthly. Daughter's symptoms are alleviated. They are no longer involved in the parent's relationship issues.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Two episodes of excessive drinking in one year. Data confirmed by daughters. Other changes sustained.
SUPPORT GROUP - Pre:	Some A.A. No Al Anon.
Post:	No A.A. Minimal Al Anon.
COMMENT: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: 1) to reduce excessive drinking related to stress; 2) to resolve losses. Focus of work was on methods of dealing with stress and on family rules and roles. Structural goals were: 1) to increase permeability of extra family boundary, to clarify spouse subsystem boundary and lessen triangulation and inter-generational coalition; 2) to decrease isolation of father and to increase flexibility of the system manifest in rigid rates and rules; 3) to increase individuation and self-differentiation of siblings. Comment: the symptomatic behaviour was reduced. Daughter's symptoms are completely alleviated. Mother's are somewhat reduced. Fighting has decreased and is no longer seen as problematic.

CASE 4

FAMILY COMPOSITION: AGES - STATUS:	Individual aged 43 (absent family system consisted of spouse and four children).
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Individual - 8. Total: 8.
SYMPTOM & STATUS AT OUTSET AND TREATMENT DETAIL:	Newly dry - in treatment. Depressed; unable to undertake job search. Pre-occupied with past concerning separation.
POST THERAPY (TERMINATION):	Remained dry for a total of 8 months. Resumed drinking for three months. Undertook more treatment, then resumed drinking again.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	One year - termination has not taken place.
SUPPORT GROUP - Pre:	Some A.A.
Post:	Some A.A.
COMMENT: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goal was: 1) to enable system to stay dry, resolve loss of family and develop satisfying life. Structural goal was: 1) to clarify individual boundary and increase self-differentiation; 2) to increase structural sufficiency through network. Major techniques were: reframing, joining, tasks, resource provision, symptom focusing, relabelling, modelling "I" behaviour and provision of supports. Outcome: not officially terminated. Client dry for eight months then began drinking.

CASE 5

FAMILY COMPOSITION: AGES - STATUS:	Couple married with two pre-school children. Ages 30's and mid-20's. Husband previously married. Separated at outset.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 7. Children included in two sessions. Total: 7.
SYMPTON & STATUS AT OUTSET AND TREATMENT DETAIL:	Alcoholic - abstaining from alcohol, but using marijuana daily. Spouse - frequent (daily) headaches. Excessive use of coedene. Fighting with violence 2 - 5 times weekly. Financial problems.
POST THERAPY (TERMINATION):	Abstaining, still using marijuana; reduction to once per week - weekend only. Headaches and abuse of medication eliminated. Fighting, constant violence eliminated.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Same as at follow up after eight months.
SUPPORT GROUP - Pre:	No A.A. Church - spouse.
Post:	No A.A. Church - spouse. Attended two times - Families Anonymous.
COMMENT: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: reduce fighting symptoms as noted. Structural goals were: 1) increase self-differentiation and lessen enmeshment; 2) to increase structural sufficiency. Major techniques: joining, relabelling, symptom re-focusing, tracking, structuralization and tasks. Comment: Couple have decided to remain separated. Spouse is symptom-free. Husband's symptoms are reduced. He is attending a course and providing increased financial and emotional support.

CASE 6

FAMILY COMPOSITION: AGES - STATUS:	Mother (50's). Three daughters - one adolescent, two adult, one grandchild.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Whole family - 2 Mother (alcoholic) only - 4. Total: 6.
SYMPTOM & STATUS AT OUTSET AND TREATMENT DETAILS:	Alcoholic - newly dry in treatment. Family - frequent conflict re: drinking and A.A. (opposed).
POST THERAPY (TERMINATION):	Remained abstinent.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	One year - abstinent.
SUPPORT GROUP -	
Pre:	No A.A. No Al Anon.
Post:	Frequent A.A. No Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: to assist alcoholic to remain abstinent. Structural goals were: to clarify boundary between mother and daughters and increase autonomy of mother. Major techniques used: joining with mother, re-enactment; role playing; provision of resources; coaching; tasks and directives. Comment: major goal achieved. Mother is dry and attends A.A. Is more independent in lifestyle thus, less enmeshed.

FAMILY COMPOSITION AGES - STATUS:	Couple, early 20's, three children in care.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 4. Total: 4.
SYMPTOM & STATUS AT OUTSET AND TREATMENT DETAILS:	Both drinking excessively despite individual treatment programs. Violence in relationship when drinking.
POST THERAPY (TERMINATION):	Drinking - continued. Violence - continued.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Unknown.
SUPPORT GROUP - Pre:	Some A.A.
Post:	Unknown.

