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Maternal Alcoholism and Family Life:
A Cultural Model for Research and Intervention

by

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by

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ABSTRACT

MATERNAL ALCOHOLISM AND FAMILY LIFE: A CULTURAL MODEL FOR RESEARCH AND INTERVENTION

This work examines the behavioral dynamics of problem family life in households wherein the apparent source of conflict is chronic alcoholism. Both the ethnographic and family systems approach are applied to eight case studies of white middle class Protestant families. In each case the mother is the identified problem drinker. Descriptions of whole family response to alcoholism and conceptual issues chosen for discussion are based on my own naturalistic, in-home observations of these families over a 22 month period. All of the families were intact and among those seeking treatment from major alcohol programs within a large county mental health system.

Among all eight families commonalities in behavioral responses to alcoholism are found. A "Family-Level Cultural Model of Alcoholism" is introduced for the purposes of analyzing these commonalities. Within this theoretical framework it is argued that families who are afflicted with chronic alcoholism must confront three major problems: one problem is to protect the family from being ostracized by society; the second is to keep the family organization functioning at a level which insures its members an adequate chance for survival; and the third is to incorporate the drinking behavior as a homeostatic mechanism which supports the stability of the family unit. These external pressures to conformity, and internal pressures for unit survival, force the family into an adaptive or "alcoholic" family culture. Family dynamics which serve to maintain both the chronic alcoholism and the alcoholic family system, are described and analyzed in terms of the cyclical nature of the drinking behavior.

This proposed model may be useful for explaining various other kinds of health problems and in families from other cultural backgrounds.

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CHAPTER 1: INTRODUCTION

Goals and Definitions

This dissertation is concerned with the role of problem drinking, or what is generally referred to as alcoholism, in the behavioral dynamics of white, middle class American families. It presents a broadly-defined cultural dimension of problem family[1] life wherein the identified source of conflict is parental alcoholism, in this case maternal alcoholism. Based on almost two years of naturalistic observation in the homes of eight such families, I have explored the adaptive measures by which families struggle to remain as functioning, stable units in the face of the disruptive and dysfunctional behavior that accompanies parental alcoholism. Inclusive in these overall objectives are three primary purposes, all of equal importance, and which are ethnographic, theoretical and applied in nature.

First, and in keeping with the broad ethnographic purposes for which the field research was orginally designed, whole family response to chronic alcoholism is considered in light of the ethnoreligious background of the research participants and the general cultural environment in which they reside. Coping strategies are described in terms of the everyday events, rituals and otherwise normal routines of middle class[2] family life as we know it or believe it to be in American society. The case studies which follow describe and explain ways in which the drinking problem is meaningfully imbedded within an individual, family and cultural context. But more than that, this study considers the broader issue of conflicting health beliefs within a pluralistic cultural society. This is a "case study" of families from one American subculture, in this instance middle class Protestant, and their experiences with a debilitating and serious

chronic illness which for them has moral, rather than -- or in addition to -- medical implications.

There is an established need for research designs that examine in more detail the cultural components and variations associated with family dynamics and alcoholism (Ablon 1980; Steinglass 1980). Thus, a second goal of this dissertation is to provide a theoretical model which can be used alone or in combination with other approaches, to assist researchers and clinicians in the organization of their observations. The analysis of family dynamics in these eight case studies has provided a "Family-Level Cultural Model of Alcoholism." The basic concepts and empirical procedures which served as the building blocks to this model evolved out of my research process. What started out to be a basic, exploratory and descriptive analysis of the everyday events and behavioral patterns in the homes of women alcoholics, developed over a two-year period into a complex, but logical and holistic, theoretical framework for understanding alcoholic family dynamics. The model has an ethnographic orientation and incorporates the family systems approach to alcoholism.

The third and applied purpose of this study is to develop a cultural perspective on alcoholic family life, one that will be useful to health professionals who treat problem drinkers, researchers in the field, and for the families who are afflicted with alcoholism themselves. Hopefully, other people can use this model as a guideline for understanding the complex nature of problem drinking in a familial context. By viewing alcoholism in terms of both the sociocultural context in which it occurs and as part of an ongoing interactional pattern within the family system, we learn that therapeutic interventions aimed at individual psychopathology -- and abstinence for the problem drinker -- are usually inadequate to the task (Steinglass 1980). From a family systems viewpoint, the alcoholism can be viewed as a characteristic

of family organization and interaction, rather than only an individual problem or a disease. It follows that therapy and other forms of treatment should focus on circular behavioral interactions of the entire family unit in addition to treatment of the afflicted family member or members.

Depending on the varying personal and ethnoreligious perspectives from among the multicultural groupings in American society, the terms "alcoholism" and "alcoholic" have different meanings for different people. Differing cultural beliefs about the nature of alcoholism are discussed in the following chapter, but for overall purposes of defining it as a health problem, I rely here on Plaut's (1967) definitions of alcoholism and problem drinking:

> ...alcoholism is defined as a condition in which an individual has lost control over his alcohol intake in the sense that he is consistently unable to refrain from drinking or to stop drinking before getting intoxicated (39).
>
> ...problem drinking is a repetitive use of beverage alcohol causing physical, psychological or social harm to the drinker or to others (37).

The element of loss of control differentiates between these two definitions, but in terms of the effect of excessive alcohol consumption on individual and family health, the overall consequences of excessive and repetitive drinking overlap.

The Families

The data for this study were collected during approximately two years of intermittent, but intensive field work starting in October, 1978, and lasting through most of the summer of 1980. The empirical descriptions of family behavior were drawn from an informant population of white, middle class, predominantely Protestant families who were troubled enough to present themselves to a clinic and who had identified alcohol problems as a contributing factor to their family conflicts or had agreed to this identification by clinicians.

Eight such families, living in several neighboring suburban areas, were studied over a six-month to a two-year period. My association with five of the eight families spans all four seasons of the year, and various hours of the night and day. In all of the families, either the mother, the husband and wife, or the entire unit was seeking treatment from county or private mental health services, and in each case, the mother had been identified by such services as an alcoholic. Among all of the women, the duration of their alcoholism ranged from four to eleven years.

