

ALCOHOLISM AND FAMILY STRUCTURE

by

Rona Preli

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APPROVED:

Howard O. Protinsky, Chair

Gloria W. Bird

James F. Keller

Lawrence H. Cross

Michael J. Sporakowski

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Under the Direction of Dr. Howard Protinsky

Department of Family And Child Development

ABSTRACT

The purpose of this research project was to explore the structural variables of hierarchical reversals, cross generational coalitions, cohesion, and adaptability as they were manifested in families with an alcoholic member, families with a recovered member, and non-alcoholic families. One hundred and twenty-five families responded to written questionnaires including The Family Adaptability and Cohesion Evaluation Scales (FACES III), the Madanes Family Hierarchy Test (MFHT), and a Demographic Questionnaire. Adult participants also completed the Michigan Alcoholism Screening Test (MAST) to ensure that control families had no potentially alcoholic members, as well as ensuring that recovered families had no actively addicted members. Information was obtained on age, ethnicity, educational attainment, employment status, family income, and the sex of participating children, to ensure that the three groups were demographically comparable. The statistical analyses confirmed structural family therapy theory and the current research on alcoholic families. The results further expanded

the understanding of the nature of coalitions and hierarchical reversals as they were manifested in these samples.

DEDICATION

**To my parents,
whose love and encouragement
have sustained me.**

**Their unending support
has made all of my dreams and
goals a reality.**

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CHAPTER I

Introduction

There is an abundance of non-empirically based literature that has explored the structural and systemic components of alcoholic families. Various authors have proposed that a variety of structural dysfunctions characterize families with an alcoholic member. Among the problems cited are a rigidity of boundaries and interactional patterns (Anderson & Henderson, 1983; Gorad, 1971; Moos & Moos, 1984; Steinglass, 1975), a lack of cohesiveness of the marital dyad (Chafetz, Blau, & Hill, 1971; Gorad, 1971; Steinglass, 1975; Wilson & Orford, 1978) marital conflict (Moos, Bromet, Tsu, & Moos, 1979), cross generational alliances (Gilbert, Christensen, & Margolin, 1984), as well as inappropriate patterns of responsibility avoidance and concomitant responsibility taking in the family members (Gorad, 1971).

Theoretical writings in the field of family therapy have also hypothesized that certain structural variables characterize maladjusted families (Haley, 1976; Hoffman, 1976; Minuchin, 1974; Teyber, 1983). In particular, structural family therapy theory has emphasized the structural variables of: (1) adaptability, (2) cohesion, (3) cross generational coalitions, and (4) hierarchy formation (Haley, 1976; Minuchin, 1974; Olson, Sprenkle, & Russell, 1979) as being important to family functioning. This study examined these

four structural variables as they related to the alcoholic family.

The concept of adaptability refers to the family's ability to adapt and accomodate to new stimuli. Olson et al. (1979) defined adaptability as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress" (p.12). They proposed that family adaptability has four levels ranging from rigid (very low) to structured (low to moderate) to flexible (moderate to high) to chaotic (very high). When adaptability levels are low (rigid systems), families are unable to change. At the other extreme (chaotic systems), families change radically which similarly results in problems coping with stress (Olson et al., 1979; Russell, 1979). Therefore, as a family maintains rigid or chaotic response patterns, the dysfunction is proposed to become a stabilizing component to the operation of the system and growth is correspondingly hindered. The literature on alcoholic families has suggested that they tend to fall at either of the polar extremes of rigidity or chaos (Anderson & Henderson, 1983; Gorad, 1971; Moos & Moos, 1984; Olson, 1986; Steinglass, 1975).

Family cohesion is similarly believed to be an important variable in family functioning. Cohesion refers to the perceived amount of separatness or connectedness to the family. Olson et al. (1979) defined cohesion as "the emotional

bonding members have toward one another and the degree of individual autonomy a person experiences in the family system" (p.5). Minuchin (1974) labeled the polar extremes of family cohesion as "enmeshed" and "disengaged". Enmeshment functions to impede the expression of individual autonomy while disengagement prohibits interdependence, connectedness, and belonging. Olson et al. (1979) delineated four levels of family cohesion: disengaged (very low), separated (low to moderate), connected (moderate to high), and enmeshed (very high). The literature on alcoholic families has reported that boundaries in these families are characteristically disturbed. The literature has suggested a curvilinear relationship with dysfunction manifested by both enmeshment and disengagement (Anderson & Henderson, 1983; Ewing & Fox, 1968; Olson, 1986).

Litz, Cornelison, Fleck, and Terry (1957) suggested that in conflict ridden marriages, children are often forced to join with one or the other parent. Hoffman (1976) has similarly hypothesized that mother/ child alliances are a result of marital conflict and the concomitant dissatisfaction with the marital partner. Thus, the child is relied upon for emotional compensation and/or an increase in interpersonal power (Gilbert et al., 1984). These cross generational coalitions, the stable alliance of two family members against a third, are often manifested by the overly close alliance of a parent with a child while the other parent remains pe-

ripheral (Madanes, Dukes, & Harbin, 1980). A cross generational coalition necessarily results in placing the child in an undesirable position of power relative to the non-aligned spouse (Gilbert et al., 1984). Theoretically, dysfunctional families are believed to contain more cross generational coalitions than functional families. The literature on alcoholic families has similarly suggested that they evidence both cross generational alliances and coalitions (Anderson & Henderson, 1983; Grisham & Estes, 1982; Jacob, Favorin, Meisel, & Anderson, 1978).

A hierarchical reversal involves a transactional process among family members in which one parent or adult caretaker is in a lateral or inferior position to a child in terms of status and decision making power (Madanes et al., 1980). Hierarchical reversals or confused hierarchies are believed to characterize dysfunctional families (Haley, 1976). Haley proposed that coalitions occur across levels of hierarchy therefore coalitions and confused hierarchies must necessarily occur simultaneously. When a family repeatedly malfunctions because of hierarchical reversals and cross generational coalitions, the resultant ambiguity of who is in charge will exacerbate power struggles and eventuate in further pathology. Alcoholic families have been proposed to have unclear generational boundaries in which children are often enlisted into age inappropriate caretaking roles superior to the addicted adult (Anderson & Henderson, 1983).

Purpose

While both the family therapy theorists and the alcoholic family literature have stated that coalitions, hierarchy, cohesion, and adaptability are important, there has been a paucity of empirical research supporting these claims. How to measure coalitions given their proposed covert nature has been problematic. Previous studies have not explored whether some coalitions occur with more frequency than others (mother/child coalitions versus father/child), or if certain hierarchical arrangements are more prominent in alcoholic families than other arrangements. It is unknown whether men, women, and children in addicted families differ in their perceptions of family adaptability, family cohesion, or level of family satisfaction. Therefore the purpose of this exploratory study was to investigate the structural variables of adaptability, cohesion, hierarchical reversals, and cross generational coalitions as they were manifested in alcoholic families, families with a recovered alcoholic member, and nonalcoholic families.

Theoretical Rationale

This study was designed to explore the relationships between the family structural variables of adaptability, cohesion, cross generational coalitions, hierarchical reversals, and alcoholism in the family. Specifically, the theoretical framework for this study was structural family therapy theory (Haley, 1976; Madanes, 1981; Minuchin, 1974).

Minuchin (1974) described the stability in dysfunctional families as a rigid commitment to maintaining the status quo through repetitious transactional patterns. Change and growth are difficult for problem families as is accomodation to the individuals' needs for age appropriate autonomy. Olson et al. (1979) coined the term "adaptability" to refer to the ability of a family to change in response to situational and developmental stress. Families may range on the adaptability continuum from rigid to structured and flexible to chaotic. The polar extremes of rigid and chaotic are proposed to characterize dysfunctional family systems. In rigid families there is an inability to accomodate to needed change. In chaotic families, change is radical, unorganized, and unstructured. Families that are classified as structured and flexible, maintain a balance between morphostasis (system maintaining or stability) and morphogenesis (system altering or change). Balanced families are hypothesized to have a mutually assertive style of communication, egalitarian leadership, successful negotiation,

positive and negative feedback loops, role sharing, and rule making with less implicit rules and more explicit rules. Although the literature has theorized that alcoholic families are characteristically rigid or chaotic (Anderson & Henderson, 1983; Gorad, 1971; Moos & Moos, 1984; Steinglass, 1975), empirical validation has been limited. A study by Bonk (1984) failed to confirm that significant changes in adaptability occur in alcoholic families pre and post-treatment.

Boundary is a structural concept which refers to the family's rules for who participates in what interaction and how. In normal families, boundaries are proposed to be "clear" allowing each subsystem within a family to function autonomously yet with interdependence. In dysfunctional families, boundaries are rigid precluding interdependence, or too diffuse, precluding autonomy (Minuchin, 1974). Olson et al. (1979) defined the degree of emotional bonding and autonomy as "family cohesion". At one polar extreme of cohesion is enmeshment which is characterized by excessive closeness and restricted individual autonomy that prevents individuation of family members. At the opposite polar extreme of cohesion is disengagement which is distinguished by little attachment or commitment to the family. High levels of autonomy result in emotional, intellectual, and/or physical isolation from the family. In alcoholic families, boundaries are characteristically disturbed (Anderson &

Henderson, 1983). Hindeman (1976) proposed that alcoholic families maintain rigid external boundaries which isolate the system from society. The family's interpersonal boundaries, in contrast, are often enmeshed. The alcoholic is frequently disengaged and peripheral to the other family members by virtue of his/her incapacitation due to continual intoxication.

When stress in the marital subsystem is chronic as with alcoholism, a third party may be utilized to diffuse the conflicts (Bowen, 1974). This process has been referred to by Minuchin (1974) as detouring. The continuous triangulation of a third member to mediate, diffuse, or detour conflicts has been termed a stable coalition (Minuchin, 1974). Haley (1976) defined a coalition as "a process of joint action against a third person" (p. 109). Coalitions can occur across two generations where one person joins another against the other's peer. In three generational coalitions the person with the least and most power align against the person in the middle. Haley proposed that coalitions are pathological when they are chronic and part of a repeated interactional pattern. In alcoholic couples, interactional styles are often rigid, conflictual, negative, hostile, and irrational (Billings & Moos, 1983; Gorad, 1971; Jacob et al., 1978). The marital conflict and distance generated by the alcoholic's drinking behaviors as well as his inability to maintain a predictable, responsible role within the fam-

ily, may eventuate in a child attempting to fill the perceived void created by the alcoholism (Grisham & Estes, 1982; Jacob et al., 1978). Anderson and Henderson (1983) suggested that the nonalcoholic spouse often forms a cross-generational coalition with a child which succeeds in excluding and infantilizing the alcoholic. There has been however, a lack of research on the incidence of coalitions in alcoholic families. It has been unknown whether children align more frequently with the alcoholic parent or with the non-alcoholic parent. Similarly, it has been unknown whether the reported alliances in alcoholic families differ from the covert coalitions proposed to exist in dysfunctional families.

The alcoholic's inability to fulfill parental and spousal roles and the concomitant abdication of responsibility, frequently necessitates that others assume the burden. The process of chronically enlisting a child to perform adult roles is indicative of a hierarchical reversal. Generational lines are proposed to delineate different functions within a family (Haley, 1976; Minuchin & Fishman, 1981). For a family to function effectively, it must be clear what the rules are, who makes them, and who enforces them. Minuchin (1974) suggested that families are comprised of a power hierarchy in which parents have a different level of authority than do the children. Haley (1976) suggested that when status positions in a hierarchy are confused through the coalition across generational lines, relationships

will be ill defined, ambiguous, and conflictual. The ensuing struggle to clarify boundaries and gain control will become repetitious and chronic preventing change or resolution of the dysfunction. The literature on alcoholic families has lacked empirical research on the incidence of hierarchical reversals. It has been unknown whether certain hierarchical arrangements occur with more frequency than others. It is also unknown whether men, women, and children differ in their perceptions of their families' hierarchies, or whether the type of reversal identified differs from member to member.

Given the theoretical importance of cohesion, adaptability, cross generational coalitions, and hierarchical reversals to family functioning, it was assumed that families with an alcoholic member would differ on these characteristics from normal families. It was hypothesized that alcoholic family members would report more hierarchical reversals, more cross generational coalitions, and lower levels of family satisfaction indicative of poor family functioning. Alcoholic families were also expected to be categorized at the extremes of cohesion and adaptability more often than the recovered or nonalcoholic families.

Given the theoretical literature, it was also hypothesized that in families in which the alcoholic has been successfully treated and has maintained a period of sobriety, the incidence of structural pathology would decrease. Thus, recovered families were expected to have fewer cross

generational coalitions, hierarchical reversals, and extreme scores on cohesion and adaptability than families with an actively addicted member.

Some areas of this study have not previously been researched with alcoholic populations, components of the research were therefore exploratory in nature and investigated whether relationships between variables could be found. This study therefore posited the following research questions:

- (1) Is there a relationship between group membership (alcoholic, recovered, non-alcoholic) and the incidence of cross generational coalitions in families?
- (2) Are cross generational coalitions in families similarly identified using several instruments?
- (3) What types of cross generational coalitions do members of alcoholic, recovered, and non-alcoholic families identify?
- (4) Is there a relationship between group membership (alcoholic, recovered, non-alcoholic) and the incidence of hierarchical reversals in families?
- (5) What types of hierarchical reversals do members of alcoholic, recovered, and non-alcoholic families identify?
- (6) Do members of alcoholic, recovered, and non-alcoholic families differ in their perception of their family cohesion?

- (7) Do men, women, and children differ in their perception of their family cohesion?
- (8) Is there an interaction between group membership (alcoholic, recovered, non-alcoholic) and family members (husbands, wives, children) on the reported levels of family cohesion?
- (9) Do members of alcoholic, recovered and non-alcoholic families differ in their perception of their family adaptability?
- (10) Do men, women, and children differ in their perception of their family adaptability?
- (11) Is there an interaction between group membership (alcoholic, recovered, non-alcoholic) and family members (husbands, wives, children) on the reported levels of family adaptability?
- (12) Is there a difference in the reported levels of family satisfaction among members of alcoholic, recovered, and non-alcoholic families?
- (13) Do men, women, and children differ in their reported levels of family satisfaction?
- (14) Is there an interaction between group membership (alcoholic, recovered, non-alcoholic) and family members on members' reported levels of family satisfaction?

CHAPTER II

Literature Review

The following review explored the family systems literature on alcoholic families. As the literature was largely devoid of empirical research on the systems approach to alcoholism, the review addressed separately the theoretical and empirical writings on cohesion, adaptability, cross generational coalitions, and hierarchical reversals as these variables related to alcoholic families.