COMMENTS: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:

Major goals were: 1) abstinance from alcohol - both parties;
2) eliminate violence in relationship.

Structural goals were: 1) lessen enmeshment and increase self-differentiation;
2) lessen fusion.

Comment: despite joining maneuvres, there was not definite agreement reached as to goals. Couple were (both) ambivalent about ceasing drinking. Sessions were terminated and shortly afterwards she sought refuge from battering. Children remained in care. No long term follow up.

CASE 8

FAMILY COMPOSITION AGES - STATUS:	Couple, two pre-school children. Early 30's. Both previously married. Separated after one session.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 2. Individual - 3 Individual - 3. Total: 8.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Alcoholism - both spouses dry for approximately eight months. Daily excessive conflict.
POST THERAPY (TERMINATION):	Remained dry. Conflict lessened.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Remained dry nine months after termination. Co-operation on major issues.
SUPPORT GROUP - Pre:	A.A. No Al Anon.
Post:	A.A. No Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES OR STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: 1) original goal was to reduce marital conflict; renegotiated to assist in separating re: parenting and financial arrangements. Structural goals were: to assist in disassembling system and increase individual autonomy. Techniques: Tasks, joining, resource provision, relabelling, emphasizing difference, constructing patterns. Comment: Couple have separated to their satisfaction. They ceased attending the same A.A. group and developed separate networks. They have opened new channels with respect to parenting and financial issues.

CASE 9

FAMILY COMPOSITION AGES - STATUS:	Couple, early 40's. Two adolescent children.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Whole family - 1. Couple - 1. Spouse (telephone only) - 2. Total: 4.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Husband - drinking excessively several times per week. Wife - depressed, frequently ill; tired; withdrawn.
POST THERAPY (TERMINATION):	
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	
SUPPORT GROUP - Pre:	No A.A. No Al Anon.
Post:	Some Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGES:	Major goal was: to convert to dry system and restructure. Structural goal was: to disengage family. Comment: This case is still in progress. Wife has not yet been disengaged and work is seen as long term.

CASE 10

FAMILY COMPOSITION AGES - STATUS:	Couple, early 30's. Separated, two children. Husband recently released from jail/paroled to half-way house.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 4. Total: 4.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Husband - excessive drinking 3 - 6 times weekly. Took treatment and aftercare. Spouse - depression. Conflict excessive in relationship.
POST THERAPY (TERMINATION):	No change apart from brief reduction in consumption.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Weekend drinking only, after a further jail sentence. Some reduction in conflict.
SUPPORT GROUP - Pre:	Some A.A. No Al Anon.
Post:	Some A.A. No Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGES:	Major goal was: to reduce conflict in the relationship. There was no agreement about ceasing consumption. Focus: to enable couple to see relationship between drinking and conflict and re-negotiate goal to include drinking (abstention). Major techniques used: joining and tasks. Some re-arranging of patterns was used and modelling of "I" behaviour, as well as emphasizing differences and blocking. Comment: Termination was chosen related to the issue of non-agreement about drinking behaviour.

FAMILY COMPOSITION AGES - STATUS:	Couple (30's) with two pre-school children. Second marriage of husband.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 8. Total: 8.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Husband - excessive binge drinking. Wife - anxiety. Marital conflict related to drinking.
POST THERAPY (TERMINATION):	Little change. Wife less anxious. Conflict reduced.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	
SUPPORT GROUP - Pre:	No A.A. No Al Anon.
Post:	No A.A. Some Al Anon plus group sessions for spouses.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goal was: to assist in resolving marital conflict and related binge drinking. Structural goal was: detachment goal. Major techniques used: joining, tracking, relabelling, support provision, emphasizing the symptom tasks. Comment: Termination was negotiated. Wife was reluctant to try Al Anon and was told that no progress could be made without that.

CASE 12

FAMILY COMPOSITION AGES - STATUS:	Couple (separated), late 20's with three children.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 2. Total: 2.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Alcoholism - active drinking despite treatment. Marital breakdown.
POST THERAPY (TERMINATION):	Drinking - continued. Wife is pursuing her own life and has custody of the children.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	
SUPPORT GROUP - Pre:	Some A.A. Some Al Anon.
Post:	No A.A. More Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: the request was for counselling to resume the marriage. No agreement for work was reached in two exploratory situations. Husband refused to consider ceasing drinking even during treatment. Wife refused to consider reconciling without this. This was labelled a mutual decision not to work together to resume the relationship. Wife was supported in pursuit of independent life.