All of the families were "intact" in the traditional sense that parents were married to one another and living in the same household together with their minor children. In all eight families, the father was the principal provider, and the mother was theoretically positioned in the traditional role of housewife. Four of the wives were employed: two held full-time and two part-time jobs. In all four cases, the women were frequently unable to report for work during drinking periods, or when suffering from severe hangovers or other alcohol-related health problems.

At the time the participants volunteered to be research subjects, I clearly explained to the entire family unit the goals of the study, and the potentially problematic nature of the field work. All of the field work procedures were carried out in accordance with established anthropological ethics and the contractual agreements arranged between myself, the families and their therapists. In consideration for invasion of privacy, the rights and personal considerations of the individual families (or individual members) received first priortiy in the research procedures. For example, in no case was a child under 18 (or older for that matter) interviewed without the express permission of both parents. The interviews were always arranged at a time and place considered most comfortable to the interviewee, and I rarely visited

a family home unexpectedly. The families never asked or expressed concern about the confidentiality factor, primarily because they viewed me initially as a professional with the more remote kind of relatonship of say a clinician or social worker, and later on as a trusted friend and confidante. In any case, all data is held as confidential and the analysis of the material will in no way identify the contributors, nor violate their private family lives. The names are pseudonyms and the specific location of the field setting is not identified.

The Field Method

The opportunity to do this research came to me during my years of graduate studies in Medical Anthropology at the University of California and under a grant from the National Institute on Alcohol Abuse and Alcoholism. Joan Ablon, the principal investigator of the study, inspired by Jules Henry's Pathways to Madness, had originally designed the project as a naturalistic study in alcoholic households. The design utlized the generic research methods of traditional anthropology. Such a project had never been proposed for the study of alcoholic families. Ablon originally designed the study to focus on families wherein the husband was the problem drinker. Because of my previous interest and research in female drinking patterns and problems (Ames 1977), the research sample was changed to be comprised of families wherein the wife-mother was the problem drinker. There is a dearth of information on female drinking behavior, particularly where female alcoholism occurs in the context of intact marriages and families.3

From the beginning, the overall goal of this study was ethnographic, that is, to describe and interpret the ordinary, everyday routine of alcoholic family life as it occurs in their natural surroundings. By definition, this meant that the data had to be collected in the homes of the research subjects, on their terms and interpreted from their point of view. The naturalistic method,

that is the observation of humans in their natural habitat, seemed to be a particularly appropriate approach to studying everyday family behavior in alcoholic households. However, I soon discovered, as perhaps others before me have, that there are certain incompatibilities between the generic methods of family research so familiar to anthropologists working in remote, traditional societies, and the realities of observing private behavior in the homes of contemporary urban families. From my own experiences, I found these incompatibilities to be practical problems of a temporal, personal and theoretical nature.

At the time I was planning the field work stage of this research — summer of 1978 — there were no methodological guidelines for how to go about studying urban families in their natural habitat over extended periods of time.[4] Jules Henry, who carried out the prototypic study in the households of problem families, those wherein there was a psychotic or autistic child, gives us little in the way of methodological accounting of his field experience (1965). In fact, throughout the family literature, there is very little mention of methodological procedures for long-term involvement with "normal" or troubled families. My early months of field work were notable for their trial and error procedures. The problems that I encountered in finding families who agreed to participate in the first place, in gaining entry to their homes for repeated and extended periods of time, and in building up a rapport and trust level which allowed for normal family life to proceed in my presence took an enormous amount of energy.

The first challenge was the formidable task of informant recruitment through the mental health establishment and accomplishing the accompanying appropriate negotiations with the families who volunteered to participate. Weeks and in some cases months went by before families felt comfortable

with my presence in their homes, a reaction which under the circumstances of maternal alcoholism was most understandable. The potentially problematic nature of doing research among so-called normal families are most surely exacerbated when working with families who have a stigmatizing health problem like alcoholism (Ames and Ablon 1981). In alcoholic families, the occasional crises of normal family life are replaced by more frequent and severe ones such as periods of excessive drinking or other kinds of behavior which family members might consider embarassing or abusive. In any case, over time and to the degree that I became more intimately involved with the problematic nature of their lives, a sufficient level of rapport and trust was established to allow the daily behavioral routines to proceed in a more natural or at best quasi-natural interactional context. The complex and emotionally-draining nature of my relationship with the eight families who so kindly allowed my presence in their homes and supported the goals and purposes of this research, evolved as perhaps the most important component for both the processual analysis and the validity of this data. Good ethnography, the description of cultural behavior in its natural form, is after all only as valid and richly perceived as the relationship between researcher and informant (Spradley 1970). In studies such as this where the integrity of the data is dependent on the degree to which the researcher can "reach" the more intimate details of family life, informant-researcher rapport emerges as the overriding variable for the validity of what we ask the reader or recipients of our analysis to accept as "truth." In keeping with my concern for these matters, I have prepared a post-field analysis of my own interactional and research processes. This further explication of my field work experience along with the discoveries of workable methods for naturalistic family research is discussed in detail in Addendum B and implicitly throughout the presentation of data in other chapters.

My principal techniques of data collection were basic methodological procedures of social anthropology: participant observation, the taking of life histories, and unstructured interviewing. My original plan for participant observation was to integrate myself into the family scene to the degree that I could sample the life style in each home repeatedly over a year span for 2 or 3 days at a time. I wanted to discover how family dynamics unfolded at various times of the day, and to observe routine events and rituals such as mealtime, shopping, visiting with relatives, holidays and so forth. In all cases, this early plan had to be limited by the drinking pattern of the mother and the level of rapport or established trust level between myself and the family. Whenever possible, I proceeded with home observation, but within the appropriate time "allotted" to me by the family participants, and most notably the mother.