Theoretical Literature

Ewing and Fox (1968) are recognized as the first authors to integrate family theory into the treatment of alcoholism. The authors proposed that alcoholism is a homeostatic mechanism and that alcoholic marriages rigidly resist change over time. Each spouse controls the other through pathological behaviors designed to maintain the status quo. Thus when one member attempts to alter his typical role behavior as in maintaining sobriety, the family equilibrium is theorized to be disrupted. This might promote the non-alcoholic spouse to instigate a relapse to re-establish the status quo.

Bowen (1974) suggested in an oft quoted article entitled "Alcoholism As Viewed Through Family Systems Theory In Family Psychology", that alcoholism "erupts" as families experience anxiety and tension. As anxiety escalates, families are suspected to become increasingly rigid in their mode of adaptation until, inevitably, alcoholism emerges. Bowen thus

hypothesized that alcoholism is a symptom of the couple's inability to deal with issues of emotional attachment and interpersonal distance or differentiation of self.

Shapiro (1977) described the marital relationship in alcoholic couples to be conflictual, competitive, and a perpetual battle for control. Basing his assumptions on his clinical work with alcoholic families, Shapiro proposed that the drinking remains an unresolved area of conflict and hostility between the members of the couple which has an impact upon communication patterns, expression of affection, and sexual intimacy. The alcoholism functions to stabilize the relationship maintaining a tightrope position between intimacy and separation.

Jacob et al. (1978), in their comprehensive review of the literature on the impact of alcoholism on individual family members, suggested that alcoholism results in family breakdown, disorganization, and a void in the family structure. Children, they proposed, may attempt to fulfill the unmet needs of the family members, resulting in inappropriate parentified behavior.

Black (1979) described relations in alcoholic families as highly competitive. Reporting on her clinical work with alcoholic families, the author described family roles as ambiguous and lacking a clear sense of identities, rights, and responsibilities.

Hindeman (1976) discussed disturbed boundaries and subsystems in alcoholic families. He suggested that such families exhibit rigid external boundaries which serve to isolate the family from the larger community. Lawson, Peterson, and Lawson (1983) further suggested that in alcoholic families, the system's rules stipulate: (1) do not talk about the alcoholism, (2) do not confront the drinking behavior, and (3) protect and shelter the alcoholic so that things don't become worse. The rules thus perpetuate the drinking, and the drinking perpetuates the need for isolation. The drinking further maintains a fixed distance in marital and parent/child relationships. Davis, Stern, and Van Dusen (1978) correspondingly suggested that interpersonal boundaries between the nonalcoholic spouse and the child(ren) tend to be diffuse and enmeshed. The alcoholic member, by virtue of the drinking behavior, remains peripheral to the other members.

Kaufman (1984) constructed a typology of alcoholic family systems that is hypothesized to generate or promote alcoholism in a family member. The author theorized that alcoholic families can be classified as (1) functional, (2) neurotic enmeshed, (3) integrated, (4) absent. Each classification specifies different drinking patterns and different modes of adaptation by family members. For example, in the functional family system, drinking often occurs outside of the home. Family members appear happy and well adjusted.

Generally the alcoholic's drinking behavior is ignored and conflict is minimized. Each type of family system is hypothesized to be stable, repetitive, and functions to perpetuate the drinking behavior.

Grisham and Estes (1982) observed communication in alcoholic families to be controlling, critical, defensive, and blaming. Due to the unpredictable nature of the alcoholic's behavior, the authors suggested that other family members are frequently forced to assume additional and often inappropriate responsibility to maintain the family's functioning. Specifically the authors observed that children are forced to adopt parental roles and age inappropriate caretaking tasks.

Anderson and Henderson (1983) proposed that alcoholic partners triangulate a third person in an effort to divert tension and stress in the marriage. The authors suggested that the most common coalition is between the nonalcoholic spouse and a child of the opposite sex. The alliance functions to both exclude and infantilize the alcoholic.

The primary emphasis of the non-empirically based literature was formulating and establishing a theoretical base for conceptualizing alcoholic family processes. The works of Bowen (1974), Ewing and Fox (1968), and Shapiro (1977) were attempts to explain the etiology and maintenance of alcoholism in families. The writings of Black (1979) and Jacob et al. (1978) were focused on describing the impact of

alcoholism on individuals within a family. The most recent literature has focused on the impact of alcoholism on the family system. Much of the literature has been based on clinical work with alcoholic families rather than scientific study.

Empirical Research

Several studies are often cited for their contribution to the understanding of alcoholic family interactions.

Gorad (1971) studied 20 alcoholic and 20 non-alcoholic couples in a controlled interactional game playing situation. He proposed that interactions in alcoholic couples are fraught with conflict in an effort to gain control in the relationship. These patterns of conflictual interaction, Gorad hypothesized, would result in either a battle of oneupsmanship (escalation of symmetry) or in rigid complementarity. Escalation of symmetry refers to a rigid, competitive pattern of doing the same behaviors to attempt to outdo the other. Rigid complementarity refers to doing the opposite of the other in a repetitive, unchanging pattern. Either interactional pattern renders an alcoholic couple incapable of functioning as a unit for their mutual benefit. Gorad compared the scores of alcoholic and nonalcoholic couples statistically. His hypotheses were confirmed with the exception that alcoholic couples showed more symmetrical rather than complementary behaviors. His work has been criticized, however, for failure to match couples on salient demographic characteristics.

Steinglass (1975) in a series of studies, observed the interactional patterns of alcoholic couples during periods of experimentally induced intoxication and during periods of sobriety. His observations lead to the conclusion that

interactional behavior during intoxication is highly patterned and dramatically different from behavior during sobriety. Steinglass hypothesized that alcoholism functions to maintain homeostasis and is, therefore, stabilizing to the family system. He further proposed (in Hindeman, 1976) that alcoholic families have rigid boundaries that both separate individual members and isolate them from the larger community.

In a 1981 publication, Steinglass cited the results of a longitudinal study in which 31 alcoholic families were observed in their homes over 6 months. Steinglass proposed that alcoholics alternate between periods of intoxication and sobriety. He further hypothesized that each phase has an associated family interactional pattern that is stable and statistically discernable. Using an interactional coding system, Steinglass concluded that alcoholic families differed in their flexibility and rigidity depending on the "phase" of alcoholism (stable wet, stable dry, or transitional). The author utilized an ANOVA and obtained statistically significant F ratios. Steinglass concluded that the families' patterns of home behavior can be used to accurately predict their current alcohol phase.

Wilson & Orford (1978) observed 11 familial relationships in which one parent was diagnosed as alcoholic. The authors discussed their findings within the context of the existing literature. They found that alcoholic families had

"poor marital relationships" with frequent parental fighting and quarreling. The limitations of this study include both sample size and representativeness of the sample. The authors stated however, that their intent was to do descriptive, qualitative research that aimed at clarifying processes of family life.

Moos et al., (1979) have researched recovered, relapsed, and non-alcoholic families in a series of studies. Using the Family Environment Scale, the authors concluded that families of recovered alcoholics perceived themselves to be less conflictual than did families with a relapsed member. Similarly the recovered and non-alcoholic families had similar perceptions of their levels of cohesion. Relapsed families consistently reported more conflict, less cohesion, and less organization than either non-alcoholic or recovered families. Moos & Moos (1984) obtained nearly identical results in later studies of families post-treatment. One was a longitudinal study of 113 married patients and their family members over a period of 6 months to 2 years post-treatment. The families were assessed through the Moos Family Environment Scale and the Health and Daily Living Form. Statistical analyses revealed that the recovered families experienced changes in family functioning and improvement in environmental stressors, coping responses, and social resources.

Peterson-Kelley (1985) studied Alateen participants aged 11-19 using the Moos Family Environment Scale. The au-

thor found that the Alateens significantly differed from norm groups in their perception of their families as less cohesive, more conflictual, less expressive, and less structured. Though Peterson-Kelley cited several limitations of her research including failure to control for whether the alcoholic was in the recovery process, she suggested that the findings parallel those of previous researchers (Fine, Yuder, Holmes, & Heinemann, 1976; Moos et al., 1979).

The empirical research on systemic features of alcoholic families has been criticized for inadequacies in methodological and experimental design, vague criteria of alcoholism, small, unrepresentative samples, control groups not demographically comparable, inappropriate statistical analyses, and questionable reliability and validity (Jacob et al., 1978). Although the empirical research on structural variables in alcoholic families has been criticized, it has contributed to the development of a theoretical base for further study.

CHAPTER III

Methodology

Sample

The sample for this study was composed of three groups: (1) families with an adult alcoholic member in a residential treatment program; (2) families with an adult, recovered alcoholic member who had maintained sobriety for a minimum of 1 year; and, (3) families without an alcoholic member. (See Chapter IV for a complete description of the sample.) Male adult alcoholic or recovered member refers to a parent, spouse, or adult caretaker. Male adults were selected because they are disproportionately represented in both treatment facilities and Alcoholics Anonymous and were, therefore, a more accessible sample than addicted adult females (AlAnon publication, 1978).

Permission to recruit families for the alcoholic group was obtained from the appropriate administrators and the Boards of Directors of the Mount Regis residential treatment program in Salem, Virginia, St. Albans Psychiatric Hospital in Radford, Virginia, Lewis Gale residential treatment program in Salem, Virginia, and the Roanoke Valley Psychiatric Hospital in Salem, Virginia. (See Appendix C for the permission to conduct research letters) Recruitment for the recovered group was accomplished through contact persons in Alcoholics Anonymous in Roanoke County, Virginia, the Northern Virginia/Washington, DC area, and Waterbury, Connecticut.

Recovered families were asked to recommend other recovered families until a sample of approximately 40 families was obtained. Verification of 1 year sobriety was provided through the Alcoholics Anonymous process of awarding 1 year sobriety chips. To minimize bias and error, the wives and children of recovered family members were given the Michigan Alcoholism Screening Test (MAST) to exclude families with an actively addicted member. (See Appendix B for a copy of the MAST) However, all of the recovered families asked to participate in the study evidenced no actively addicted members according to the results of the MAST. Therefore, no recovered families were excluded from the sample. The criteria for inclusion in the recovered group were clearly delineated to all those willing to recommend participants, thus contributing to the accuracy of the referral process.

The nonalcoholic group was recruited from the elementary school system in West Haven, Connecticut. Parents of students age 12 or older in the sixth grade were contacted by the students' teacher to request their participation in the study. The age specification of 12 was established by Olson, Portner, and Lavee (1985) as the minimum age at which valid results on the FACES can be obtained, a primary instrument used in the study. All families who agreed to participate were asked to complete the MAST. The MAST was used to identify control families that had a potentially alcoholic member. Seven potential control families were identified as

having an adult alcoholic member and were not included in the control group.

Procedure

Each family completed a series of questionnaires. The adults each completed the Demographic questionnaire, the Madanes Family Hierarchy Test (MFHT), and the Family Adaptability and Cohesion Evaluation Scales (FACES III). The participating children completed the MFHT and the FACES III. Directions for completion of the MFHT were standardized to eliminate potential bias. The members were asked to work independently in completing the questionnaires and to not consult with each other until they had finished. All participating families were asked to sign a consent to participate form, designating the parameters of their involvement and assuring them of confidentiality. (See Appendix A for copies of the release of information forms used in this research) The participants were members of intact families with two adults and at least one child above age 12.

Instrumentation

Family Adaptability and Cohesion Evaluation Scales (FACES)

The FACES were initially developed in 1978 by David H. Olson, Joyce Portner, and Richard Bell. FACES has since been revised twice. Olson et al. had designed FACES to measure the Circumplex Model which postulates that cohesion and adaptability are two central dimensions of marital and family structure. The model proposed that families located on the

central (balanced) areas of the Circumplex Model are healthier than those at the polar extremes. A marital or family system is considered balanced when it can experience the extremes on the dimensions when appropriate without becoming stuck at these extremes (Olson et al., 1979).

The original FACES, developed in 1978, was a self-report scale containing 111 items. The instrument measured family member's perceptions of family cohesion and adaptability. Scores were obtained on 9 subscales of cohesion and 7 subscales of adaptability. It was initially designed for use with couples and families with an adolescent (Olson et al., 1979). FACES was revised in 1981 to address the limitations of the original FACES. FACES II created a shorter scale with simplified sentences for use with children aged 12 and a 7th grade reading level. The number of double negatives were reduced from the original instrument and a 5 point Likert response scale was added.

FACES II was constructed to be given twice, once for how family members presently perceive their family and secondly, for how each family member would ideally like the family to be. From the perceived and ideal scales, it is possible to determine the present level of satisfaction with the family system. Additional information on how each family member would like to change the present family system is obtained when comparing the perceived and ideal scales. Overall, the perceived and ideal scales combined provide a more compre-

hensive family portrait (Olson et al., 1982). Perceived and ideal scales in FACES II were included to minimize bias as well. Extreme family types are hypothesized to be functional as long as all family members are satisfied with their family system. Thus various ethnic and religious family systems are not perceived to be pathological though they differ in norms for cohesion and adaptability.

Initially, FACES II was based on the responses of 464 adults to 90 items. Respondents were an average age of 30.5. The 90 items covered the 15 content areas of cohesion and adaptability with 6 items per content area. The 90 item scale was reduced to 50 items as a result of factor analysis and reliability analysis (Olson et al., 1982). The 50 item scale was administered to 2,412 individuals in the National Survey. The 50 item scale was then reduced to 30 items. The final FACES II contains 16 cohesion items and 14 adaptability items. That scale consists of 2 items for each of the following dimensions: family boundaries, emotional bonding, coalitions, space, time, friends, interests, recreation, decision making, leadership, assertiveness, discipline, roles, rules, and negotiation.

FACES III was developed primarily to improve reliability, validity, and clinical utility. (See Appendix B for a copy of FACES III) The major objectives were: (1) to shorten the instrument so it can be administered under perceived and ideal conditions; (2) to develop two empirically independent

(orthogonal) dimensions so it better achieves the theoretical criteria for the Circumplex Model; (3) to eliminate negative items so it is easier to score and compare to establish norms; (4) to rewrite the ideal version so that it could be more easily understood by family members; (5) to develop items that were relevant for a variety of family forms (nuclear, blended, single-parent) and couples (married, cohabitating) without children; (6) to have specific norms for adults across the life cycle, adults and adolescents combined for the adolescent stage, and young couples without children (Olson et al., 1985).