FAMILY COMPOSITION AGES - STATUS:	Single mother. Four teenagers. Alcoholic boyfriend.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Mother and teenagers - 5. Total: 5.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Mother - drinking. Irresponsible spending related to drinking of both mother and boyfriend. Lack of co-operation on part of children re: household tasks. No control over children - on mother's part. 15-year old isolated and threatened to leave.
POST THERAPY (TERMINATION):	Mother - abstaining completely. Children - co-operating in work. Mother - ceased funding boyfriend's habit. New rules for visitors were developed. 15-year old felt included and decided to stay with family. Mother - obtained employment.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Abstaining after six months.
SUPPORT GROUP - Pre:	No A.A.
Post:	A.A. regularly.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: 1) assist mother to abstain; 2) increase co-operation and sharing of tasks; 3) decrease number of "visitors" in the household; 4) assist 15-year old to "belong" to family; 5) increase financial management and stability; Structural goals were: related to assessment of under-organized system, lack of hierarchy, diffuse boundary of nuclear family system. Major techniques used: joining, re-labelling, choreography, enactment, restructuring. Focus on work was on outer system boundary through rule definition and role classification. This was related to a change in the cultural context (from rural reserve to Urban) and development of new rules.

FAMILY COMPOSITION AGES - STATUS:	Parents (40's) and two children, ages 16 and 14.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Whole family - 5. Total: 5.
SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:	Father - excessive drinking. Family breakdown (daughter left home). Excessive conflict between mother and daughter. Son - withdrawn at home. Son - stealing money from other family members.
POST THERAPY (TERMINATION):	Drinking - reduced. Family - reunited. Conflict slightly reduced. Son - less withdrawn; stealing stopped.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Reduction in drinking sustained. Family remain reunited. Conflict somewhat reduced.
SUPPORT GROUP - Pre:	Nil.
Post:	Nil.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGES:	Major goals were: to assist family to reunify and for father to stop drinking. Structural goals were: to clarify inter-generational boundary; lessen triangulation pattern. Major techniques used: structuralization, choreography, tasks (given to spouse (parent) subsystems and sibling subsystems, joining. Focus: was on parent-child issues primarily - work on negotiating allowance, rules for discipline, desensitization of issue of drinking, father and son involvement was increased. Lifestyle: spouse subsystem have developed a different social group which de-emphasizes drinking.

FAMILY COMPOSITION AGES - STATUS: Couple (early 30's) with one child.

UNIT SEEN IN THERAPY & NUMBER OF SESSIONS: Couple - 10.
Total: 10.

SYMPTOM STATUS AT OUTSET AND TREATMENT DETAILS:
Husband - dry for four months at outset.
Extreme conflict twice weekly.
Little involvement apart from fighting.
Sexual problems. Violence. Child being triangled.
Wife - obesity and temper.

POST THERAPY (TERMINATION):
Husband - remained dry.
Conflict reduced to approximately twice monthly.
Couple now doing things together and enjoying.
Sexual improvement. Violence ceased. Less triangulation.
Wife joined weight program.

AT FOLLOW UP AND LENGTH OF FOLLOW UP: All improvement sustained at three months after termination.

SUPPORT GROUP -
Pre: A.A. three times weekly.
Al Anon.

Post: A.A. (less)
Al Anon.

COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:
Major goals were: 1) included all symptoms as listed during the process, with new goals being added;
Major techniques used: joining, "I" messages, re-enactment and prescribing the symptom were used, tasks were given.

Comments: A.A. was being used to avoid involvement in family life. Couple were triangled re: A.A. (in place of drinking). Individual boundaries were initial focus - then spouse subsystem boundary.
Lifestyle: Changes were major re: mutual pursuits and motivation to address weight loss on the wife's part.

FAMILY COMPOSITION AGES - STATUS:	Couple (30's); childless; husband previously married.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 9. Total: 9.
SYMPTOM STATUS AT OUTSET & TREATMENT DETAILS:	Both spouses newly dry and in treatment. Conflict and occasional object directed violence, 2-4 times weekly. Some uncertainty about continuing marriage.
POST THERAPY (TERMINATION):	Dry - no resumption of drinking. Conflict substantially reduced in frequency and severity. Decision to stay married.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Dry - two months later. Changes sustained. Co-operation has continued to improve.
SUPPORT GROUP - Pre:	A.A. (both. No Al Anon.
Post:	A.A. (both). No Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES AND STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goal was: to learn to live together sober and manage conflict (reduction of fights). Structural goals were: 1) related to assessment of fusion manifest in extreme triangulation patterns in A.A.; 2) aftercare; 3) extended family context; 4) to assist in self-differentiation and system development (boundary). Major techniques used: structuralization,"I" behaviours modelled and stimulated mapping; and genograms related to system boundary clarification; re-enactment; joining; and tasks (homework). Outcomes: favourable as noted