Personal life histories and verbal accounts of everyday normal life were taken from all of the parents and most of the adult children. With this data, I traced the family of procreation from its inception, thereby gaining an historical dimension to the drinking problem as well as a diachronic analysis of the existing family culture. Each family member's input and perception of the history of the mother's drinking behavior and of the family process around that behavior was important and relevant data. This material helped determine whether the family's existing structure and behavioral patterns evolved with the drinking problem or were predispositions to the drinking problem, if radical behavioral changes had taken place, and how, when and for what reason had these changes occurred.

The semi-structured interviews were taken in two ways. The more formal prearranged interviews were taken from family members, individually,

on specific topics of interest to the study. On some occasions, I interviewed two or more family members together. These were one to three hour sessions and were almost always tape recorded. Other more informal types of interviews were taken in the form of conversations with one or several family members during the course of a meal, a shopping excursion, or a recreational event. Another source of information on ongoing behavioral dynamics, and most particularly in time of trauma or crises, was the frequent telephone contacts from various family members. Since I had only occasional access to the homes when the mother was intoxicated and in her drinking period, these informal, verbal accounts of family life emerged as critical and highly supportive data for my analysis of the structural and behavioral adaptations to the disruptive situation of maternal alcoholism.

Scope of the Problem

Few people who know anything about alcohol problems would deny that excessive, habitual drinking of one family member has a damaging effect on the whole family unit. There is a growing consensus among professionals in the field that alcoholism contributes to family stress and instability, and that wives, husbands and children of alcoholics have "relatively high rates of physical, emotional and psychosomatic illness" (Straus 1971:259). Reflecting the disruptive nature of alcohol abuse and family relationships, a nationwide survey reported that 25 to 33 percent of problem drinkers associated marital discord with excessive drinking (Cahalan 1970). In general, "alcoholic marriages" or marriages where there is an alcoholic, have consistently shown more marital conflicts, separation and divorce than control groups (Bailey 1961). The destructive effects of parental alcoholism for children's emotional and developmental well-being has been comprehensively discussed by Fox (1962)

and her finding that 40 to 60 percent of all alcoholics come from problem drinking backgrounds (1956) suggest that children of alcoholics are at high risk for the development of drinking problems themselves.[5]

Until recently, these data and other indicators of alcohol-related family problems have not been given adequate attention by the medical and scientific communities. Primarily, this unfortunate omission was related to the prevailing medical model for explaining alcoholism, an approach which views alcoholism as a progressive disease. Since the disease process is described in terms of the individual the inclusion of whole families for research and clinical treatment seemed unnecessary and irrelevant to the traditional establishment in the field of alcoholism.

It is only within the last decade, and out of a history of research and clinical neglect that professionals in the field have recognized the need to consider alcoholic problems in the context of family life. Increasing awareness of the importance of family factors for the treatment process is clearly represented in the growing number of clinicians who apply family therapy techniques to alcoholic clients (Steinglass 1976) -- and from another treatment perspective -- in the growth of such self-help groups as Al-Anon, Alateen and Alafam, organizations which consider the needs of alcoholic family members[6] (Steinglass 1980). Unfortunately, the enthusiastic demand and support for new treatment techniques has far outpaced workable family-oriented conceptual models of alcoholism (Ibid). To date, attempts to build conceptual models of family interaction and alcoholism have emerged from the varying perspectives of stress theory (Jackson 1954), transactional analysis (Steiner 1971) behavioral learning theory (Paolino and McCrady 1977), longitudinal family development (Steinglass 1980), and family systems (Ewing and Fox 1968; Steinglass, Weiner and Mendelson 1971a,b; Bowen 1974). The highly sophisticated model of

Peter Steinglass and his associates (1971a,b) wherein the alcoholic family is viewed as a system with its own structure, interactional behavioral patterns and homeostatic mechanisms, is without a doubt the most significant contribution in the literature dealing with alcoholic treatment and family therapy.

While there is no question that all of the above efforts have made forward strides towards the inclusion of families in alcohol problems, there are two notable oversights in these models. To begin with, they do not consider the sociocultural context in which families live or to what extent whole family behavior is the living out of cultural expectations or prescriptions. For some years Ablon (1976; 1979; 1980) has been the lone voice in her suggestion that more attention be given to cultural, social or economic aspects of alcoholic family life. Her most recent study of drinking behavior among nonlabeled, Irish-Catholic families (1980) illustrates the significance of cultural patterning for both the inception and continuance of excessive drinking patterns.

Secondly, most of the research data for the above models were gathered from clients in a clinical or agency setting and therefore tend to focus on the **extraordinary** psychosocial interrelationships of family members to the exclusion of the most relevant context in which these problems occur -- the natural environment of the family home. Before we can understand the dynamics by which families generate and maintain problems such as alcoholism, schizophrenia, anorexia, and others, we must have a framework or understanding how they conduct their lives within the familiar, everyday environment of their natural habitat. (Others who have spoken at length to this need are Henry 1965, Ablon 1979, and Kantor and Lehr 1975). While most of us share the common experience of family life in one form or another, it is difficult to

extend that private and personal knowledge to other families from the remote context of a clinical setting or a formalized interview situation. In order to understand how families cope with disrupting problems such as chronic alcoholism, we should be there; we should observe ongoing family dynamics in the homes, and in a context as nearly as possible as uncontrived and natural as our own family environments.