FACES III is a 20-item scale containing 10 cohesion items and 10 adaptability items. There are two items for each of the concepts related to cohesion: emotional bonding, supportiveness, family boundaries, time and friends, and interest in recreation. There are also two items for each of the following concepts on the adaptability dimension: leadership, control, and discipline, and four items for the combined concept of roles and rules (Olson et al., 1985).

A concern of FACES II was bias due to social desirability. In FACES III, the correlation between adaptability and social desirability was reported by Olson et al. (1985) to have been reduced to zero from .38 in FACES II.

Michigan Alcohol Screening Test (MAST)

The MAST is a 25-item, true-false, self-report instrument that addresses drinking habits. Its purpose is to

distinguish between alcoholics and nonalcoholics. The present MAST is a modified version of the original. (See Appendix B for a copy of the MAST) The initial instrument, developed by Selzer (1971), utilized a quantifiable, structured interview format. It was later revised to be self-administered. The MAST has been tested for reliability using the Kuder-Richardson Formula 20 and is reported to be .84. Moore (1972) obtained a .78 correlation between scores on the MAST and global ratings of psychiatrists which was significant at .001.

The MAST is scored by adding one point for each "key" response. The total score is the number of "key" responses. The scores may range from 0 to 25. Scores from 0 to 3 are interpreted as "no drinking problem". Scores from 4 to 6 are interpreted as "potential drinking problem". Scores of 7 and above are interpreted as "evident drinking problem". The limitation of the MAST is reportedly in diagnosing those without drinking problems in the "potential" range (Moore, 1972). The MAST is reportedly highly accurate in diagnosing alcoholics in the "evident" range.

The MAST is not designed to be relevant to non-drinkers. Therefore, a question was included on the Demographic questionnaire asking whether the participants consume or have ever consumed alcohol. The MAST was then administered only to those family members that claimed to drink.

Madanes Family Hierarchy Test (MFHT)

The MFHT was developed in 1978 to assess the presence of hierarchical reversals in a family. (See Appendix B for a copy of the MFHT) The test consists of four diagrams of family patterns and asks each member to select the one which he/she believes most closely represents his/her family. Each figure in the selected diagram is then labeled. A hierarchical reversal was defined as a representation in which: (1) one parental person is placed below the other; (2) a parental person is below or at the same level as the child or adolescent; (3) the child or adolescent is placed above one parental person and/or at the same level as a parental person.

The MFHT was first utilized in a study that succeeded in differentiating the family structures of heroin addicts, schizophrenics, and high achievers. Measures of interrater reliability for hierarchical reversals were 90% and 100%. Reliability between 3 judges who scored the diagram for distance between the figures was reported to be 95% (Madanes et al., 1980).

A 1983 study by Madden and Harbin utilized the MFHT to distinguish between the family structure of assaultive and nonassaultive adolescents. The authors reported that the instrument evidenced a significant difference between the two groups of families in terms of the absolute number of choices of a hierarchical reversal. The MFHT did not succeed in

significantly differentiating between the two groups on cross generational attachments.

A 1985 study by Johnson, Muyskens, Bryce, Palmer, and Rodnan utilized the MFHT to differentiate family structures of children with Cystic Fibrosis by birth order. Although the MFHT indicated increased levels of hierarchical reversals in the predicted direction, the results did not reach statistical significance.

The MFHT was administered in stages. First each member was individually shown diagrams of four different family organizations. The explanation of the diagrams was standardized to reduce bias and to increase consistency. The individuals were asked to select the diagram that best resembled how they perceive their family. They were then asked to label each figure in the selected diagram using a "M" to designate the female adult, a "F" to designate the male adult, and a "C" to designate the child. Each member was finally asked to draw a circle around the dyad in their family that has the closest relationship.

Demographic Questionnaire

A demographic questionnaire was created for the purposes of obtaining information on ethnic background, educational attainment, parents' employment status, and level of family income, to provide a means of comparison between the three groups. (See Appendix B for a copy of the Demographic questionnaire)

Data Analysis

Cohesion and Adaptability

Raw scores on the FACES III were obtained for family members age 12 or older on the cohesion scale and on the adaptability scale. The cohesion raw score was computed as the sum of all the odd numbered items, and the adaptability raw score as the sum of all the even numbered items. Measures of internal consistency reliability were obtained for the cohesion and adaptability scales and are reported in Table 1.

The raw scores on the cohesion scale were used to classify each person as disengaged, separated, connected, or enmeshed. The following norms and cutting points proposed by Olson et al. (1985), for families with adolescents, were used for the classification: Disengaged: Range 10-31; Separated: Range 32-37; Connected: Range 38-43; Enmeshed: Range 44-50.

Similarly, the adaptability scores were used to classify each family member as rigid, structured, flexible, or chaotic according to the norms and cutting points proposed by Olson et al. (1985) for families with adolescents: Rigid: Range 10-19; Structured: Range 20-24; Flexible: Range 25-29; Chaotic: Range 30-50.

Table 1

Reliability Analyses of the Cohesion and Adaptability Scales
of the FACES III

| Variables | Alpha |
|-----------------------------------|-------|
| Husbands' Perceived Cohesion | .90 |
| Wives' Perceived Cohesion | .89 |
| Children's Perceived Cohesion | .86 |
| Husbands' Perceived Adaptability | .78 |
| Wives' Perceived Adaptability | .69 |
| Children's Perceived Adaptability | .59 |
| Husbands' Ideal Cohesion | .95 |
| Wives' Ideal Cohesion | .92 |
| Children's Ideal Cohesion | .86 |
| Husbands' Ideal Adaptability | .87 |
| Wives' Ideal Adaptability | .80 |
| Children's Ideal Adaptability | .78 |

The Circumplex Model proposes that families located within the balanced ranges are healthier than those at the extremes. Accordingly, the cohesion and adaptability raw scores were used to classify the respondent as healthy or dysfunctional depending upon their classification. Each individual who obtained a score within the balanced range (cohesion 32-43; adaptability 20-29) was assigned a value of zero. Each individual who obtained a score within the extreme range assigned a value of one. The mean scores found on Tables 8 and 10, therefore, represent the proportion of each group scoring in the extreme range. Although the dichotomous scores obtained in this manner represent nominal classifications, it is permissible to treat any dichotomous variable as though it represents an interval measure. Therefore, it was possible to analyze this dichotomous variable using a repeated measures ANOVA.

Family Satisfaction

Family satisfaction scores were calculated by subtracting the raw perceived scores from the raw ideal scores on both the cohesion and adaptability scales for each family member. A large discrepancy between the perceived and ideal scores indicated low satisfaction with the family functioning as perceived by each family member. A small discrepancy between the perceived and ideal scores indicated high satisfaction. Separate factorial ANOVAs tested whether there were significant differences between mean satisfaction scores on

the cohesion scale and on the adaptability scale. The ANOVAs consisted of three factors. The first factor was group membership (alcoholic, recovered, control), and the second was family members (husbands, wives, children). As discussed previously, the original raw cohesion and adaptability scores were recoded into dichotomous classifications. The third factor of the factorial ANOVAs was assignment into the balanced or extreme range (a value of one assigned to extreme scores). Therefore, the dichotomous cohesion and adaptability scores were treated as independent variables in this analysis. It could then be determined whether significant differences existed in the level of satisfaction for those who were classified as having balanced or extreme scores. Theoretically, Olson et al. (1985) have postulated that the extent of dysfunction reflected by extreme scores on the cohesion and adaptability dimensions is related to the level of family satisfaction. Families that fall within the extremes, but are highly satisfied, are proposed to be functional, while families that fall within the extremes but are dissatisfied, are proposed to be dysfunctional. Family satisfaction scores, therefore, served a twofold purpose. Firstly, the scores provided a measure of satisfaction with which family members and groups could be compared. Secondly, the scores provided additional information about the functionality of families scoring within the extreme ranges. Families which scored in the polar extremes but reported high

family satisfaction were considered functional in keeping with Olson's theory.

Hierarchical Reversals

For the purposes of data analysis a hierarchical reversal was defined by at least one member's selection of a diagram indicative of a reversal on the MFHT. Families were then classified as hierarchically reversed or not reversed. To identify different problematic hierarchical arrangements, the data was coded as follows: "0" no reversal, "1" mother/child lateral hierarchical arrangement, "2" father/child lateral hierarchical arrangement, "3" child superior to two parents, "4" child superior to one parent. A crosstabulation was used to compare the types of hierarchical arrangements reported in each group (alcoholic, recovered, control). A Chi Square Test of Independence was used to test the significance of the relationship between group membership and hierarchical reversals.

Cross Generational Coalitions

The MFHT provided an overt means of identifying coalitions. Those families that circled a parent and child as having the closest relationship were diagnosed as coalesced. To compare the groups (alcoholic, recovered, control) by the type of coalition identified, the data was coded as follows: "0" no coalition, "1" mother/child coalition, "2" father/child coalition, "3" coalitions identified with both parents. A crosstabulation was used to compare the types of

cross generational coalitions reported in each group. A Chi Square Test of Independence was used to test the significance of the relationship between group membership and cross generational coalitions.

Olson et al. (1985) has reported that discrepancy scores on the FACES can theoretically be used to identify family coalitions. It was, therefore, hoped that covert coalitions could be identified by using discrepancy scores from the FACES III. It was assumed that family members who were coalesced would have similar perceptions of their family, and that the non-coalesced parent would differ markedly. A study by Bell & Bell (1982) had theorized that in a chronic coalition, the allies would be more similar to one another and dissimilar from the excluded person as the coalesced individuals are more likely to share their perceptions and attitudes with each other and accept each other's views of the family. The authors used the Moos Family Environment Scale.

In an attempt to test the ideas of Bell & Bell, raw total (sum) scores on the two continuum of FACES III were subtracted for each dyad (mother - child; father - child; mother - father), and 6 discrepancy scores were obtained. High discrepancy scores implied low agreement, as low discrepancy scores implied high agreement. The results however, failed to provide a means of identifying covert coalitions. On the two continua of adaptability and cohesion, there was little consistency in the discrepancy scores be-

tween dyads. In those few instances in which there was a lower discrepancy score for the same parent and child on the two continua, and high discrepancy scores on the two continua for the other dyads, there was no consistency with the MFHT in reported coalitions. A Pearson correlation was run to measure the relationship between identification of coalitions on the MFHT and low dyadic discrepancy scores on the FACES III. The correlation coefficients were very small ($r=.21$ was the highest correlation), indicating that the relative levels of agreement between dyads on FACES III was not related to the identification of coalitions on the MFHT.

CHAPTER IV

Findings and Discussion

Description of the Sample

The Family Adaptability and Cohesion Scales (FACES III), the Madanes Family Hierarchy Test, (MFHT), the Demographic questionnaire, and the Michigan Alcoholism Screening Test (MAST) were administered to 125 families. Of those families, 39 had an adult alcoholic member, 44 had a recovered adult alcoholic member, and 42 had no alcoholic members. All participant families consisted of twomarried adult caretakers and at least one child between the ages of 12 and 21.

One of the primary criticisms of previous empirical research on alcoholic families was that the control groups were not demographically comparable (Jacob et al., 1978). This study, therefore, sought to compare the three groups (alcoholic, recovered, and control) on various demographic criteria, to ensure similarity.

Age and Race

The alcoholic, recovered, and control groups were comparable in the mean ages of the respondents as can be seen on Table 2. Men, women, and children in the control group were, on the average, younger than members of both the alcoholic and recovered group. The age difference, however, was not marked.

The three groups were also quite homogeneous in ethnicity. The alcoholic group was identified as 82.1%

Table 2

Mean Age of Family Members in the Alcoholic Recovered, and Control Groups

| | | Alcoholic | Recovered | Control |
|----------|-----------|-----------|-----------|---------|
| Husbands | <u>n</u> | 38 | 44 | 42 |
| | \bar{x} | 45.9 | 45.9 | 41.5 |
| | <u>sd</u> | 9.6 | 9.5 | 5.7 |
| Wives | <u>n</u> | 38 | 44 | 42 |
| | \bar{x} | 43.1 | 42.8 | 39.8 |
| | <u>sd</u> | 8.9 | 7.6 | 5.1 |
| Children | <u>n</u> | 38 | 44 | 42 |
| | \bar{x} | 15.5 | 16.7 | 13.8 |
| | <u>sd</u> | 2.5 | 3.0 | 2.1 |

Note: N = 372

White/Caucasian, the recovered group was identified as 95.5% White/Caucasian, and the control group was identified as 92.9% White/Caucasian. The greatest heterogeneity was within the alcoholic group in which 7 of the 37 respondents were Black. Two of the 44 respondents in the recovered group were of Native American/American Indian heritage, and 1 respondent of 42 in the control group was Black.

Educational Attainment

The control males reported somewhat higher educational levels than both the alcoholic and recovered males. As can be seen on Table 3, of control males, 23.8% had a graduate degree compared to 9.1% of recovered males and none among the alcoholic males. Also, more alcoholic men had less than a 12th grade education than the recovered and control men.

The women were quite similar in educational attainment. However, more control women reported advanced education, 35.7% having completed college or higher, compared to 15.9% of wives of recovered men and 18.4% of wives of alcoholic men. (See Table 4)

Thus, the members of the control group had higher levels of educational attainment, however, the differences were not large enough to be considered marked.