FAMILY COMPOSITION AGES - STATUS:	Father and daughter (age 14).
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Father and daughter - 3. Total: 3.
SYMPTOM STATUS AT OUTSET & TREATMENT DETAILS:	Conflict between father and daughter. Father - depression.
POST THERAPY (TERMINATION):	Conflict reduced. Depression remained the same.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Unknown (father re-located).
SUPPORT GROUP - Pre:	
Post:	
COMMENTS: GOALS: MAJOR TECHNIQUES & STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: 1) co-operation in household tasks; 2) lessen depression. This system required boundary work related to recent separation of spouses of family. Focus of work was on rules and management of household and on assisting family to work out areas of autonomy and areas of co-operation. Techniques used: joining; exaggerating the symptom; structuralization; enactment; tracking; "I" behaviour modelled. Conflict was reduced and a task system devised. No long term follow up.

FAMILY COMPOSITION AGES - STATUS:	Parents (40's) and two children ages 9 and 12 - in temporary guardianship.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Parents - 6. Parents, children and C.A.S. worker - 1. Total: 7.
SYMPTOM STATUS AT OUTSET & TREATMENT DETAILS:	Both parents - drinking excessively. Children - apprehended. Wife - extremely suspicious and jealous. Sexual difficulty - wife dissatisfied. Marital conflict.
POST THERAPY (TERMINATION):	Drinking - stopped.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Dry - both. Stable in short term (2 months).
SUPPORT GROUP - Pre:	Nil.
Post:	Nil.
COMMENTS: GOALS: MAJOR TECHNIQUES & STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: 1) resolve issue of drinking; 2) assist couple to resolve conflict without alcohol. Structural goals were: 1) couple assessed as enmeshed; 2) system under-organized - lack of hierarchy; 3) mother over-involved with children fluctuating with father over-involved. Techniques used: joining; resource provision; education; "I" messages used; enactment; structuralization tasks. Outcome: A.A. explored and rejected. Couple have developed some social life excluding alcohol. Work on parenting is continuing.

FAMILY COMPOSITION AGES - STATUS:	Couple (50's) and daughter aged 19. Wife previously married.
UNIT SEEN IN THERAPY & NUMBER OF SESSIONS:	Couple - 5. Couple and daughter - 3. Total: 8.
SYMPTOM STATUS AT OUTSET & TREATMENT DETAILS:	Both - drinking excessively. Wife - abusing pills also. Extreme conflict in all possible ways and combinations. Two suicide attempts on part of mother - ending in intensive care - one prior to work; one during work. Sexual problems.
POST THERAPY (TERMINATION):	Wife has ceased drinking. Has taken treatment.
AT FOLLOW UP AND LENGTH OF FOLLOW UP:	Case is ongoing and work in progress.
SUPPORT GROUP - Pre:	Nil.
Post:	Wife - A.A. and Al Anon.
COMMENTS: GOALS: MAJOR TECHNIQUES & STRATEGIES: SIGNIFICANT LIFESTYLE CHANGE:	Major goals were: 1) wife assisted in cessation of drinking; 2) conflict reduction. Structural goals were: 1) lessen enmeshement; 2) assessment of fusion and triangulation; 3) mother-daughter coalition; 4) spouse subsystem boundary has been focus of work; 5) individual work with mother re: symptoms. No contract with father, but work is ongoing. Daughter is de-triangled. Major techniques used: use of crisis; joining; structuralization; tasks; prescribing the symptoms (fighting); "I" behaviour; modelling. Comment: work partially completed and further work contracted for.

Analysis of Cases and Outcomes

As noted in Chapter V, (Description of Cases), the cases can be classified as "wet", "newly dry" and "longer term dry" at the outset of family treatment. With reference to the charts provided as an overview of practicum work, the following is a breakdown by category of the nineteen cases:

11 cases began as "wet system" (2,3, 7, 9, 10,11,12,13,14,18 and 19)

5 cases began as "newly dry" (1,4,6,15 and 16)

2 cases began as "longer term dry" (8,17).

Case 5 is an exception as drug abuse was involved.

Cases Classed as "still in progress" are cases 4, 9, and 19. In case 4, the individual has requested detoxication, in case 9, one spouse is now "dry" and "off pills". The other spouse is still drinking. The "dry" spouse is beginning Al Anon and A.A.. The goal is to disengage her.