On a purely practical level, this brings up another reason why the everyday life styles of problem-laden families have been neglected as a subject of research; problem families are simply too difficult to reach. In-home studies of family life present difficult and oftentimes unpleasant situations for both the researcher and the research participants. In light of the elusive, problematic nature of family research per se, and the lack of methodological procedures for naturalistic observation[7] among American urban families, it is not surprising that so few researchers have attempted in-home studies with either normal or problem families.[8]

Family Culture

In an effort to address some of these issues, and resulting from two years of fieldwork, I present in this volume a cultural and systems analysis of alcoholic family life. However, before moving on to a discussion of an analytical model, it is important to note that subsumed within the more structured elements of this study, is a basic description of family life from what is known in anthropology as the "insider's point of view" (Spradley 1970:7). This means, very simply stated that I, the researcher-anthropologist, attempt to describe and conceptualize the life style of the families under study in a way which as nearly as possible approaches their own definition of reality (Ibid). While other points of view and other perspectives on problem family life are possible,

and for other purposes, equally relevant, this view presents a descriptive account of behavioral interaction as it occurs behind the closed boundaries of stigmatized family life, and from the participants' own reflective point of view and existential experience. What may appear to be the uninvolved outsider as an unusually private, but otherwise stable, ordinary family unit, is in fact from the insider's view, an ongoing charade of normalcy. That charade is the cumulative result of conflicting beliefs about alcoholism, adjusted values, role reversals, intrapychic struggles, ongoing crises, perennial guilt and the cultural pressure to hide these problems from the outside world. To the degree that these ideological, structural and behavioral adjustments become the norm for the families of this study, and that they are learned, shared and transmitted among all of the family members, what I have described here in this book, can be called a family "culture." In that sense, this book is an ethnography of alcoholic family culture as it exists for the selected sample of middle-class Protestant Americans. The experience of maternal alcoholism as described for this sample group may or may not be similar in families from other ethnic or sociocultural backgrounds or even to other middle class Protestant families. The sample is small. And lastly, the proposed analytical model which I present in the following chapters, is not narrowly limited to chronic alcoholism or only one subcultural group. It may be useful as an analytical "grid" for explaining the complex nature of other kinds of "problem families" with various other kinds of social or health related problems -- including but not limited to alcoholism.

A Family-Level Cultural Model of Alcoholism

The proposed model which I outline below, has been given the tentative title of "A Family-Level Cultural Model of Alcoholism. It is tentative only in the sense that I propose it here and hope that other researchers in the

field will contribute to its further development. It consists of three levels or frames for analyzing alcoholism and family life. These are: 1) Cultural patterning and alcoholic family behavior; 2) The alcoholic family system and basic survival, and 3) Chronic alcoholism and family problem solving.

The basic concepts and empirical procedures which served as the building blocks to this analytical process (the model) are explained first in this chapter, again in Chapter 7, and generally throughout the text. Although all eight families were included in the analytical development and tentative conclusions which support this approach, extensive case studies of only three families are presented in Chapters 3, 4, and 5. While each family is notably idyosyncratic in the development of the drinking problem, and in their structural and behavioral responses to maternal alcoholism, the underlying themes for certain behavioral trends are strikingly similar among all eight families. These similarities are reflected theoretically in the final discussion of the model.

By way of contrast but complementary to the previously discussed conceptual approaches to alcoholism and family life and those reviewed in more detail in the Appendix, this analytical framework has both a strong ethnographic orientation[9] and it incorporates the family systems approach to alcoholism. While there is no question but that I utilized conceptual and theoretical tenets of my profession or that I built upon the theories of leaders in the field of family research, the model itself was not preconceived or set up as a hypothetical framework to be tested in the field; as a mode of analysis, it evolved out of my research process. In effect, the analysis of this data started out with basic ethnographic description of family behavior and from there proceeded towards a more structural, theoretical framework of explanation for whole family response to the parental alcoholism.

My overall theoretical orientation is in the tradition of structural-functional anthropology insofar as I view the family as a system with consideration for both external and internal pressures on family structure and interaction.[10] In the former, the family is viewed as one of several other social systems in a society with the focus of investigation on family structure and behavior as related to **exterior** factors such as cultural norms, beliefs and values, and in terms of family interaction with other relevant social organizations such as church, school and workplace. Reflecting this perspective, the behavior of the identified problem drinker[11] and whole family response to that behavior, is examined in the context of the basic sociocultural traditions and environment in which the family members live. In the family cases of this study, the cultural context is predominantly middle class Protestant. Therefore, particular attention is given to family behavior in light of conflicting "culture bound" norms, beliefs and values around the divided issue of whether alcoholism is a so-called moral problem, a medical problem or something else. The wide gap between scientific-intellectual and cultural-emotional responses to alcoholism as it exists in America on a culture-wide basis, is viewed here as one important underlying variable directing the ways families cope with drinking problems. As outlined in Chapter 2, this medical-moral dilemma in its cultural and historical context, has far-reaching implications for differing perspectives on the health and treatment of alcoholics. In sum, the external (or macrofunctional) level of analysis considers the impact of outside social and cultural factors on alcoholic family behavior, and it constitutes the **first level** of the analytical model, "Cultural Patterning and Alcoholic Family Behavior."

In terms of internal pressures (or microfunctional analysis) a perspective utilized by leaders in the field of family systems theory (Bowen 1974; Davis

et al. 1974; Steinglass, Weiner & Mendelson 1971a; 1971b; Weakland 1977), I view each nuclear family as a system, with its own structure, functions, internal and external boundaries.

Steinglass (1979) describes the notion of family system as it is conceptualized and applied by family therapists:

> Drawing on concepts from general systems theory, family therapists have found it profitable to think of the family as an operational system. This view treats the whole family as the primary organizational unit. Individuals within the family represent component subsystems of this primary organizational unit. The emphasis is on patterns of interrelationship between these component parts, hence the focus on interactional behavior, structural patterning within the family, and the balance or stability of the system as a whole. Any single piece of behavior for the family systems therapist has to be understood first in terms of how all the component parts (individuals) are contributing to or making the behavior possible, and secondly, how the behavior is affecting all the individuals in the family. Pathology becomes redefined as a structural or functional imbalance in the family rather than as difficulties being experienced by any single individual within the family. Therapy is focused on the improved understanding of the structure and patterns of functioning within the family, and on correcting these imbalances that have led to stress or strain within the "system" (151).