Family Income

The three groups reported comparable levels of family income with 46.2% of alcoholic families, 48.8% of recovered families, and 52.4% of control families earning between

Table 3

Educational Attainment of Husbands by Group

| | | Less Than 12th Grade | 12th Grade | Some College | Completed College | Some Graduate Work | Completed Graduate Work | Total |
|-----------|----------|----------------------------|---------------|-----------------|----------------------|--------------------------|-------------------------------|----------------|
| Alcoholic | <u>n</u> | 10 | 10 | 8 | 9 | 2 | 0 | 39 |
| | % | 25.6 | 25.6 | 20.5 | 23.1 | 5.1 | | 100 |
| Recovered | <u>n</u> | 8 | 12 | 13 | 5 | 2 | 4 | 44 |
| | % | 18.2 | 27.3 | 29.5 | 11.4 | 4.5 | 9.1 | 100 |
| Control | <u>n</u> | 3 | 12 | 10 | 4 | 3 | 10 | 42 |
| | % | 7.1 | 28.6 | 23.8 | 9.5 | 7.1 | 23.8 | 100 |
| Total % | | 16.8 | 27.2 | 24.8 | 14.4 | 5.6 | 11.2 | <u>N</u> = 125 |

Table 4

Educational Attainment of Wives by Group

| | | Less Than 12th Grade | 12th Grade | Some College | Completed College | Some Graduate Work | Completed Graduate Work | Total |
|-----------|----------|----------------------------|---------------|-----------------|----------------------|--------------------------|-------------------------------|----------------|
| Alcoholic | <u>n</u> | 6 | 11 | 14 | 1 | 3 | 3 | 38 |
| | % | 15.8 | 28.7 | 36.8 | 2.6 | 7.9 | 7.9 | 100 |
| Recovered | <u>n</u> | 5 | 18 | 14 | 6 | 1 | 0 | 44 |
| | % | 11.4 | 40.9 | 31.8 | 13.6 | 2.3 | | 100 |
| Control | <u>n</u> | 3 | 17 | 7 | 7 | 4 | 4 | 42 |
| | % | 7.1 | 40.5 | 16.7 | 16.7 | 9.5 | 9.5 | 100 |
| Total % | | 11.3 | 37.1 | 28.2 | 11.3 | 6.5 | 5.6 | <u>N</u> = 124 |

\$30,000-\$49,999 None of the alcoholic families, however, reported incomes of greater than \$50,000 compared to 14% of recovered families and 16.7% of control families. Therefore, the control and recovered groups had slightly higher family incomes, however, the differences were not marked. (See Table 5)

Employment

Both men and women were similar in employment status across groups. Of control men, 100% were employed full time, as were 86.4% of recovered men and 82.1% of alcoholic men. Two of the male alcoholic respondents were unemployed, as were three of the recovered respondents. Five alcoholic men and three recovered men were retired.

Of women in alcoholic families, 63.1% were employed full or part time compared to 79.6% of women in recovered families, and 78.6% of control women. Nine alcoholic wives, eight recovered wives, and five control wives reported being homemakers.

Child's Sex

There were nearly equal numbers of male and female children in each of the three groups. Children of alcoholic families were 53.8% male, recovered families were 56.8% male, and control children were 45.2% male.

Thus, a comparison of the three groups by age, ethnicity, educational attainment, employment status, family income, and the childrens' sex, generally revealed the groups

Table 5

Family Income Across Groups

| | | Less Than 10,000 | 10,000 19,999 | 20,000 29,999 | 30,000 39,999 | 40,000 49,999 | 50,000 And Over | Total |
|----------------|----------|------------------------|------------------|------------------|------------------|------------------|--------------------|----------------|
| Alcoholic | <u>n</u> | 2 | 9 | 9 | 9 | 10 | 0 | 39 |
| | <u>%</u> | 5.1 | 23.1 | 23.1 | 23.1 | 25.6 | | 100 |
| Recovered | <u>n</u> | 2 | 10 | 5 | 16 | 4 | 6 | 43 |
| | <u>%</u> | 4.7 | 23.3 | 11.6 | 37.2 | 9.3 | 14 | 100 |
| Control | <u>n</u> | 1 | 0 | 5 | 17 | 12 | 7 | 42 |
| | <u>%</u> | 2.4 | 0 | 11.9 | 40.5 | 28.6 | 16.7 | 100 |
| Total % | | 4.0 | 15.3 | 15.3 | 33.9 | 21.0 | 10.5 | <u>N</u> = 124 |

to be comparable on the selected criteria. The control group was slightly younger, better educated, and reported more full time employment. However, those differences were not marked.

Cross Generational Coalitions

Research Question 1

The first research question asked: Is there a relationship between group membership and the incidence of cross generational coalitions in families? A primary goal of this study was to determine whether alcoholic families, recovered families, and control families differed in terms of reported cross generational coalitions. The MFHT was used to identify cross generational coalitions. Families which reported that a parent and child had a closer relationship than the two parents were determined to be coalesced.

Table 6 shows the results of the crosstabulation between group membership and cross generational coalitions. As was expected, coalitions were far more prevalent among alcoholic families (30 of 39), than in recovered families (21 of 44), or control families (14 of 42). The relationship between group membership and the presence or absence of coalitions was tested for significance using the Chi Square Test of Independence and the results were significant at the .01 level ($\chi^2 = 15.89$).

The findings supported the literature on alcoholic families which suggests that these families have an increased

Table 6

Crosstabulations of Group Membership and Types of Cross
Generational Coalitions

| | | No Coalition | Mother/ Child | Father/ Child | 2-Parent/ Child | Total |
|-----------|---|-----------------|------------------|------------------|--------------------|-------|
| Alcoholic | n | 9 | 15 | 8 | 7 | 39 |
| | % | 23.1 | 38.5 | 20.5 | 17.9 | 100 |
| Recovered | n | 23 | 19 | 1 | 1 | 44 |
| | % | 52.3 | 43.2 | 2.3 | 2.3 | 100 |
| Control | n | 28 | 11 | 1 | 2 | 42 |
| | % | 66.7 | 26.2 | 2.4 | 4.8 | 100 |
| Total | N | 60 | 45 | 10 | 10 | 125 |
| | % | 48 | 36 | 8 | 8 | 100 |

incidence of cross generational coalitions (Anderson & Henderson, 1983; Grisham & Estes, 1982; Jacob et al., 1978). The results further supported the existing family therapy theories which suggest that in dysfunctional families, the child is relied upon for emotional compensation and an increase in interpersonal power (Gilbert et al., 1984), as well as to diffuse, detour, and mediate conflicts between the spouses (Minuchin, 1974). The current results corresponded as well, with the theoretical proposition that pathology begins to alleviate with recovery, freeing children to assume age appropriate roles, and the parents to establish an appropriate marital and parental hierarchy and subsystems (Moos et al., 1979; Peterson-Kelley, 1985).

Research Question 2

The second research question asked whether cross generational coalitions are similarly identified using several instruments.

It was hoped that covert coalitions could be identified by using discrepancy scores from the FACES III as was stated in Chapter III. Although the study failed to contribute to the identification of covert coalitions, it was a productive avenue of exploration that warrants further inquiry. This will be discussed further in Chapter V.

Research Question 3

The third research question asked what types of cross generational coalitions were identified by families.

The crosstabulation of group membership and cross generational coalitions found on Table 6 shows the types of coalitions reported by the families. The table shows cross generational coalitions to be far more prevalent in the alcoholic group than in the other two groups. In all three groups, the most predominant type of coalition is between mothers and children. Father/child and two parent coalitions were almost nonexistent among the recovered and control families, but were present in a substantial number of the alcoholic families.

Anderson & Henderson (1983) have suggested that children of alcoholic families more frequently align with the nonalcoholic parent. The results supported the propositions of Anderson & Henderson, as most reported coalitions were between mothers and children. It was further discovered that in alcoholic families, the children also align with the addicted adult more often than in recovered families. Additionally, in alcoholic families, children are more likely to be coalesced with both parents than are children of recovered or control families. Therefore, the current results support the theoretical literature which proposes that cross generational coalitions place the child in age inappropriate positions of fulfilling spousal, parental, and nurturant roles for the addicted person, the non-addicted person, or for both (Grisham & Estes, 1982; Jacob et al., 1978).

Hierarchical Reversals

Research Question 4

The fourth research question asked: Is there a relationship between group membership and the incidence of hierarchical reversals in families? A goal of this study was to determine whether alcoholic families, recovered families, and control families differed in the reported incidence of hierarchical reversals. Hierarchical reversals were measured by the MFHT and included: (1) a mother and child placed laterally either below or above the father; (2) a father and child placed laterally either below or above the mother; (3) a child placed in a superior position to both parents; (4) a child placed in a superior position to one parent.

The Chi Square Test of Independence was used to test the significance of the relationship between hierarchical reversals and group membership. The test was significant at the .01 level ($\chi^2 = 39.51$) and showed a disproportionate number of reversals in the alcoholic group. As seen on Table 7, hierarchical reversals were found for a majority of the alcoholic families (23 of 39) but were present in only six of the recovered families and in only one control family.

The findings supported family therapy theory which suggests that dysfunctional families more frequently lack clear hierarchical structures in which adults maintain appropriate status and decision making power (Haley, 1976). The literature on alcoholic families has similarly suggested that children are often enlisted into age inappropriate caretaking

Table 7

Crosstabulation of Group Membership and Types of Hierarchical Reversals

| | | No Reversal | Mother/ Child Lateral | Father/ Child Lateral | Child Superior to Both Parents | Child Superior To One Parent | Total |
|-----------|---|----------------|-----------------------------|-----------------------------|---|---------------------------------------|-------|
| Alcoholic | n | 16 | 8 | 5 | 3 | 7 | 39 |
| | % | 41. | 20.5 | 12.8 | 7.7 | 17.9 | 100 |
| Recovered | n | 38 | 4 | | 2 | | 44 |
| | % | 86.4 | 9.1 | 0 | 4.5 | 0 | 100 |
| Control | n | 41 | 1 | | | | 42 |
| | % | 97.6 | 2.4 | 0 | 0 | 0 | 100 |
| Total | N | 95 | 13 | 5 | 5 | 7 | 125 |
| | % | 76 | 10 | 4 | 4 | 5.6 | 100 |

roles, which is consistent with the current findings (Anderson & Henderson, 1983; Grisham & Estes, 1982; Jacob et al., 1978). The relative lack of hierarchical reversals in recovered families suggests that, with sobriety, the family reorganizes to a more appropriate and effective structure, which is further consistent with the findings of Moos et al. (1979).

Research Question 5

The fifth research question asks what types of hierarchical reversals do members of alcoholic, recovered, and control families identify.

Table 7 shows the crosstabulation of the types of hierarchical reversals by group membership. The most prevalent hierarchical reversal was that of mothers and children placed laterally, either superior or inferior to the male. The alcoholic families showed greater variation in reported hierarchical reversals than the recovered and control families. As can be seen in Table 7, 15 alcoholic families selected hierarchical reversals other than that of mothers and children placed laterally, compared to only two recovered families and no control families.

As discussed in Chapter I, there is no empirical research documenting the types of hierarchical reversals manifested by alcoholic families. Thus, there is no previous research with which to compare the current findings. Structural/strategic family therapy theory has proposed that

hierarchical reversals characterize dysfunctional families which is consistent with the current results (Haley, 1976). Furthermore, the findings that mothers and children are disproportionately placed laterally and in a superior position to the addicted adult, supports the writings of Anderson & Henderson (1983) which suggest that children are enlisted into hierarchically inappropriate caretaking positions superior to the addicted adult. (The MFHT allows for a variety of structural arrangements in which the mother, child, or both may be placed in a superior position to the addicted adult.) The relative lack of hierarchical reversals by type and frequency in the recovered group supports the findings of Moos et al.(1979) and Peterson-Kelley (1985) that the structural dysfunction abates with sobriety and that children resume age appropriate positions.

Cohesion

Research Questions 6,7,8

Another aim of this study was to explore the variable of perceived family cohesion as measured by individual family members' responses to the FACES III. The corresponding research questions were: (Question 6) Do members of alcoholic, recovered, and control families differ in their perception of their family cohesion?; (Question 7) Do men, women, and children differ in their perception of their family cohesion?; (Question 8) Is there an interaction between

family members and group membership on the reported levels of family cohesion?

Perceived cohesion was measured by the FACES III. All raw scores that fell within the extreme ranges on the cohesion continuum (enmeshment/disengagement) were assigned a value of one. All raw scores within the balanced range of the cohesion continuum (separated/connected) were assigned a value of zero. Table 8 shows the means for the dichotomous cohesion scores. As extreme scores were assigned a value of one, the means shown on Table 8 are the proportion of subjects in each subgroup whose cohesion scores were in the extreme range.

A repeated measures ANOVA was used to test the significance of the differences between the means. As seen on Table 9, the main effect for group membership and the interaction effect were both significant at the .05 level. The cell means which are presented graphically in Figure 1, show a higher incidence of extreme scores among members of alcoholic families. For husbands and children, the incidence of extreme scores is highest in the alcoholic group and lowest in the control group. The alcoholic wives had the highest proportion of extreme scores (46%), while the control wives evidenced a higher incidence of extreme scores (43%) than the recovered wives (23%).

The results supported the theoretical literature which suggest that alcoholic families have characteristically

Table 8

Means and Standard Deviations on the Cohesion Continuum
for Husbands, Wives, and Children by Group

| | | Husbands | Wives | Children | Total |
|-----------|-----------------------------|----------|-------|----------|----------------|
| Alcoholic | <u>n</u> | 39 | 39 | 39 | |
| | <u>\bar{x}</u> | .49 | .46 | .64 | <u>M</u> .53 |
| | <u>sd</u> | .51 | .51 | .49 | <u>SD</u> .50 |
| Recovered | <u>n</u> | 44 | 44 | 44 | |
| | <u>\bar{x}</u> | .41 | .23 | .52 | <u>M</u> .39 |
| | <u>sd</u> | .50 | .42 | .51 | <u>SD</u> .49 |
| Control | <u>n</u> | 42 | 42 | 42 | |
| | <u>\bar{x}</u> | .31 | .43 | .21 | <u>M</u> .32 |
| | <u>sd</u> | .47 | .50 | .42 | <u>SD</u> .47 |
| Total | <u>M</u> | .40 | .37 | .46 | <u>N</u> = 375 |
| | <u>SD</u> | .49 | .48 | .50 | |

Table 9

Repeated Measures Analysis of Variance Summary for
Dichotomous Cohesion Scores

| Source of Variation | Degrees of Freedom | Mean Square | F |
|---|--------------------------|----------------|---------|
| Between Subjects | | | |
| Group Membership (Alcoholic, Recovered, Control) | 2 | 1.417 | 4.580 * |
| Error | 122 | .309 | |
| Within Subjects | | | |
| Family Members (Husbands, Wives, Children) | 2 | .243 | 1.282 |
| Group Membership X Family Members | 4 | .790 | 4.162 * |
| Error | 244 | .190 | |