Because work is not complete in these cases, no further comment can be made concerning outcome.

Outcomes in Remaining Sixteen Cases: in the remaining cases, outcomes can be roughly categorized from "most favourable" to "least favourable" (ie: no change or deterioration).

Most Favourable Outcomes are evident in cases 1, 2, 13, 15 and 16.

Favourable Outcomes are evident in cases 3, 6, 8, 14, 17, and 18.

Little Change is evident in case 5.

No Change or Deterioration is evident in cases 7, 10, 11 and 12.

Of sixteen cases, "favourable outcomes" are evident in eleven instances (combining the first two categories) and "unfavourable outcomes" are evident in five cases. The following section will provide a summary related to these categories of outcome.

Summary and Discussion of Outcomes by Category

MOST FAVOURABLE cases are those in which:

- all goals are met as per therapist-client contract
- symptomatic behaviour is eliminated or reduced to non-problematic level
- evidence is provided of significant improvement in functioning, reflecting more structural adequacy.

In case 1, the alcoholic has remained sober. The couple have sustained a stable marriage and plan their future to include children. Follow up of one year.

In case 2, family life has improved qualitatively. The previously uninvolved father is sober now and involved in family life. He still attends A.A., but more moderately than before. The family do things together for the first time; a change they view as

positive and with which the author concurs.

In case 13, the household is running co-operatively. The mother, who has remained sober, has found employment. The son (age 15) now feels part of the family and has remained at home. Work with this family was undertaken in the home.

In case 15, the couple who previously fought a great deal and did little together, recently took a holiday hiring a babysitter to do so. The child had been triangled by the parents. The spouse subsystem is viewed by both partners as improved and conflict reduced. Parents can now co-operate regarding the child. The husband has moderated his A.A. attendance. This was a goal in therapy.

In Case 16, both adults have remained dry and plan to stay together. They were uncertain about their relationship at the outset of therapy. Fighting is no longer a problem.

FAVOURABLE OUTCOME cases are those that also show cessation of or reduction in, symptomatic behaviour, attainment of goals and positive changes in living; but represent situations about which the author has some reservations or questions in terms of outcome.

Case 3 was assessed as "drinking as a symptom of system stress". Drinking has been reduced from two to three times per week at a problematic level and accompanied by marital conflict to two incidents in the past year of follow up. In the author's opinion, longer term follow

up would be more conclusive concerning the drinking. Marital conflict is now not seen as problematic according to all family members. The daughters are pursuing more independent lifestyles. Termination in this case was seen as premature. The family were required to care for two elderly and ill relatives and this was a factor in termination. Impotence, not part of the contract, is resolved.

Case 6 is seen as "qualified" in that the author saw many unresolved family issues which were not contracted around. The mother has sustained abstinance and remains detached from the daughters. The choice was made to "join" with the mother in therapy. The author was unable to sufficiently engage the rest of the family and to reduce scapegoating.

Case 8 involved an original request for marital counselling followed by a decision to separate. The resolution was a satisfactory separation. This was the re-negotiated goal.

Case 14 was assessed by the author and a "co-therapist", as an "alcoholic system in denial". The request was to reunite the family. To gain leverage and support the executive subsystem, their concerns were dealt with and the family reunified. The issue of drinking was related to the family problems in an effort to break through the denial. The alcoholic moderated his drinking and has continued to remain moderate. Longer term follow up would be more conclusive.

Stealing on the part of the son was stopped and mother-daughter conflict reduced. Couple changed social networks to moderate and non-drinking persons. Couple system boundary was strengthened and husband engaged in family more.

Case 17. A goal of increase co-operation in household tasks was achieved. Little re-structuring took place. Work was short term. The issue of the recent separation of the spouses was not addressed in therapy.

Case 18 was one in which both spouses achieved a cessation of drinking which has been sustained in the short term (six months). They were resistant to A.A. Long term follow up would be necessary to provide meaningful outcome comment. Positive change in social network and activities took place and this had been the context of the drinking. Differentiation was the structural goal.

LITTLE CHANGE or DETERIORATION includes cases 5, 7, 10, 11 and 12.

In case 5, the wife's symptoms (headaches and coedene abuse) were eliminated. However, the husband's abuse of marijuana, though reduced from weekly to once per weekend), still continued. This couple maintained separation with frequent contact, thus, no major lifestyle changes indicative of re-structuring took place.

In Case 7, neither spouse would consider a temporary cessation of drinking, despite attendance in treatment. Shortly after termination, the wife left.

In Case 10, the husband has reduced his drinking, but has been back in jail in the interim between termination and follow up. This couple have expressed an interest in further counselling.