As an analytical procedure, the family systems approach helps the researcher (or therapist) to identify and understand the role of alcoholism for the whole family unit. According to Steinglass et al (1971b), the systems model examines the following question:

> Is the identified patient's drinking behavior an emergent symptom signaling the appearance of stress or strain within the family, or is the drinking part of an ongoing pattern of interaction between family members that helps to stabilize the family system? (406)

In either case, the underlying assumption of the family systems approach is that if an alcoholic family is intact, as all of these participating families

were, it must be viewed as a working, operational system. In other words, if one parent is addicted to alcohol and always or periodically unable to fulfill expected parental role duties, certain changes have most probably taken place in that system. These changes compensate for the absence or dysfunction of the afflicted parent. That compensation takes place in the form of role reversals, altered communications patterns, changes in traditional family rule systems and adjustments of ordinary behavioral patterns. In most cases various kind of family-level physical and psychological symptoms related to the drinking behavior also occur. As demonstrated in the case studies which follow, all this maneuvering around the drinking and non-drinking periods of the mother has more of a functional than dysfunctional effect in the sense that it helps maintain a homeostatic family balance; it helps to make the system "work" (Steinglass et al. 1971b), or in effect, adapt to the dysfunctional member. In turn, the problem drinker adapts her behavior to the system. These circular processes by which the family system is sustained and the drinking behavior is maintained, are identified, described and explained empirically in the text of the case studies, and later theoretically in the discussion chapter. This microfunctional view of alcoholic family life is accomplished on the second and third analytical levels of the model.

At the second level of analysis, "The Alcoholic Family System and Basic Survival," these issues which I have just discussed are addressed at what I call the "basic survival level" of the alcoholic family life. Here is where I examine the more practical, mundane problems around family adjustment to the on again, off again drinking patterns of the mother and to the subsequent "see-saw" nature of her maternal role duties. When she is in her drinking stage, decisions have to be made on life-sustaining matters such as getting food into the house, preparing at least quasi-nutritional meals for young, growing children,

cleaning the house, laundering the clothes and coordinating school and social activities. With respect to emotional needs, I examine family adjustments to the frequent and periodic withdrawal of a nurturing, affectionate wife and mother. As a point of comparison, behavioral manifestations of these adjustments are described in terms of her drinking and non-drinking periods and in some cases, "transitional" stages between the two.

The third level of analysis, "Chronic Alcoholism and Family Problem Solving," examines interactional behavior which serves to support and maintain both the drinking problem, and the alcoholic family system. Over a research period of close association with families and in relation to my changing perceptions of the underlying causes for certain family behaviors, this stage of the model was formulated, changed and reformulated several times. For example, in the beginning stages, the drinking periods of the mother seemed to be related to her own struggles with personality factors such as depression, or lack of self-esteem. I discovered later on that she oftentimes planned her drinking periods so they would not interfere with certain family rituals and special events, or with vital maternal role duties. Still later, and after in-depth analysis of repeating patterns of family behaviors, I discovered a relationship between the mother's drinking cycles and certain behavioral patterns of other family members. These and other pecularities, when more broadly described and analyzed, emerged as behavioral manifestations of family participation in the ongoing maintenance of the drinking problem. As a unit, family structure and dynamics were organized or adjusted to accommodate the drinking behavior and to satisfy particular needs of individual members.

Steinglass, Weiner and Mendelson (1971 a,b), all practicing psychiatrists, presented a specific model for examining whole family interaction and family systems maintenance. They based their model on an observational study of

three familial pairs of chronic alcoholics before, during and after a fourteen day period of experimentally induced intoxication in private quarters set up for the study within a clinical setting. Their observations led them to propose that alcoholic behavior can best be understood in the context of how it contributes to the equilibrium and stability of an interactional human system such as a family.

> Each member of this system has carefully selected or manipulated each other member of the system, and adjusted his or her own behavior, such that there is a complementary relationship of psychopathology, needs, strengths, cultural values, etc. within the family. The purpose of such maneuvering is to get the system to 'work,' that is, continue to function as a system, maintain the solidity of the family group, insure that the members of the system stay together, etc. (1971b:405).

The authors suggest that the manipulation and ongoing alcoholic family tradeoffs may function as an integral part of one of the working programs within the system.

> For example, alcoholism might serve to satisfy unconscious needs of the members of the system or, as we noted in the third pair, it might cement clear-cut role differentiation or power distribution and thereby reduce tension in the system emanating from ambiguity about role power (Steinglass et al. 1971a:278).

Drawing from some aspects of this theory, I will later on empirically describe alcoholic family maintenance empirically -- as it occurs in the home in the course of everyday routines of family life.

This third analysis then deals with the more mental or "intrapsychic level" of coping strategies, meaning that certain family members have predictable personality and behavioral changes coinciding with the mother's drinking and non-drinking periods. At first glance, these "mood swings" seemed to emerge in order to accommodate the cyclical nature of the mother's drinking patterns. However, a deeper, more intimately observed analysis of such behavior

suggested that certain family members had over time developed subconscious, or at best, implicit reciprocal arrangements between themselves and the problem drinker which accommodate individual needs or personality problems of their own. These "built-in" interpersonal strategies also helped maintain the mother's drinking problem. Behavioral manifestations of this analytical stage came into my view only after many months of close and more trustful association from all family members. It was by far the most difficult -- and delicate -- stage of the descriptive and analytical processes.

FOOTNOTES

1. Family, for the purposes of this study, is defined as a married couple with children. The unit is intact and all members who are minors and/or unmarried are residing in one household, or in the case of a single adult, maintain lineal ties to that unit.

2. In a relatively open society such as the United States, the concept of social class and especially the notion of middle class is difficult to define due to the fluid and heterogeneous nature of socioeconomic groupings. For example, high material standard of living, sexual morality, higher education and espect of property ownership, values which are characteristic of the middle class may alo be included in the value structure of many people from other socioeconomic groupings. By established definitions for socioeconomic class, the participants in this study range from lower middle class to upper middle class.