*p < .05

Note: N = 375

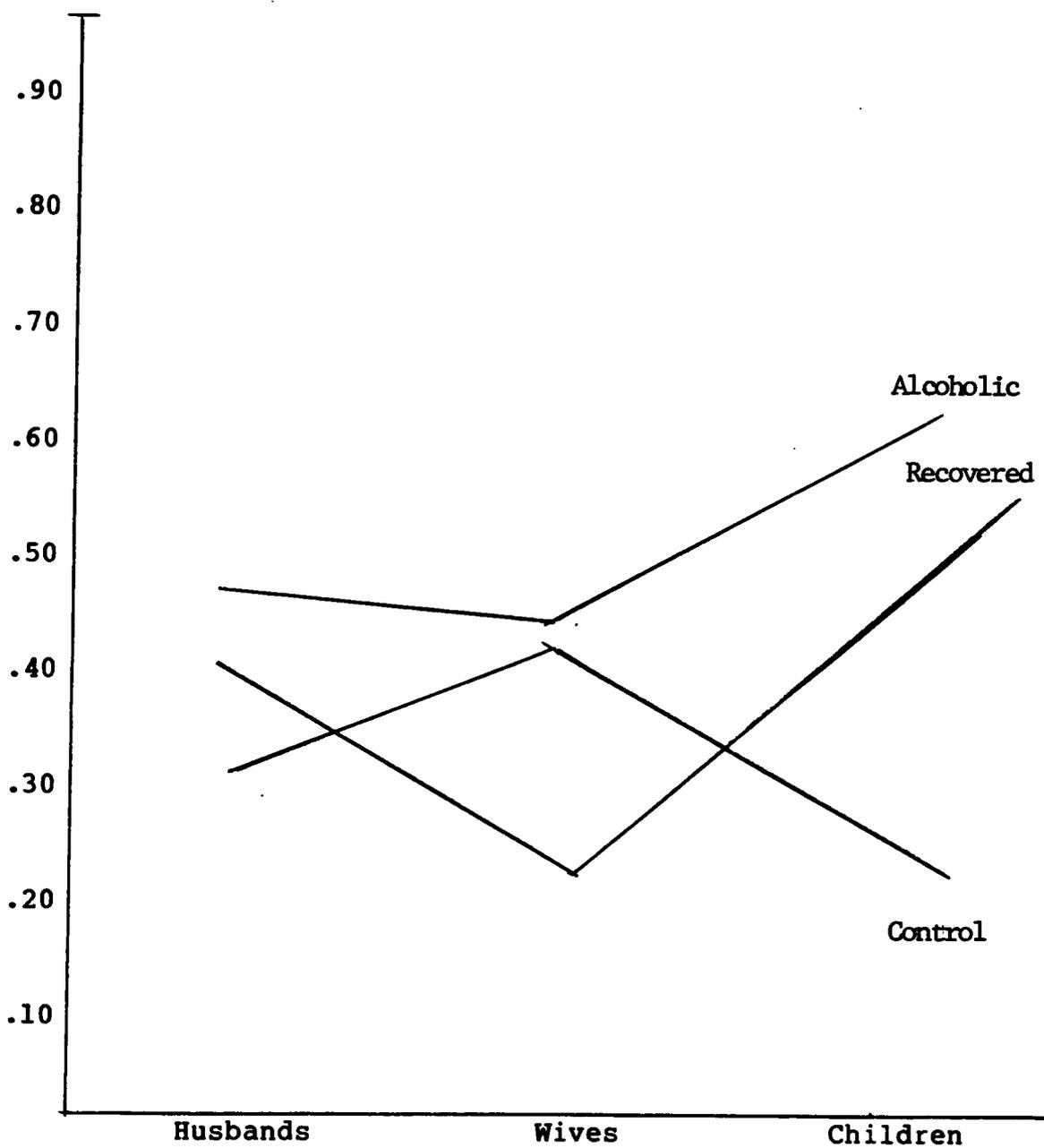


Figure 1

Proportion of Scores in the Extreme Range on the Cohesion Scale

disturbed boundaries (Anderson & Henderson, 1983; Davis et al., 1978; Moos et al., 1979; Steinglass, 1975). The fact that the adolescent children identified the most disturbance corresponds with family therapy theory which proposes that dysfunctional families have difficulty with emotional bonding and individual autonomy (Minuchin, 1974; Olson et al., 1979). Enmeshment is believed to preclude autonomy, disengagement to preclude interdependence (Minuchin, 1974). Both extremes are proposed to effect the family's ability to function effectively as a unit as well as to provide adequately for the emotional needs of the members. The recovered group's cohesion scores suggest that dysfunctional boundaries modify with recovery which corroborates with the findings of Moos & Moos (1984) and Steinglass (1981).

Adaptability

Research Questions 9, 10, 11

The research questions asked: Do men, women, and children differ on their perception of their family adaptability?; Do members of alcoholic, recovered, and control families differ on their perception of their family adaptability?; Is there an interaction between group membership and family members on the reported levels of family adaptability?

Adaptability was measured by individual family members' responses to the FACES III. Raw scores were recoded to form a dichotomous classification as on the cohesion scale, with

a value of one assigned to members who scored in the extremes of rigid and chaotic, and a value of zero assigned to scores in the balanced range (structured/flexible). Therefore, the means shown in Table 10 are the proportion of subjects in each subgroup whose adaptability scores were in the extreme range.

A repeated measures ANOVA was used to test the significance of the differences between the means. As shown in Table 11, the main effect of family members and the interaction effect were both significant at the .05 level. The cell means, which are presented graphically in Figure 2, show a wide variation in the proportion of extreme scores among husbands, wives, and children in the alcoholic group, and a similarity in the proportion of extreme scores among the members of the recovered and control groups. Alcoholic men had the highest incidence of extreme scores, in marked contrast to the wives in the alcoholic group who had the lowest incidence of extreme scores, which explains the significant interaction.

The variation in scores among alcoholic family members was surprising. The results implied little common understanding or shared experience among members of alcoholic families. Alcoholic men frequently experienced their families as rigid and/or chaotic. This confirms both the existing theory and the literature which suggest that dysfunctional families have difficulty adapting to

Table 10

Means and Standard Deviations on the Adaptability Continuum
for Husbands, Wives, and Children by Group

| | | Husbands | Wives | Children | Total |
|-----------|---------------|----------|-------|----------|---------------|
| Alcoholic | $\frac{n}{x}$ | 39 | 39 | 39 | |
| | \bar{x} | .69 | .08 | .33 | \bar{M} .38 |
| | sd | .47 | .27 | .48 | SD .48 |
| Recovered | $\frac{n}{x}$ | 44 | 44 | 44 | |
| | \bar{x} | .36 | .30 | .25 | \bar{M} .30 |
| | sd | .49 | .46 | .44 | SD .46 |
| Control | $\frac{n}{x}$ | 42 | 42 | 42 | |
| | \bar{x} | .40 | .40 | .43 | \bar{M} .41 |
| | sd | .50 | .50 | .50 | SD .49 |
| Total | \bar{M} | .48 | .26 | .34 | $N = 375$ |
| | SD | .50 | .44 | .47 | |

Table 11

Repeated Measures Analysis of Variance Summary for
Dichotomous Adaptability Scores

| Source of Variation | Degrees of Freedom | Mean Square | F |
|---|--------------------------|----------------|---------|
| Between Subjects | | | |
| Group Membership (Alcoholic, Recovered, Control) | 2 | .392 | 1.581 |
| Error | 122 | .248 | |
| Within Subjects | | | |
| Family Members (Husbands, Wives, Children) | 2 | 1.671 | 8.572 * |
| Group Membership X Family Members | 4 | 1.183 | 6.068 * |
| Error | 244 | .195 | |

*p < .05

*Note: N = 375

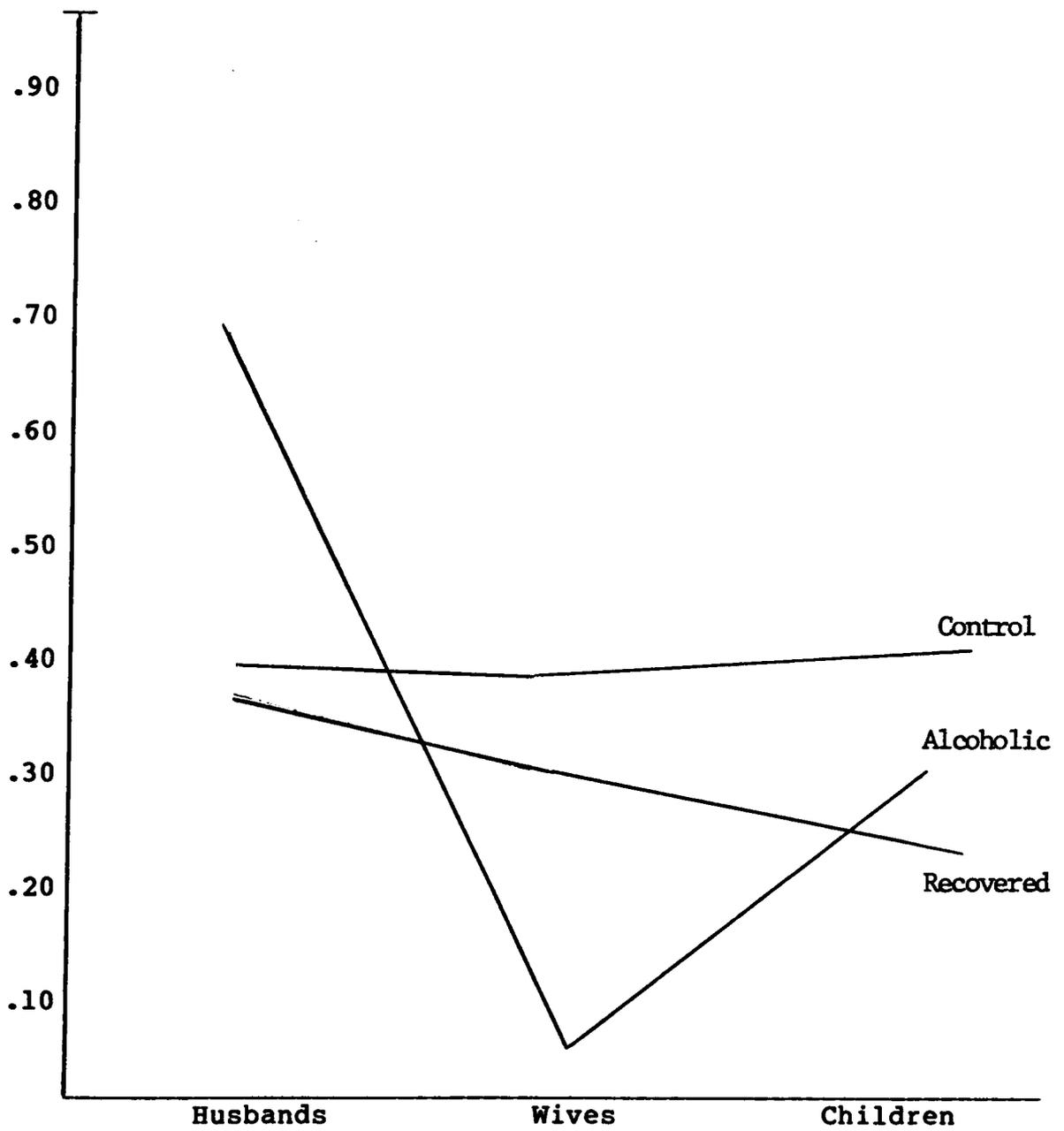


Figure 2

Proportion of Scores in the Extreme Range on the Adaptability Scale

situational and developmental stress (Olson et al., 1979; Steinglass, 1981). Wives, however, almost exclusively perceived their families as balanced. This result is contrary to the expected rigid stability proposed to characterize dysfunctional families (Bowen, 1974; Ewing & Fox, 1968; Minuchin, 1974), and/or the proposed chaotic and unorganized patterns of change (Davis et al., 1978; Grisham & Estes, 1982; Hindeman, 1976; Jacob et al., 1978). The results are, however, consistent with the research of Bonk (1984) who had failed to show significant changes in alcoholic families on adaptability as measured by FACES III.

The findings were also surprising in that the alcoholic wives reported more dissatisfaction with their family adaptability than their husbands although the husbands reported more pathology. It is reported by Olson (1985) that the correlation between social desirability and adaptability was reduced to zero on FACES III. However it is possible that alcoholic wives attempted to present their families in a favorable manner and/or have greatly distorted belief systems about their families resulting from the chronic alcoholism.

Another possible reason for the unexpected results is that although FACES III is normed for adolescents age 12-21, many of the adaptability questions address discipline, which may be irrelevant for adolescents of alcoholic families. Many of these adolescents had been identified as superior to an adult(s) in terms of status and decision making responsi-

bility on the MFHT, suggesting that they were responsible for household functioning including setting rules and limits. The fact that the alcoholic wives were not responsible for setting rules and consequences may therefore have impacted upon their responses resulting in what appears to be a "flexible" system of rule enforcement.

Although the FACES III is administered to family members, it is an individual self report instrument. It, therefore, does not address the issue of interpreting largely discrepant family scores. Olson (1985) identified the lack of agreement among family members as a conceptual and methodological issue facing researchers. It can be questioned whether the lack of common perception of the alcoholic group is not in itself, problematic. The responses of the recovered and control group were quite similar indicating relatively balanced family adaptability. The mean scores of the family members of those groups were also quite consistent suggesting that a factor in the discrepant reports of the alcoholic group is the alcoholism.

Family Satisfaction

Research Questions 12, 13, 14

The next three research questions were concerned with the mean differences in the reported levels of family satisfaction. The questions were stated as follows: (Question 12) Is there a difference in the reported levels of family satisfaction among members of alcoholic, recovered, and con-

trol groups?; (Question 13) Do men, women, and children differ in their reported levels of family satisfaction?; (Question 14) Is there an interaction between group membership and family members on members' reported levels of family satisfaction?

Satisfaction scores were obtained by calculating the difference between the perceived and ideal raw scores on the two scales (cohesion/adaptability) of FACES III. High discrepancy scores indicated low levels of satisfaction. Correspondingly, low discrepancy scores indicated high levels of satisfaction. Separate 2X3X3 ANOVAs were used to test whether significant differences existed among the mean satisfaction scores. The independent variables in the analysis were group membership (alcoholic, recovered, control), family members (husbands, wives, children), and assignment into the balanced or extreme range. As discussed previously, the original raw cohesion and adaptability scores were recoded into dichotomous classifications. A value of one was assigned for those scores that fell within the extreme range. Therefore, in the 2X3X3 ANOVAs, the dichotomous cohesion and adaptability scores were treated as independent variables. It could then be determined whether significant differences existed in the level of satisfaction for those who were classified as having balanced or extreme scores. Theoretically, Olson et al. (1985) have postulated that the extent of dysfunction reflected by extreme scores on the cohesion and adaptability

dimensions is related to the level of family satisfaction. Families that fall within the extremes, but are highly satisfied, are proposed to be functional, while families that fall within the extremes but are dissatisfied, are proposed to be dysfunctional.

The results of the factorial ANOVAs will be reported and discussed first for the adaptability scale and then for the cohesion scale.