In Case 11, binge drinking has continued. The wife showed some evidence of increased detachment, as she attended an educational group about alcoholism.

Case 12. In this situation, after a request for marital counselling, the husband, who was continuing to drink became involved in an extra-marital affair. Termination with this couple was unofficial as he dropped out of sessions after attending twice. Support was given to the wife, as she pursued legal separation and an independent lifestyle.

Other Relationships

Relationship of Outcome to Status (wet-dry) at Outset:

Of the eleven cases with favourable outcomes, five began as wet systems, four were "newly dry" and two had been "dry" for six months or more.

Of the five cases of less favourable outcomes, four were still "wet" systems at the beginning of treatment and the fifth situation also involved active abuse (marijuana and coedene).

A.A. Factor: Favourable Outcomes:

In one of the eleven "favourable outcome" cases, the A.A. factor

is not relevant as alcohol abuse was not a current problem. Of the remaining ten cases, A.A. was begun concurrently with, or initiated during, family therapy in five instances. A.A. was resumed at termination in one other case, and was being used prior to therapy in two other cases. Thus, in eight cases of ten (where A.A. applied), A.A. and family therapy combined to show favourable outcomes.

In two cases of these eight, A.A. was not continued to any extent after termination (cases 1 and 3), yet outcomes were favourable after a one-year follow up.

In four cases, A.A. and family therapy constituted the total treatment package with favourable outcomes (cases 2, 3, 13 and 15). Of these four, three began as wet systems (cases 2, 3 and 13).

A.A. Factor: Unfavourable Outcomes"

In four of the five cases of no treatment success, the client also had some A.A. exposure. In one other, he did not; and although this would have been desirable, the author was not able to stimulate this.

Other Treatments, A.A. and Family Therapy: Favourable Outcomes:

In five cases of ten (where drinking was a symptom), A.A., A.F.M. group therapy for the alcoholic, and family therapy were combined and outcomes were favourable. Several of this group also had one or more sessions with the Clinical Psychologist.

Other Treatments: Unfavourable Outcomes:

In three of five cases of unfavourable outcome, A.F.M., A.A. and family work were combined.

Al Anon Use: Favourable Outcomes:

Al Anon was also a significant factor in treatment in two cases where it was initiated as part of therapy and resumed in a third instance. In a fourth case, it was being used both prior to and after therapy. The author saw Al Anon as a possible resource in two additional cases, but was unable to stimulate client involvement. Al Anon has been started in two of the incompleted cases as well, and the author sees this as a positive indication of beginning detachment.

Al Anon: Unfavourable Outcomes:

In one of five cases minimal exposure to Al Anon took place and in one additional case, Al Anon was used regularly by the client.

Summary Comments

In the foregoing section, the author has attempted to give an over-view of the practicum cases and delineate some of the treatment combinations that were used. The intention was not to compare treatment combinations, but simply to show the combinations.

From this breakdown, A.A. can be seen as a common factor in the majority of cases of successful resolution despite the fact that

in some instances, it was not continued after treatment.

A.A. can also be seen as a common factor in the majority of cases of unsuccessful resolution.

In at least two instances, one of the author's goals was to reduce the extent of A.A. involvement as it was being used to avoid family involvement. In the vast majority, however, a goal was to begin or increase use of A.A.. The willingness of clients to try A.A. and Al Anon was a significant indicator of flexibility of the system.

In those cases where clients were reluctant, they were generally assessed as less differentiated and more rigidly organized or triangulated around alcoholism.

It is also notable that the cases of poor outcomes all involved dealing with a wet or abusing system at the outset. These cases were chronic in terms of years abusing and rigid patterns. In two of these instances, both executive members were actively abusing. These cases which present a high degree of difficulty were referred early in the practicum period. In three instances, the referral followed individual group therapy treatment which had been unsuccessful in that abuse had been sustained during treatment. The author sees therapist inexperience and degree of difficulty as significant factors in these poor outcomes. The necessary leverage to convert these systems to a dry state was never gained.

With respect to objective three of this practicum, family therapy can be seen as effective in combination with traditional treatment and/or A.A. and Al Anon. Eleven of a possible sixteen

cases showed positive outcomes. In the three additional situations in which treatment is seen as not complete, family members were engaged and work was underway.

The treatment combination was successful in nearly equal numbers of "wet" and "newly dry" presenting situations and was applicable to "two situations where the alcoholic had been dry for over six months at the outset of treatment. The author notes that in four instances of favourable outcomes, no individual treatment for the alcoholic was used apart from attendance at A.A.