   An acceptable definition of a middle class way of life is outlined by Nye and Berardo (1973) both leaders in the field of family sociology:

   > The middle class averages both a higher income level and more stable incomes, because salaries rather than wages are the modal pattern. Also, most middle-class individuals defer some gratifications while they obtain advanced education. These larger and more stable incomes lead to higher expectations in the middle-class level of living. It is expected that middle-class peoople will live up to "a middle class way of life." Housing should not only be comfortable but look attractive within and without. An automobile becomes not only a means of transportation but an object of beauty. A library and magazines should serve the intellectual interests of the educated parents and stimulate the mental development of the young. Food should be varied and attractive as well as nourishing. Clothing should reflect style and taste as well as comfort. In short, middle-class occupations require more education, are more complex, involve more responsibility, and as a consequence command larger financial rewards. The norms reflect the expectation that these larger financial resources will be reflected in a more generally desirable level of living. The family whose way of life doesn'treflect such a level of living may be thought to be exercising poor judgment in the use of its resources (64-65).

3. Over the past two decades, the number of American women who use alcohol has increased from 45 to 66 percent (Gallup 1958, 1978). The incidence of alcoholism among women increased from one million in 1966 (Kinsey 1966) to three million by 1974 (Chafetz 1974). These figures do not include the large number of women who drink secretly and/or those who are inhibited from seeking professional help for their drinking problems Until recently, the alcohol literature reflected the notion that while alcohol

addiction and heavy drinking patterns are incorporated into the behavioral patterns of men, for women, these factors are deviant, if not immoral behaviorisms. According to Block (1966) these differential attitudes prevailed because heavy drinking among women runs counter to American ideals of self-controlled, lady-like behavior "and because it produces even greater disruption in family life than alcoholism among men" (5). This widespread differential atttude imposes on women a heavy constraint against excessive drinking patterns, and for the population at large, it confers a "cultural protection" against female alcoholism (Knupfer 1964). Families, clinicians, and the afflicted women themselves are more concerned with masking the problem from the larger community than in taking constructive measures to confront and change it. Recent reviews of literature on alcoholic women can be found in Lindbeck (1972), Schuckit (1972) and Sandmaier (1980).

4. Four years later (1981) Hansen reported on her field experiences while observing daily routines among urban families. She participated in a project directed by Jules Riskin, at the Mental Research Institute, Palo Alto, California where the purpose was to compare several groups of families, including "normals." Hansen lived in with three "normal" families for a week each. Her discussion of methodological experiences centered on the effect of the researcher's presence on family behavior and on her own (the researcher's) emotional response to the research experience.

5. Current research efforts of Bennett, Wolin & Noonan (1976) are seeking the needed empirical understandings of intergenerational aspects of alcoholism, and the effects of parental alcoholism on children (Bennett & Wolin are also researching this latter issue).

6. Al-Anon is a self-help group for spouses of alcoholics, Alateen is for teenage children of alcoholics, and Alafam, a rare and fledgling organization, includes the entire family. The alcoholic member is excluded from attending meetings of the first two groups, but is encouraged to attend the Alafam meetings (Ablon 1974).

7. This is relevant to Western society only. Anthropologists have a long and distinguished tradition in the formal study of family life in traditional, exotic societies; unfortunately, few anthropologists have studied American families (Ablon 1979:196).

8. There are a few studies which focus on family structure in relation to particular community or environmental situations, such as socioeconomic status, ethnic solidarity and poverty (for a review of these works see Bott 1971; Gans 1962; Howell 1973; Lewis 1959; Liebow 1967; Stack 1974). The lone study of problem family behavior as observed in the natural environment of the home is Jules Henry's Pathways to Madness (1965), an analysis of family life wherein there is a psychotic or autistic child.

9. Ethnography means the study of culture; ethnographic orientation here means that family life is viewed and described in terms of a family "culture" or if you will, in terms of their own unique structure and interactional patterns of behavior as influenced not only by the sociocultural environment in which they live, but also by the alcoholism problem.

10. Hill and Hansel (1960) refer to these as macrofunctional and microfunctional analysis of family life.

11. The concept of "Identified Patient" according to Steinglass (1980) is as follows:

> Perhaps the most revolutionary impact of family therapy on psychiatry has been the redefinition of psychopathology in family terms. The schizophrenic individual becomes the schizophrenic family. The alcoholic individual becomes the alcoholic family. The antisocial individual becomes the antisocial family. This transformation occurs via the concept of the identified patient. According to his concept, the symptomatic member of the family -- be he or she schizophrenic, alcoholic, or psychopathic -- is not merely a disturbed individual who would be clearly symptomatic in his own right regardless of the behavioral setting. Instead he or she is the labeled or identified patient selected by the family system of which he or she is a member to express for the entire family the particular disturbance represented by the symptom selected (152).

CHAPTER 2: ALCOHOLISM AND AMERICAN CULTURE

A Problem of Conflicting Beliefs

In order to place the interactional framework of alcoholic family life in its proper theoretical context, it is imperative first to consider from the differing perspectives, American beliefs about alcohol use and alcoholism, and their connecting links to the study of any (or perhaps all) aspects of problem drinking. A whole family's particular and oftentimes dysfunctional adaptive strategies to the situation of parental alcoholism, as described in this book, make more sense when viewed against this historical and cultural backdrop of alcoholism in America.

One of the most significant difficulties in dealing with alcoholism on any level is that so few people agree on what it is. There are differing and controversial perspectives from among the medical professions, the academic and scientific communities and the population at large as to whether habitual, excessive consumers of alcohol are diseased, victims of conflicting cultural norms, weak-willed degenerates, or a combination of these possibilities.[1] (See Room, forthcoming, on attitudes of general population.) The stigma-related aspects of alcoholism and the general paradigmatic split among professionals has had far-reaching implications not only for prevention and treatment programs (the success rate of both is marginal), but also for the affective behavior of the afflicted drinker and the responses of significant others to that behavior. (See Straus, 1976, on attitudes of medical and research communities.)