Family Satisfaction: Adaptability Scale

The means and standard deviations of the satisfaction scores for the adaptability scale are shown in Table 12. The 2X3X3 ANOVA shown in Table 13 revealed significant main effects for assignment into the balanced or extreme range and family members as well as a significant two way interaction for family members and group membership ($p < .052$). Although the .052 level of significance may be considered borderline, it is considered important for the purposes of this study.

Inspection of the cell means presented graphically in Figure 3 shows that alcoholic husbands, wives, and children had higher mean scores than the recovered group suggesting greater dissatisfaction with family functioning. For husbands and wives, the reported level of dissatisfaction with their families' adaptability was greatest in the alcoholic group. Childrens' scores varied markedly across groups with alcoholic children reporting far more dissatisfaction than

Table 12

Means and Standard Deviations for Satisfaction Scores on the Adaptability Continuum for Members
Of Alcoholic, Recovered, and Control Families

| Group | Balanced | | | | Extreme | | | | Total |
|-----------|--|--------------------|--------------------|---------------------------------------|--|--|----------------------|-----------------------------|-----------------------------|
| | Husbands | Wives | Children | Total | Husbands | Wives | Children | Total | |
| Alcoholic | $\frac{n}{\bar{x}}$ 12 <u>sd</u> 5.5 4.42 | 36 7.56 5.72 | 26 7.08 4.93 | $\frac{M}{SD}$ 7.05 5.24 | $\frac{n}{\bar{x}}$ 27 <u>sd</u> 6.96 8.89 | 3 2.33 7.77 | 13 11.08 11.82 | $\frac{M}{SD}$ 7.88 9.88 | $\frac{M}{SD}$ 7.36 7.27 |
| Recovered | $\frac{n}{\bar{x}}$ 28 <u>sd</u> 6.64 3.21 | 31 6.90 4.81 | 33 4.21 6.02 | $\frac{M}{SD}$ 5.86 4.99 | $\frac{n}{\bar{x}}$ 16 <u>sd</u> 4.56 4.86 | 13 7.31 2.95 | 11 5.91 7.26 | $\frac{M}{SD}$ 5.83 5.63 | $\frac{M}{SD}$ 5.85 5.03 |
| Control | $\frac{n}{\bar{x}}$ 25 <u>sd</u> 4.12 3.60 | 25 6.16 4.99 | 24 7.54 5.63 | $\frac{M}{SD}$ 5.92 4.94 | $\frac{n}{\bar{x}}$ 17 <u>sd</u> 6.53 4.89 | 17 8.53 4.62 | 18 11.78 8.28 | $\frac{M}{SD}$ 9.00 6.47 | $\frac{M}{SD}$ 7.19 5.80 |
| Total | $\frac{M}{SD}$ 5.46 <u>SD</u> 3.73 | 6.96 5.20 | 6.07 5.73 | 6.25 5.06 | 6.20 6.95 | 7.48 4.56 | 10.02 9.40 | 7.70 7.49 | |
| Total | (Husbands) $\frac{M}{SD}$ = 5.82 5.51 | | | (Wives) $\frac{M}{SD}$ = 7.09 5.03 | | (Children) $\frac{M}{SD}$ = 7.40 7.38 | | N = 375 | |

Table 13

Analysis of Variance Summary for Satisfaction Scores on the
FACES III Adaptability Scale

| Source of Variation | Degrees of Freedom | Mean Square | F |
|---|--------------------------|----------------|---------|
| Adaptability Score (Balanced, Extreme) | 1 | 223.394 | 6.397 * |
| Family Members (Husbands, Wives, Children) | 2 | 121.822 | 3.489 * |
| Group Membership (Alcoholic, Recovered, Control) | 2 | 71.218 | 2.040 |
| Adaptability X Family Members | 2 | 66.229 | 1.897 |
| Adaptability X Group Membership | 2 | 66.933 | 1.917 |
| Family Members X Group Membership | 4 | 82.785 | 2.371 * |
| Adaptability X Family Members X Group Membership | 4 | 34.656 | .992 |
| Residual | 357 | 34.919 | |

*p < .05

*Note: N = 375

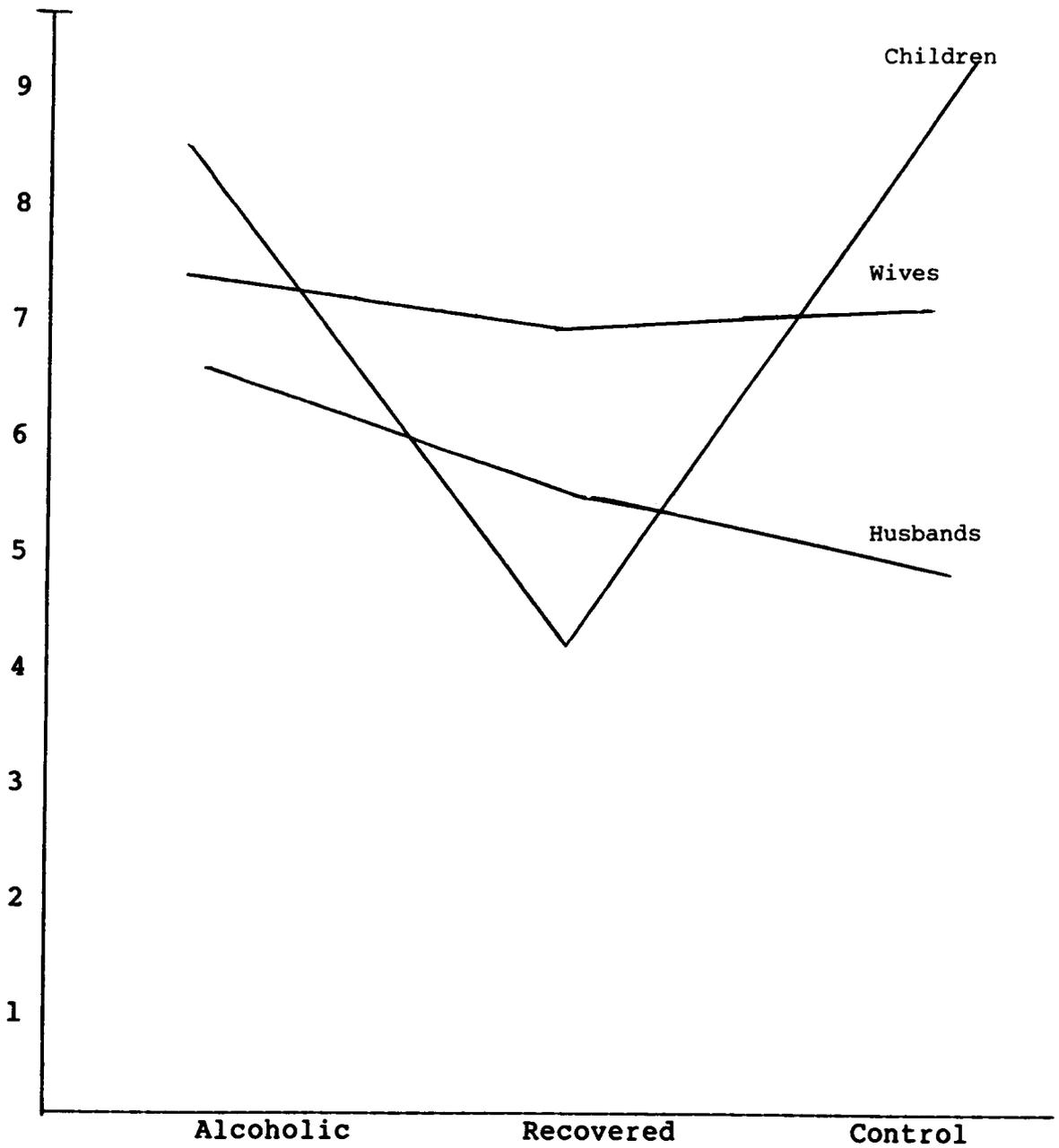


Figure 3

Graph of the Interaction Effect of Family Members and Group Membership on Adaptability Satisfaction Scores

recovered children, and control children reporting the greatest amount of dissatisfaction.

The results collectively suggest that with recovery, satisfaction with family adaptability increases for husbands and wives. However, the alcoholic wives' levels of satisfaction were in contrast to their raw scores on the adaptability scale. Although they reported their families to be functioning in a healthy manner, the wives were none the less, more dissatisfied than their husbands who had reported more dysfunction. It was expected that given the accuracy of the wives' perceptions, the fact that their families were functioning in a healthy manner would be matched with high satisfaction.

The results confirmed the theoretical literature which suggest that family satisfaction is lower among members of alcoholic families (Gorad, 1971; Moos et al., 1979; Shapiro, 1977; Wilson & Orford, 1978). The results further support the findings of Moos et al.(1979) and Peterson-Kelley (1985) which had stated that alcoholic family members express dissatisfaction with their families' ability to adjust and accomodate to change.

Family Satisfaction: Cohesion Scale

The means and standard deviations of the satisfaction scores for the cohesion scale are shown in Table 14. The 2X3X3 ANOVA shown in Table 15 revealed significant main effects for assignment into the balanced or extreme range and

group membership, as well as a significant two way interaction for group membership and assignment into the balanced or extreme range ($p < .05$).

The cell means associated with the significant interaction are presented graphically in Figure 4. It can be seen that the members of the alcoholic, recovered, and control families that scored within the balanced range were highly satisfied with their family cohesion. Members of alcoholic and recovered families that scored within the extreme range were more dissatisfied, with the level of dissatisfaction increasing markedly in the alcoholic group (1.84 to 12.37).

In control families, the level of satisfaction did not vary markedly for those with extreme scores and those with balanced scores. In fact, satisfaction with family cohesion was slightly higher for those control families that scored in the extreme range. Olson et al. (1985) have suggested that scores in the extreme range are not indicative of dysfunction if the members are satisfied. Therefore, the extreme scores of the control families were not considered to reflect pathological boundaries, in contrast to the alcoholic and recovered family members whose extreme scores were matched with high levels of dissatisfaction.

The results supported the theoretical literature which proposes that as dysfunction increases, so does relative levels of dissatisfaction (Moos & Moos, 1984). The alcoholic members reported more enmeshment and disengagement and also

Table 14

Means and Standard Deviations for Satisfaction Scores for Members of Alcoholic, Recovered, and Control Families on the Cohesion Scale

| Group | Balanced | | | | Extreme | | | | Total |
|-----------|---------------------------|--|----------|---|---------------------------|--|----------|---------------------------|---------------------------|
| | Husbands | Wives | Children | Total | Husbands | Wives | Children | Total | |
| Alcoholic | $\frac{n}{\bar{x}}$ 20 | 21 | 14 | \bar{M} 1.84 | $\frac{n}{\bar{x}}$ 19 | 18 | 25 | \bar{M} 12.37 | \bar{M} 7.42 |
| | $\frac{sd}{\bar{x}}$ 1.15 | 1.52 | 3.29 | $\frac{SD}{\bar{x}}$ 6.35 | $\frac{sd}{\bar{x}}$ 9.74 | 11.83 | 14.76 | $\frac{SD}{\bar{x}}$ 8.85 | $\frac{SD}{\bar{x}}$ 9.37 |
| Recovered | $\frac{n}{\bar{x}}$ 26 | 34 | 21 | \bar{M} 3.91 | $\frac{n}{\bar{x}}$ 18 | 10 | 23 | \bar{M} 6.67 | \bar{M} 4.98 |
| | $\frac{sd}{\bar{x}}$ 4.28 | 4.80 | 2.48 | $\frac{SD}{\bar{x}}$ 4.15 | $\frac{sd}{\bar{x}}$ 4.72 | 9.90 | 6.78 | $\frac{SD}{\bar{x}}$ 7.81 | $\frac{SD}{\bar{x}}$ 5.97 |
| Control | $\frac{n}{\bar{x}}$ 29 | 24 | 33 | \bar{M} 3.89 | $\frac{n}{\bar{x}}$ 13 | 18 | 9 | \bar{M} 2.98 | \bar{M} 3.60 |
| | $\frac{sd}{\bar{x}}$ 3.49 | 4.21 | 3.55 | $\frac{SD}{\bar{x}}$ 3.75 | $\frac{sd}{\bar{x}}$ 4.46 | 2.39 | 4.56 | $\frac{SD}{\bar{x}}$ 5.06 | $\frac{SD}{\bar{x}}$ 4.21 |
| Total | \bar{M} 3.23 | 3.75 | 3.16 | 3.39 | 6.10 | 7.72 | 9.93 | 8.01 | |
| | $\frac{SD}{\bar{x}}$ 5.94 | 3.81 | 4.17 | 4.72 | 6.74 | 9.37 | 9.0 | 8.55 | |
| Total | | (Husbands) \bar{M} = 4.38 $\frac{SD}{\bar{x}}$ = 6.40 | | (Wives) \bar{M} = 5.21 $\frac{SD}{\bar{x}}$ = 6.69 | | (Children) \bar{M} = 6.25 $\frac{SD}{\bar{x}}$ = 7.58 | | N = 375 | |

Table 15

Analysis of Variance Summary for Satisfaction Scores
on the FACES III Cohesion Scale

| Source of Variation | Degrees of Freedom | Mean Square | F |
|--|--------------------------|----------------|----------|
| Cohesion Scores (Balanced, Extreme) | 1 | 1493.666 | 41.098 * |
| Family Members (Husbands, Wives, Children) | 2 | 84.803 | 2.333 |
| Group Membership (Alcoholic, Recovered, Control) | 2 | 257.746 | 7.092 * |
| Cohesion Scores X Family Members | 2 | 61.006 | 1.679 |
| Cohesion Scores X Group Membership | 2 | 840.934 | 23.138 * |
| Family Members X Group Membership | 4 | 64.440 | 1.773 |
| Cohesion Scores X Family Members X Group Membership | 4 | 14.168 | .390 |
| Residual | 357 | 36.344 | |