Conclusions

As the final chapter illustrates, the period of over a year spent in work with alcoholic families was both challenging and rewarding. In this, the closing section, the author makes broad observations based on the knowledge gained and the practicum experience and also makes critical comments related to the experience and literature.

At a conceptual level, the challenge was in being able to integrate the two models, so that each could be drawn from in practice from an integrated framework. The author concludes that this approach was effective and that each model has some merit related to the clinical situation at hand.

At the outset, it was postulated that family therapy had the capacity to add breadth to alcoholism treatment. Authors were cited

in Chapter I who stressed the need for this, particularly as related to early alcoholism. The viewing of some alcoholism as a symptom of system stress and the approach to treatment derived from this assessment do provide increased breadth. In the practicum case of this type, the outcomes were favourable.

In other respects, breadth is increased using a family systems approach. The range of options or points of potential intervention increase when the family is seen as the client. Intervening with the alcoholic is not the only option.

In Chapter I, it was noted that traditional treatments entail rigid categorization of persons as either "alcoholic" or "not alcoholic". The discussion of alcoholism conceptually and in terms of existing knowledge (Chapter I) shows that this practice is questionable theoretically and results also in unitary forms of treatment which are applied with little allowance for individual variation.

The author notes that to an extent family therapy practice replicates this pattern of categorization in seeing some alcoholism as a symptom of stress and some as "alcoholic family system" type. Although the approach differs in that assessment is based on interactive system features, the categorizations are made. Instead of the individual being seen as "alcoholic", the family system is seen as "alcoholic". In both approaches, the label is used and both entail seeing drinking as a primary issue. Both approaches assume that

meaningful change cannot take place until the drinking is stopped.

The family therapy approach does stress that this categorization is not rigid and that some cases present as a mix. The approach also leaves the option of re-negotiating.

A practice issue emerges around a point noted by Rossi (1978) who suggests that the traditional response to intoxicated behaviour is to assume that beneficially theraputic work cannot proceed during an intoxicated state. It was noted in Chapter III that most authors concur with that view, and some therapists refuse to work at all with a "wet" system. Rossi concludes that since family therapists prefer to work with directly observable behaviour, retrospective reports of intoxicated behaviour are often overlooked or not solicited. His concern is that abusive drinking rarely becomes the focus for theraputic interest. Certainly, Rossi's points are valid, particularly with reference to contexts other than alcoholism treatment agencies. It is not difficult to speculate that many instances of alcoholism go unaddressed in such situations. This is less likely in an alcoholism treatment agency because of the implicit message in seeking such specialized help.

Rossi's point raises a second practice difficulty. Family therapy assumes that the best way to understand the function of the symptom in the system is through direct observation of the system in its intoxicated state. The point is stressed that understanding the

function of the symptom is essential in developing an appropriate intervention. This means that direct observation of the intoxicated "state" is extremely important in assessment. This requirement entails practical difficulties including disruption to others in the setting. The confines of an experimental setting such as joint hospitalization of the couple (as used in the development of interactional models) permit direct observation. Home visits provide another means of observing the "sober" and "intoxicated" states. However, few therapists have the luxury of time and resources to permit these methods. Therefore, most therapists must rely on retrospective accounts of the drinking behaviour and related interaction. This was the case in the practicum.

Davis (1974) among others, has demonstrated that what is observed is radically different than what families predicted regarding the effects of intoxication on family interaction. Based on this, there is good reason to think that reliable retrospective accounts are impossible to obtain. This means that the therapist is working from assumptions which, without the opportunity for direct observation, are impossible to verify. In the author's experience, it is difficult to see the function of the drinking behaviour in its adaptive sense in many situations.

Without the benefit of direct observation of these different interactional states (intoxicated and sober), the author relied on Berenson (1976) and Steinglass (1977) to form hypothesis.

As noted in the analysis section, in four cases with good outcomes, the alcoholic was not involved in any individual treatment program apart from A.A. Three of the four began as wet systems. A conclusion drawn is that the effectiveness of family therapy as the only treatment modality combined with A.A. and Al Anon should be explored further. This could be done using a control group treated in the traditional manner with group therapy for the alcoholic. Both groups would share the A.A./Al Anon factor.

The author would be interested in a comparison of recividism rates in such a study. Theory suggests that family therapy would lower recividism in that it has the capacity to address resistance on the part of the family.

A second major area for further research would be the effectiveness of different types of family therapy in alcoholism treatment. This would entail careful delineation of process elements, so that process could be related to outcomes.