The absence of a culture-wide explanatory model for alcoholism created an enormous amount of confusion and frustration for the families who participated in this study. Repeatedly, during the several years I frequented

their homes, I observed the painful, ongoing struggle with definitions for the mother's drinking problem; husbands and children alike were reluctant to verbalize her habitual erratic behavior in terms of alcoholic-related language. In the early stages of the study, the mother's frequent absences from the family circle and the family's accounts of alcohol-related incidents were more often than not explained in relation to her "sickness" or her "problem." In turn, her "sickness" was viewed as a symptom of one or more of her various nervous and physical ailments -- or of some recent stressful incident. Even though the families were humiliated, angered and frustrated by the mother's drinking behavior, the word alcoholic was rarely used. These were middle class Protestant families, and within their ethnoreligious tradition, "alcoholism" as a concept is generally equated with drunkenness and lack of willpower. "Weak-willed drunkard" is an unacceptable label for one's own mother. In response to the immoral connotations of this widespread perspective, protection of the mother (and the whole family by association) from the stigma-related aspects of alcoholism, took precedence over health or safety considerations.

The confusion surrounding this situation was never more vividly exercised than when the problem drinker or other family members sought help from among the various alcohol-related treatment modalities. They discovered that differing and sometimes innovative frameworks for treatment were adopted by physicians, psychiatrists, private hospitals, community mental health services, the Alcoholics Anonymous program and religious ministers. It was not unusual for the family-client-patient to receive conflicting messages about both the etiology and effects of alcoholism from among several treatment services and in some cases within the same service.

From an anthropological perspective, a family's denial of the seriousness of the mother's condition and the "grab-bag" of treatment approaches to alcoholism are problems related to conflicting cultural beliefs about health and illness -- in this case about alcoholism. Conceptually, beliefs can be defined as learned understandings or ideas or assumptions concerning the nature of the cause and effect of things in both the natural and symbolic (or social) world. In the case of health-related matters, some of the notions we have about what causes what are based on Western "scientific" definitions, but others, and to a much larger degree, are based on word of mouth or popular belief. In either case, health beliefs, like other belief categories, values and attitudes, are impressed upon people through the enculturation processes of early childhood -- usually in the familial environment -- and later, by the broader social and cultural milieu in which they reside, work, worship and recreate. In this view, it can be said that we sometimes overtly and sometimes without being fully aware of the process, accept as our own the basic assumptions of our society. In a multicultural society, such as the United States, people sometimes experience a conflict of beliefs between the society at large and the bounded subcultural milieu to which they hold ethnic, religious, class or occupational allegiances. It follows that where there are conflicting health beliefs intraculturally (meaning American culture overall), there are also conflicting behavioral responses to the health problem(s) in question. Such is the case with alcoholism -- as a health problem -- in American society.

Ethnoreligious Views

The anthropological literature on alcohol use and abuse has helped us to understand the variety of beliefs about alcohol use and drinking behaviors within and across cultural boundaries (See Pittman and Snyder 1962; MacAndrew and Edgerton 1969; Everett, Waddell & Heath 1976; Marshall 1979).

Ethnographic accounts have left little doubt that such beliefs, values and attitudes -- including historical circumstances -- exert a profound influence on drinking behaviors in important ways "including ways relevant to treatment of alcohol problems" (Marshall 1979:1). In many smaller, traditional societies, drinking behavior, like most other health or social problems, is defined and treated, limited or tolerated in accordance with the fundamental, unified beliefs of that culture. In the more complex, multicultural societies like the United States, the beliefs about such matters are not so easily integrated or universally agreed upon. In the case of alcohol use, the various drinking norms, patterns and behaviors of identifiable American subcultures more often reflect each subgroup's ethnoreligious tradition than the cultural frame of the whole society. For example, alcohol consumption among the Jewish population has traditionally been limited to a religious and familial context, a factor influencing their moderate drinking patterns, low incidence of alcoholism, and general disapproval of drunkenness[2] (Snyder 1958). The Mormons, an American religious subgroup which views alcohol consumption as deviant behavior, forbids its members to use it. With no established norms and no social context for drinking, it follows that Mormons as a group have no means of "sanctioning" occasional drunkenness, much less alcoholism (Straus and Bacon 1953, reviewed in Skolnick 1958). Similarly, among Methodists, Baptists, Presbyterians and most other Protestant denominations, children are taught that heavy drinking is a violation of good Christian behavior and problem drinking is deviant (Skolnick 1958). In sharp contrast, Irish-Catholics use alcohol as a basic ingredient for conviviality; their emphasis on drinking and sociability is a traditional cultural factor encouraging heavy drinking and a more tolerant view of drunkenness (Bales 1962; Stivers 1967). The Italian-Americans, like the Irish, retain ancestral traditions of heavy drinking practices, but their choice of beverage is generally limited to

wine and only with meals (Lolli 1958). This belief of Italians, that food and alcoholic beverage should not be separated, results in a low rate of social and behavioral complications of alcoholism (many suffer from physical complications, however -- see Whitehead and Harvey 1974). This quick glance at differing American perspectives on alcohol use and abuse illuminates the scope of subcultural understandings about alcoholism and the obvious implications of such beliefs for attitudes towards those persons who develop drinking problems from within or outside of these groups. Some of these stereotypes on subcultural drinking practices are in the process of change. (See Heath 1982, for a review of current, updated studies on ethnicity and drinking.)

The Medical-Moral Dilemma

When we move from the various ethnoreligious perspectives on alcoholism, to a culture-wide level, the problem of beliefs, values and attitudes is exacerbated by the lack of agreement among researchers, policy makers and clinicians for a universal explanatory model on cause and effect of alcoholism. Although the voluminous literature on the subject leaves little argument as to the concommitant importance of biomedical, psychological and sociocultural aspects of alcoholism, and that it is either a serious health problem in its own right or can lead to other health problems, there are still two basic opposing definitional questions which frame the general direction of all research and treatment: is alcoholism a "disease" with biological (including mental) predispositions and therefore a pathological concept, or is it an "illness" described in terms of learned behavior and therefore a cultural or psychosocial concept. This debate is often referred to as the nature/nurture controversy (Madsen 1974; Albrecht 1973). When we look beyond the entrenched positions of most alcohol researchers and policy makers to the inclusion of traditional

beliefs and emotional responses to drinking behavior, alcoholism becomes a medical/moral controversy.