*p < .05

*Note: N = 375

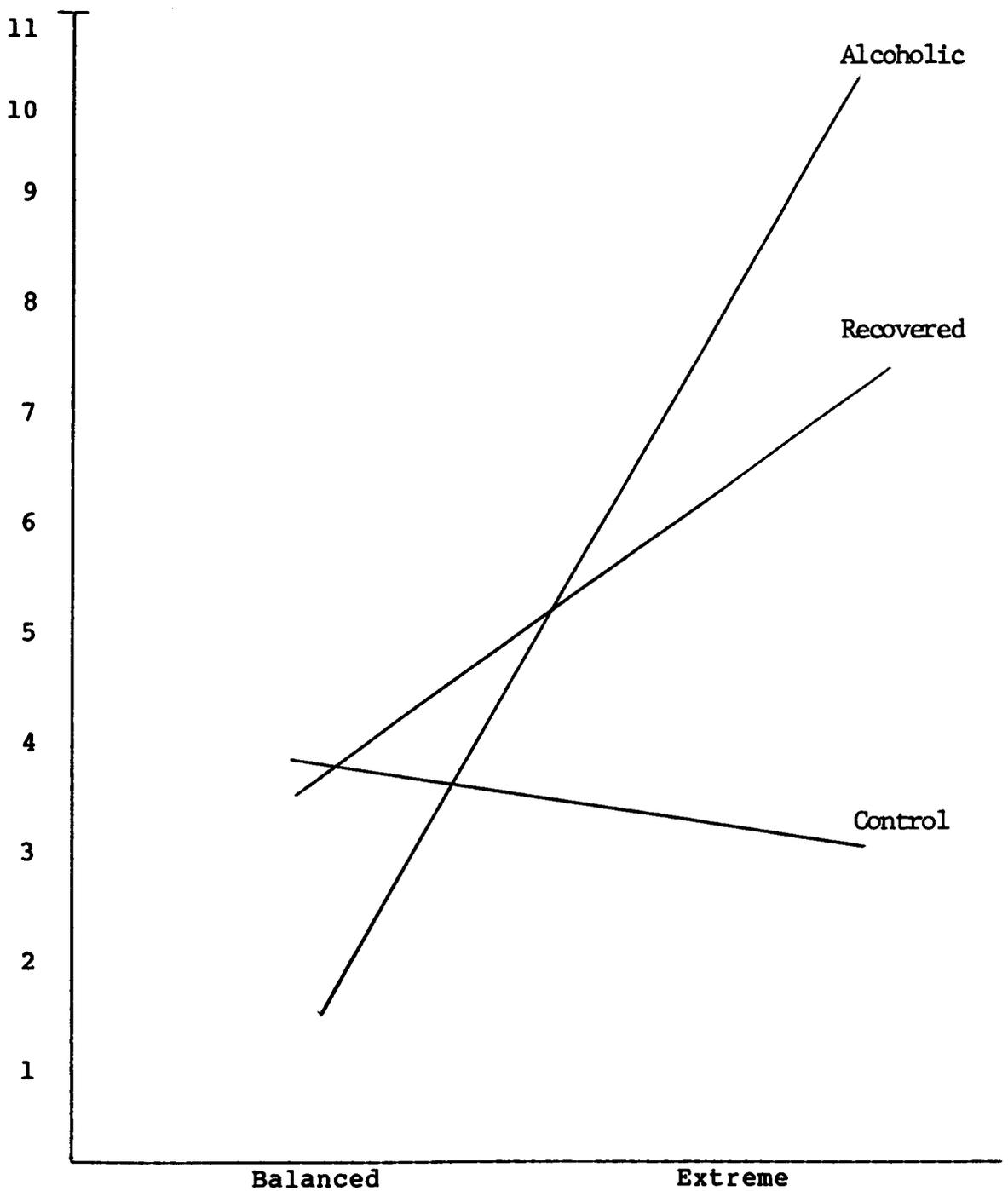


Figure 4

Graph of the Interaction Effect of Group Membership and
Dichotomous Cohesion Scores on Satisfaction Scores

were highly dissatisfied with their families' functioning. However, the control group reported satisfaction with their families despite extreme scores. Given the younger mean ages of the control children, this finding implies that the extremes of cohesion are perceived by these families to be appropriate and acceptable. Therefore, these families would in fact be considered less dysfunctional than the recovered and alcoholic groups, confirming the theoretical literature that boundaries in normal families more successfully meet the members' needs for autonomy yet interdependence (Minuchin, 1974).

CHAPTER V

Summary

Procedure

One hundred and twenty-five families responded to written questionnaires designed to explore the structural variables of cross generational coalitions, hierarchical reversals, adaptability, and cohesion as they were manifest in alcoholic families, families with a recovered alcoholic member, and nonalcoholic (control) families. Of those 125 families, 39 had an adult alcoholic member, 44 had a recovered, adult alcoholic member, and 42 had no alcoholic members.

Each participant completed the Family Adaptability and Cohesion Evaluation Scales (FACES III) and the Madanes Family Hierarchy Test (MFHT). Adult participants also completed the Michigan Alcoholism Screening Test (MAST) and the Demographic questionnaire. The variables of perceived family cohesion, perceived family adaptability, and family satisfaction were measured by individual responses to the FACES III. Cross generational coalitions and hierarchical reversals were measured by the family members' responses to the MFHT. The MAST was administered for the purposes of ensuring that control families had no potentially alcoholic members, as well as ensuring that recovered families had no actively addicted members. Information was obtained on age, ethnicity, educational attainment, employment status, family income, and the

sex of participating children to ensure that the three groups were demographically comparable as previous empirical research had been criticized for failure to control for salient demographic variables.

Significant Findings

The first research question asked whether there was a relationship between group membership and the reported incidence of cross generational coalitions in families. The Chi Square Test of Independence was significant at the .01 level ($\chi^2 = 15.89$) and showed a disproportionate number of cross generational coalitions in the alcoholic group and a disproportionate lack of coalitions in the control group.

The second research question concerned whether cross generational coalitions could be similarly identified by several instruments. It was hypothesized that high agreement between dyads as measured by FACES III, which would theoretically indicate a covert coalition, would be related to the overt identification of coalitions on the MFHT. The weak correlation obtained ($r=.21$) indicated that the identification of cross generational coalitions on the MFHT was not related to high agreement between family members on responses to the FACES III.

The third research question addressed the types of cross generational coalitions identified by families. The cross-tabulations showed a predominance of mother/child coalitions which supported the theoretical literature. The alcoholic

group also identified an increased number of coalitions between fathers and children (27%), as well as coalitions between children and both parents (23%). The fact that recovered families continue to have increased numbers of cross generational coalitions compared to the control group suggests that the coalition formation does not entirely abate with sobriety, which corresponded with the findings of Patterson-Kelley (1985).

The fourth research question asked whether there was a relationship between group membership and the incidence of hierarchical reversals in families. The Chi Square Test of Independence was significant at the .01 level ($\chi^2 = 39.51$) and showed a disproportionate number of hierarchical reversals in the alcoholic group and a disproportionate lack of reversals in the control and recovered groups.

The fifth research question proposed to explore the types of hierarchical reversals identified by families. Crosstabulations revealed that the most frequently identified type of hierarchical reversal was mother and child placed laterally, either superior or inferior to the male. The alcoholic group showed the greatest variation in reported reversals, with 17.9% identifying a child to be superior to one parent, and 12.8% of fathers and children placed laterally.

Research questions 6,7,8 were addressed by a repeated measures ANOVA, and explored differences between groups and family members on cohesion scores. The repeated measures

ANOVA was significant at the .05 level and revealed differences between groups ($F = 4.580$), as well as an interaction effect of family members and group membership ($F = 4.162$) on reported levels of cohesion. There was a higher incidence of extreme scores among family members of the alcoholic group. The significant interaction revealed that alcoholic wives had the highest incidence of extreme scores, while recovered wives had the lowest incidence.

Research questions 9,10,11 were addressed by a repeated measures ANOVA, and similarly explored differences between groups and family members on adaptability scores. The ANOVA was significant at the .05 level for the repeated measure of family members ($F = 8.572$) and for the interaction of family members and group membership ($F = 6.068$). The results supported previous theoretical and empirical research for husbands, and indicated that alcoholic men more frequently perceived their families to be rigid and/or chaotic in responding to change than either recovered or control men. However, the results were contrary to previous findings for wives. Alcoholic wives almost exclusively perceived their family adaptability to be balanced. The alcoholic group showed the greatest variation in scores between family members indicating little common consensus or shared experience in that group.

Research questions 12,13,14 asked whether satisfaction scores differed for husbands, wives, and children in the al-

coholic, recovered, and control groups. On the adaptability scale, the 2X3X3 ANOVA was significant at the .052 level for the interaction of family members and group membership ($F = 2.371$). On the cohesion scale, the 2X3X3 ANOVA was significant at the .05 level for the interaction of scores within the balanced and extreme ranges and group membership ($F = 23.138$). The results of both 2X3X3 ANOVAs supported both the existing theory and previous empirical research suggesting that alcoholic family members have lower family satisfaction with their families' ability to adapt and accommodate to change and with their families' boundaries.

Implications and Recommendations

As was discussed in Chapter I, family therapy theory has proposed that a variety of structural dysfunctions characterize families with an alcoholic member. The empirical research in this area is limited, however. This study, therefore, was an exploratory endeavor to investigate the structural variables of cohesion, adaptability, cross generational coalitions, and hierarchical reversals as they were manifested in alcoholic, recovered, and control families.

The findings generally supported both the existing family therapy theory (Haley, 1976; Minuchin, 1974), and the previous theoretical and empirical literature on alcoholic families cited in Chapter II. The results indicated that alcoholic families manifest the proposed structural

dysfunctions of cross generational coalitions, hierarchical reversals, disturbed boundaries, and a rigidity of interactional patterns. The control group provided a means of comparing alcoholic families and nonalcoholic families. The findings indicated that nonalcoholic families do not manifest the structural dysfunction that alcoholic families do. Nonalcoholic families have higher family satisfaction, significantly fewer cross generational coalitions and hierarchical reversals, and more functional boundaries with less reported enmeshment and disengagement. The current results also indicate that the structural dysfunction of recovered families is less than that of the alcoholic families which suggests that the structural dysfunction is alleviated with recovery. This finding corresponds with the propositions of both family therapy theory (Haley, 1976; Minuchin, 1974), and the theoretical and empirical literature on alcoholic families (Moos et al., 1979; Peterson-Kelley, 1985; Steinglass, 1981). On all of the variables, recovered families evidenced less pathology and more satisfaction than did alcoholic families.

The scores of the three groups on the adaptability continuum of FACES III were contrary to both the expectations and the existing theory. The scores suggested that alcoholic wives and children perceived their family adaptability as less chaotic or rigid than did the wives and children of the recovered and control groups. Bonk (1984), however, had

similarly failed to find significant differences in adaptability scores on pre and post treatment measures using FACES III. The findings would suggest that for wives, family adaptability is not negatively impacted upon by the alcoholism. However, the vast difference in perception between family members of the alcoholic group, in contrast to the recovered and control groups, suggested that other variables were influencing adaptability scores. As discussed in Chapter IV, the fact that alcoholic husbands' adaptability scores reflected more dysfunction than their recovered or control counterparts, as well as the fact that alcoholic wives and children expressed far more dissatisfaction with their family adaptability despite their balanced scores, further confused the findings. Olson (1985) has discussed the issue of lack of agreement among family members and identified it as a conceptual and methodological problem facing researchers. Clearly the lack of common perception and shared experience of alcoholic family members as evidenced by adaptability scores, needs to be further researched. Why alcoholic wives report more flexibility than their husbands in accomodating to change, yet why they also report more dissatisfaction, is an area warrenting investigation. Perhaps comparing an objective measure of family adaptability with a subjective, individual self report measure as FACES III may shed more light on the issue.

The other area of the study that did not yield the expected results was the identification of covert coalitions. As was discussed in Chapter I, there is currently a paucity of empirical research exploring the identification of covert coalitions and whether the overt coalitions identified by the family, match the covert coalitions identified by other means. Although this study failed to show any relationship between the overt coalitions identified by family members on the MFHT, and low discrepancy scores between dyads on the FACES III (a measure of covert coalitions), this area warrants continued exploration.

Family therapy theory, as well as communication theory and organizational theory, have continually proposed that coalitions in dysfunctional families are covert (hidden) and involve a "tendency toward compatibility" (Hoffman, 1981). This corresponds with the propositions of Bell & Bell (1982) who had maintained that coalesced individuals are more likely to share the other's views, perceptions, and attitudes. There is, however, little empirical evidence documenting that coalesced family members perceive their families more similarly than non-coalesced individuals. One's perception of his/her family may be primarily a function of their different ages, roles, positions, and experiences, preventing any two individuals from perceiving the family alike. Thus, the overt admission that a parent and child have a closer relationship than the two parents do, may be a better indicator

of a covert coalition than is similar responses to a self report instrument. Clearly, there is a deficit in the current means of accurately identifying covert coalitions. Similarly, more research is needed to explore whether the overt statements of family members about closeness and distance between dyads, is an accurate identifier of hidden, covert, coalitions.

The current results have implications for family therapy, the study of alcoholism, and the field of alcoholism treatment. A primary goal of the study was the empirical validation and exploration of the structural variables theoretically proposed to characterize dysfunctional families. The current findings confirm Structural/Strategic family therapy theory (Haley, 1976; Minuchin, 1974) as well as provide additional information about several of the variables. The types and frequency of cross generational coalitions and hierarchical reversals manifested by the three groups comprising the sample, contributes to the prevailing knowledge and may provide a basis for further exploration.

The current thinking about alcoholism proposes that it is a "family disease" systemically having an impact upon all members (Bepko & Krestan, 1985). Increasing attention has been paid to understanding the phenomenon of "co-dependency" or, in what ways the entire family system contributes to the maintenance of the alcoholism. The results of this research confirm the systemic manifestations of the alcoholism in

family structure and functioning. The empirical study of family structure in alcoholic families can thus provide an invaluable data base for understanding the nature and extent of the impact of alcoholism.

Despite the prevailing thought that alcoholism is a family disease, most addiction treatment remains individually oriented. Residential treatment programs are beginning to integrate family members into some components of treatment, and AlAnon, Alateen, and Adult Children of Alcoholics (ACOA) are gaining increasing acceptance. The results of this study graphically demonstrate the systemic aspect of alcoholism and support the trend toward multidimensional, multidisciplinary treatment of addiction.

Within the recent past, there has been increasing interest in children of alcoholics and understanding the lasting impact of the disease on family members. The current findings demonstrate the devastating impact alcoholism has on family structure and thus the probable developmental impact on the children. The results support the existing theories about the inappropriate roles children of alcoholics assume. Continued empirical research can only contribute to the understanding of the transgenerational effects of alcoholism and the current and prolonged impact of the disease on all family members.

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APPENDIX A
RELEASE OF INFORMATION FORMS

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

CENTER FOR FAMILY SERVICES (703) 961-7201

I do willingly give my permission for myself and my family to participate in a research project exploring alcohol use and family organization. The project is developed through the Center for Family Services and the Department of Family and Child Development. I understand that the information I provide will be completely confidential and I maintain the right to refuse to participate at any time. My decision to participate will not affect my treatment at Mt. Regis Center in any way. I may request the results of the research.