As a third area for research, the author suggests long term study of cases in which the alcoholism is assessed as a symptom of system's stress or crisis. (The reader notes the author's reservations with regard to two cases of moderated drinking, one of which was assessed as a "stress symptom" alcoholism.) In these cases, the qualification or reservation of the author was related to follow up time and one year or less in the author's view is inadequate.

In closing, the author stresses two additional points made by other writers and reinforced through her own experience. The first is that knowledge of alcoholism and family therapy is necessary to work effectively with alcoholic families. The author found the literature on alcoholism in families to be more useful than the more general family therapy literature. The latter tended to emphasize cases with symptomatic children. Knowledge of the denial phenomenon is essential in working with alcoholism. Without that awareness, the practitioner would be handicapped and in many instances, would be trapped into joining with the system in denial and thereby maintaining the alcoholism itself.

A second point is that A.A. and Al Anon are valuable resources to utilize in practice. Alcoholic families can be "exhausting" to work with. The level of anxiety in alcoholic systems is very high, and much of that anxiety is present in sessions. These self-help resources provide a channel to "disperse" some of the anxiety and correspondingly reduce the "drain" on the therapist.

The principles of these groups are compatible with family therapy, thus little conflict is involved. More importantly, the author saw many couples and families in which members had lost any sense of self in relation to "community". They reflected the stigma of alcoholism in their rigidly bounded systems. These groups for many provide a way of beginning to recover or develop a sense of

self in a "community" context. Thus, the author stresses the therapist role in assisting this linkage where it is needed.

On the other hand, it is not uncommon for these resources to be both misinterpreted and misused. This has been noted with respect to several cases in the practicum. Families were seen who had been "dry" for lengthy periods with no structural change. Thus, the patterns enacted were those of the "alcoholic family system". Instead of being triangled around alcohol use, the families were triangled around the issue of A.A. use.

The therapist's role in these instances is to assist the family to increase their functional ability so as to be able to use A.A. in a balanced manner that contributes to individual development and family life.

This example clearly shows the potential of an integrated approach to alcoholism treatment. Family therapy combined with A.A. or Al Anon provides the capacity to reconcile competing needs of the individual and the family system in a way that enhances healthy development of both. This allows families to survive without "depending" on alcoholism to do so.

APPENDIX I

Letter and Questionnaire

"APPENDIX I"

Letter and Questionnaire

ALCOHOLISM FOUNDATION OF MANITOBA

Dear

I am writing to persons, couples or families whom I have seen during the past year with this request for some feedback which I require in order to evaluate my work. You will note a code number in the left hand corner of the attached form. This is so that I can relate your name to your feedback, however, this information will not be used in any way (verbal or written) in which you could be identified.

I would appreciate it greatly if you would take the time to fill in the attached form - please use the back for any additional feedback and comments positive and/or negative.

In the case of couples or whole families, I would appreciate it if <u>each member would fill in their own response</u>.

I've enclosed a reply envelope.

Yours truly,

EVALUATION FORM

1. Reason for seeking counselling: (Please check one or more)

   - drinking excessively
   - difficulty remaining sober
   - communication problems
   - relationship breakdown
   - relationship conflict
   - family breakdown
   - depression
   - anxiety
   - feelings about self
   - relationship with children
   - other (please elaborate) _____

   _____

2. Who referred you or suggested counselling? _____

   _____

3. Approximate number of sessions attended (please circle)

   2 3 4 5 6 7 8 9 10 11 12 More:

4. Was there any improvement or deterioration in the areas you were having difficulty with?
   Please elaborate as specifically as you can: _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. Did you feel in general that you were being understood during the counselling? (Yes or no and please elaborate)

_____

_____

_____

6. Was any 'homework' assigned to you at any time during the counselling? ____yes ____no.
If YES, did you try to do it? ____yes ____no
Please elaborate, if NO: _____

_____

_____

_____

7. Were you in A.A., Alanon or another support group when you began the counselling? ____yes ____no

8. Have you subsequently begun participating in A.A., Alanon, or another support group? ____yes ____no

_____

_____

9. Would you seek counselling again in the future if you were experincing difficulty? ____yes ____no

10. Have you made or experienced any major changes in your lifestyle or relationship since the counselling ended? Please elaborate:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

11. Please indicate general satisfaction with the counselling:
Unsatisfactory---Somewhat Unsatisfied---Neutral---
Satisfied---Very Satisfied.
Check or circle one.

12. Have your feelings about or views of yourself changed in any way (positive or negative)
Please specify: _____

_____

_____

_____

_____

_____

13. Would you recommend counselling of this type to a friend or relative? ____yes ____no

Please use remaining space for any additional feedback, comments, ecetera, if you wish.

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