Parent/Guardian

Parent/Guardian



VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

CENTER FOR FAMILY SERVICES (703) 961-7201

I do willingly give my permission for myself and my family to participate in a research project exploring alcohol use and family organization. The project is developed through the Center for Family Services and the Department of Family and Child Development. I understand that the information I provide will be completely confidential and I maintain the right to refuse to participate at any time. I may request the results of the research.

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Parent/Guardian

Parent/Guardian

APPENDIX B
INSTRUMENTS

David H. Olson, Joyce Portner, and Yoav Lavee

| 1 | 2 | 3 | 4 | 5 |
|-----------------|--------------------|-----------|------------|------------------|
| ALMOST NEVER | ONCE IN A WHILE | SOMETIMES | FREQUENTLY | ALMOST ALWAYS |

DESCRIBE YOUR FAMILY NOW:

- _____ 1. Family members ask each other for help.
- _____ 2. In solving problems, the children's suggestions are followed.
- _____ 3. We approve of each other's friends.
- _____ 4. Children have a say in their discipline.
- _____ 5. We like to do things with just our immediate family.
- _____ 6. Different persons act as leaders in our family.
- _____ 7. Family members feel closer to other family members than to people outside the family.
- _____ 8. Our family changes its way of handling tasks.
- _____ 9. Family members like to spend free time with each other.
- _____ 10. Parent(s) and children discuss punishment together.
- _____ 11. Family members feel very close to each other.
- _____ 12. The children make the decisions in our family.
- _____ 13. When our family gets together for activities, everybody is present.
- _____ 14. Rules change in our family.
- _____ 15. We can easily think of things to do together as a family.
- _____ 16. We shift household responsibilities from person to person.
- _____ 17. Family members consult other family members on their decisions.
- _____ 18. It is hard to identify the leader(s) in our family.
- _____ 19. Family togetherness is very important.
- _____ 20. It is hard to tell who does which household chores.

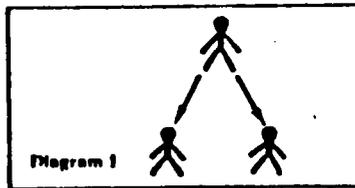
FACES III: Ideal Version Appendix B
David H. Olson, Joyce Portner, and Yaov Lavee

| 1 | 2 | 3 | 4 | 5 |
|-----------------|--------------------|-----------|------------|------------------|
| ALMOST NEVER | ONCE IN A WHILE | SOMETIMES | FREQUENTLY | ALMOST ALWAYS |

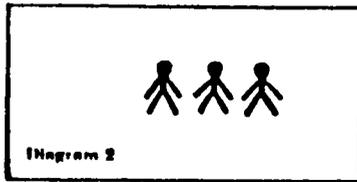
IDEALLY, how would you like YOUR FAMILY TO BE:

- _____ 1. Family members would ask each other for help.
- _____ 2. In solving problems, the children's suggestions would be followed.
- _____ 3. We would approve of each other's friends.
- _____ 4. The children would have a say in their discipline.
- _____ 5. We would like to do things with just our immediate family.
- _____ 6. Different persons would act as leaders in our family.
- _____ 7. Family members would feel closer to each other than to people outside the family.
- _____ 8. Our family would change its way of handling tasks.
- _____ 9. Family members would like to spend free time with each other.
- _____ 10. Parent(s) and children would discuss punishment together.
- _____ 11. Family members would feel very close to each other.
- _____ 12. Children would make the decisions in our family.
- _____ 13. When our family got together, everybody would be present.
- _____ 14. Rules would change in our family.
- _____ 15. We could easily think of things to do together as a family.
- _____ 16. We would shift household responsibilities from person to person.
- _____ 17. Family members would consult each other on their decisions.
- _____ 18. We would know who the leader(s) was in our family.
- _____ 19. Family togetherness would be very important.
- _____ 20. We could tell who does which household chores.

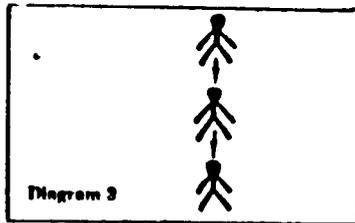
Figure 1. Madanes Family Hierarchy Test



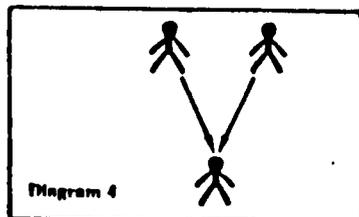
One person
in charge of
two other people



All three people
equal



One person
in charge of
second person
in charge of
third person



Two people
being equal
in charge of
a third person

Appendix B
Michigan Alcoholism Screening Test

DIRECTIONS: ANSWER EACH QUESTION BY PLACING AN "X" THROUGH THE SPACE PROVIDED TO THE RIGHT OF EACH QUESTION. THERE IS ONLY ONE ANSWER FOR EACH QUESTION.

- | | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| 1. DO YOU FEEL YOU ARE A NORMAL DRINKER? | [] | [] |
| 2. HAVE YOU EVER AWAKENED THE MORNING AFTER SOME DRINKING THE NIGHT BEFORE AND FOUND THAT YOU COULD NOT REMEMBER A PART OF THE EVENING BEFORE? | [] | [] |
| 3. DOES YOUR WIFE, HUSBAND, A PARENT OR OTHER NEAR RELATIVE EVER WORRY OR COMPLAIN ABOUT YOUR DRINKING? | [] | [] |
| 4. CAN YOU STOP DRINKING WITHOUT A STRUGGLE AFTER ONE OR TWO DRINKS? | [] | [] |
| 5. DO YOU EVER FEEL BAD ABOUT YOUR DRINKING? | [] | [] |
| 6. DO YOUR FRIENDS OR RELATIVES THINK YOU ARE A NORMAL DRINKER? | [] | [] |
| 7. DO YOU EVER TRY TO LIMIT YOUR DRINKING TO CERTAIN TIMES OF THE DAY OR TO CERTAIN PLACES? | [] | [] |
| 8. ARE YOU ALWAYS ABLE TO STOP DRINKING WHEN YOU WANT TO? | [] | [] |
| 9. HAVE YOU EVER ATTENDED A MEETING OF ALCOHOLICS ANONYMOUS? | [] | [] |
| 10. HAVE YOU GOTTEN INTO FIGHTS WHEN DRINKING? | [] | [] |
| 11. HAS DRINKING EVER CREATED PROBLEMS BETWEEN YOU AND YOUR WIFE, HUSBAND, PARENT, OR OTHER NEAR RELATIVE? | [] | [] |
| 12. HAS YOUR WIFE, HUSBAND, PARENT, OR OTHER NEAR RELATIVE EVER GONE TO ANYONE FOR HELP ABOUT YOUR DRINKING? | [] | [] |
| 13. HAVE YOU EVER LOST FRIENDS BECAUSE OF DRINKING? | [] | [] |
| 14. HAVE YOU EVER GOTTEN INTO TROUBLE AT WORK BECAUSE OF DRINKING? | [] | [] |
| 15. HAVE YOU EVER LOST A JOB BECAUSE OF DRINKING? | [] | [] |
| 16. HAVE YOU EVER NEGLECTED YOUR OBLIGATIONS, YOUR FAMILY, OR YOUR WORK FOR 2 OR MORE DAYS IN A ROW BECAUSE YOU WERE DRINKING? | [] | [] |
| 17. DO YOU DRINK BEFORE NOON FAIRLY OFTEN? | [] | [] |

Appendix B
Michigan Alcoholism Screening Test

18. HAVE YOU EVER BEEN TOLD THAT YOU HAVE LIVER TROUBLE? CIRRHOSIS? [] []
19. AFTER HEAVY DRINKING, HAVE YOU EVER HAD DELIRIUM TREMENS (D.T.'S) OR SEVERE SHAKING? [] []
20. AFTER HEAVY DRINKING, HAVE YOU EVER HEARD VOICES OR SEEN THINGS THAT WEREN'T REALLY THERE? [] []
21. HAVE YOU EVER GONE TO ANYONE FOR HELP ABOUT YOUR DRINKING? [] []
22. HAVE YOU EVER BEEN IN A HOSPITAL BECAUSE OF DRINKING? [] []
23. HAVE YOU EVER BEEN A PATIENT IN A PSYCHIATRIC HOSPITAL OR ON A PSYCHIATRIC WARD OF A GENERAL HOSPITAL? [] []
24. HAVE YOU EVER BEEN IN A HOSPITAL TO BE "DRIED OUT" (DETOXIFIED) BECAUSE OF DRINKING? [] []
25. HAVE YOU EVER BEEN IN JAIL, EVEN FOR A FEW HOURS, BECAUSE OF DRUNK BEHAVIOR? [] []

Alcohol Use and Family Structure

Please answer the following questions about yourself and your family. Your answers will aid us in interpreting the results of our research.

1. What is your present age? _____ YEARS
2. What is your sex? (Circle number)
 - 1 MALE
 - 2 FEMALE
3. Which of the following best describes your racial or ethnic identification? (Circle number)
 - 1 BLACK
 - 2 SPANISH OR MEXICAN HERITAGE
 - 3 NATIVE AMERICAN (AMERICAN INDIAN)
 - 4 WHITE (CAUCASIAN)
 - 5 ORIENTAL OR PACIFIC ISLANDER
 - 6 OTHER (PLEASE SPECIFY) _____
4. What is your current marital status? (Circle number)
 - 1 NEVER MARRIED
 - 2 MARRIED
 - 3 DIVORCED
 - 4 SEPARATED
 - 5 WIDOWED
5. What is the number of children presently living in your home in each age group? (If none, write "0")
 - _____ UNDER 5 YEARS OF AGE
 - _____ 5 TO 13
 - _____ 14 TO 18
 - _____ 19 TO 24
 - _____ 24 AND OVER

Demographic Questionnaire

6. Please specify the age and sex of each child taking part in this study.

| | AGE | | SEX |
|---|-------|--------|-------|
| 1 | _____ | —————> | _____ |
| 2 | _____ | —————> | _____ |
| 3 | _____ | —————> | _____ |
| 4 | _____ | —————> | _____ |

7. What is the last grade in school that you completed?
(Circle number)

- 1 LESS THAN 12TH GRADE
- 2 12TH GRADE
- 3 SOME COLLEGE
- 4 COMPLETED COLLEGE
(SPECIFY DEGREE) _____
- 5 SOME GRADUATE WORK
- 6 COMPLETED GRADUATE WORK
(SPECIFY DEGREE) _____

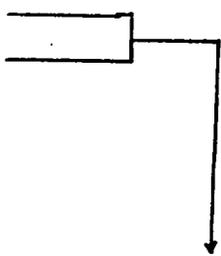
8. Do any adults presently live in your home other than those taking part in this study? (Circle number)

- 1 NO
- 2 YES (If yes, please describe the relationship of each adult to you)

Demographic Questionnaire

9. Are you presently: (Circle number)

- 1 EMPLOYED FULL TIME
- 2 EMPLOYED PART TIME
- 3 UNEMPLOYED
- 4 RETIRED
- 5 FULL TIME HOMEMAKER



If yes, please specify occupation:

Specify hours per week) _____

10. If you were employed in 1985, what was your approximate income before taxes? (Please respond to both columns.)

| | INDIVIDUAL INCOME | FAMILY INCOME |
|---|-------------------|------------------|
| 1 | LESS THAN 10,000 | LESS THAN 10,000 |
| 2 | 10,000 TO 19,999 | 10,000 TO 19,999 |
| 3 | 20,000 TO 29,999 | 20,000 TO 29,999 |
| 4 | 30,000 TO 39,999 | 30,000 TO 39,999 |
| 5 | 40,000 TO 49,999 | 40,000 TO 49,999 |
| 6 | 50,000 AND OVER | 50,000 AND OVER |

11. Do you ever drink alcoholic beverages, including beer, wine, liquor, or mixed drinks? (Circle number)

- 1 NO
- 2 YES

APPENDIX C
PERMISSION TO CONDUCT RESEARCH

Permission to contact the patients of Mt. Regis Center and their families to request their participation in a research project on alcoholism and family structure is:

APPROVED Yes

DENIED _____

SIGNED _____

Return to:

Rona Preli, ACSW
Center for Family Services
Department of Family and Child Development
Virginia Polytechnic Institute and State U.
1601 South Main Street
Blacksburg, Virginia 24060

Appendix C
SAINT ALBANS PSYCHIATRIC HOSPITAL
RESEARCH REVIEW COMMITTEE
January 14, 1987

Those attending: David J. Moore, Ph.D.; Thomas C. Camp, Ph.D.; Joseph McVoy, Ph.D.; Paul Hlusko, M.D.; Gina Rhea, M.D.IV. and Neil P. Dubner, M.D.; Medical Director.

Prior attitudes and policies regarding research were discussed. In the past research was discouraged at the hospital. The present committee unanimously endorsed research as an important endeavor of our hospital. The committee recognized that the testing of new drugs and the utilization of invasive procedures was not compatible with the mission of a private psychiatric hospital. Nevertheless it was felt, with these exceptions, that meaningful clinical research could be done.

The committee unanimously agreed that a memo should be sent to each department head and program director advising them that research is to be encouraged at this hospital.

The committee directed Dr. Dubner to develop procedures which would lead to a formation of an institutional review board to review research projects.

A research project by Rona Preli, A.C.S.W., family therapy intern, was presented by Dr. McVoy and reviewed by the committee. The hypothesis to be tested by the project was the following: "Alcoholic families will manifest considerably more structural disfunction than will recovered or non-alcoholic families". Structural disfunction refers, for example, to disfunction of the family in the areas of adaptability and cohesion. The committee emphasized the importance of getting physician approval before signed informed consent was obtained from the patient. The project was accepted unanimously by the committee. It was also recommended that Ms. Preli make a presentation to the Medical Staff at a Journal Club in the future.

Dr. Dubner presented preliminary ideas on a project being developed by Drs. Abse, McGraw and Dubner on the use of tincture of opium in the elderly depressed patient with organic brain disease who has not responded to conventional therapy.

The committee resolved to meet quarterly and more frequently, as needed, to review research projects. Also, the committee asked that these minutes be reviewed by the Executive Committee of the Medical Staff and the Executive Committee of the Board of Directors on a regular basis.

Neil P. Dubner, M.D.
Medical Director

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