From a societal perspective, alcoholism has been declared a treatable illness, as defined by the American Medical Association (1961) and the World Health Organization (1952) and as far as illnesses go it is far from uncommon, governmentally-sanctioned estimates of rate of alcoholism in the United States is 10 million (Chafetz 1974). In keeping with this established explanatory model for a widely prevalent health problem, it should follow that alcoholism is not necessarily a sign of weakness, of moral dissipation or basic mental instability. Still, as anyone who is familiar with the subject knows, millions of Americans afflicted with the problem perceive themselves as deviant rather than ill, and take measures to conceal their addiction and to protect themselves from the widespread social stigma associated with it. They also know that there is an anomalous distinction between acceptable norms for alcohol consumption and subsequent drinking behavior if or when a social drinker becomes a heavy or addictive drinker. Unlike some others, America is a society which in general encourages both men and women to drink socially but then condemns them for drinking heavily. In the case of women, our society ostracizes them for drunkenness.

Even the terminology for drinking problems is controversial and contributive to immoral connotatons of alcoholic behavior. "Alcoholic" and "alcoholism," concepts which are widely-used in relation to alcohol addiction and the subsequent physical and social effects of drinking, conjure up differing emotional responses among researchers, clinicians, and the general population relative to the situational context of their use (Room 1970; Clark 1975). The prevailing negative response to these terms, whether used in relation to disease, illness or affective behavior, is generally related to the loss of control aspects

surrounding both drinking patterns and alcoholic behavior (Cahalan 1970). A frequently proposed explanation for negative reactions to the loss of control factor is that such symptomatic behavior is not compatible with the dominating Protestant ethic in American society. Edwin Lemert commented on the philosophical roots of that incompatibility in Social Pathology (1951):

> The Protestant attitudes toward drunkenness took their substance from the general Calvinistic condemnation of frivolity and the extollation of frugality, thrift, and industry as religious virtues. Drunkenness among the American Puritans was abhorred along with sexual shenanigans it precipitated, chiefly because it diverted human beings from the earnest task of making a living and capital accumulation, and also because it interfered with parental instruction of children in lessons of work and religion (355).

Today, in the twentieth century, the loss of self control on the part of the drinker still symbolizes deviation from these characteristics of the old Protestant ethic. According to Lemert, character weakness (as symbolized by a drinking problem) is a vivid isolating distinction in a culture which attributes "morality, success and respectability to the power of the disciplined will" (356). While this explanation for negative responses to alcoholism is true to some degree, the source of the problem is not quite that simplistic. The conflicting beliefs about alcohol use and drunkenness, the emotional responses to alcoholism, the stigma aspects, the ongoing clinical and scientific arguments and the significance of these factors for those persons affected by the problem, are more clearly understood when examined in the historical context influencing their formation. The emergence of alcoholism as a health problem, treatable by the established medical professions, is so recent and so obviously tenuous that its developing processes can be placed on a continuum of culture, history and developing theoretical models of definition and cause.

The Evolution of the Moral Model

Alcoholism was not always conceptualized as a "moral" problem in American society. In the colonial period, consumption of alcohol was an integral part of normal, everyday living, but it was not particularly problematic. Gusfield (1962) for example, points out that in this period, drinking took place within a social system in which it was limited and controlled: "Drunkenness occurred and was punished but it was seldom frequent or widespread" (104). Since no empirical surveys of the incidence or prevalence of drinking problems exist for this period, it is difficult to judge the accuracy of such statements; early records of widespread use and to some extent misuse of alcohol can be found in the Puritan ministers' sermons which condemned it, and colonial laws which made public drunkenness punishable by law. However, drunkenness was condemned because it was an abuse of the "good creature of God," the good creature being the drink, not the drinker (Keller 1976:16-17). Levine, in his excellent review of Puritan drinking patterns, noted that in the 17th and early 18th century America, "alcohol was held in high esteem as food, medicine, or social lubricant" (Levine 1978:145). Excessive use of alcohol was normal behavior and a part of both formal and informal gatherings, whether they were related to church, work, home, or the key town institution: the tavern. Drunkenness was a fact of life; there were those who drank habitually to the point of drunkenness, but almost everyone "habitually" drank moderate amounts of alcohol.3 Drunkards became deviants (or problematic) only when they became dependent on society and at that point they were not distinguished as a class from criminals, the poverty stricken or insane. However, if a drunkard were self-supportive or owned property, he was treated like anyone else of his class. (Ibid) Levine concludes that the most radical distinction between colonial and contemporary ideas about alcohol misuse is that in colonial times

"addicted meant habituated and one was habituated to drunkenness, not to liquor" (147). In other words, where contemporary thought considers alcoholics devoid of willpower and/or hopelessly addicted to alcohol, the traditional colonial view was that drinkers loved to drink and get drunk because it was a self-indulgent pleasant experience (albeit an abuse of a "good" thing). The Puritan ministers spoke out against habitual drunkenness as sin, but in light of their own ideological dictates, could carry it no further, for within Puritan theology "other than God's will, there can be no compulsion upon man: the individual was always viewed as having the free will to choose to sin or not" (Ibid:151). So whether the early colonials viewed drinking as sin or pleasurable experience, it was viewed not as a compulsion/addiction -- but as a choice and therefore as natural and normal behavior.

In the late 18th century, the Quaker influence changed the definition of alcohol from "God's good creature" to "demon rum." By this time, rum was arriving in abundance from the West Indies and various alcoholic beverages were being manufactured locally. The change in colonial drinking customs from moderate to heavy was first objected to in the writings of a Quaker teacher, Anthony Benezet and another highly-regarded leader for that era, Benjamin Rush, a professor of medicine, member of the Continental Congress, signer of the Declaration of Independence, and "father of American Psychiatry" (Rush 1785, cited in Glaser 1976). Rush viewed excessive drunkenness as a disease which was brought on by an act of vice and could be cured by compassion, understanding, and total abstinence. He tried to awaken Americans to the social consequences of alcohol misuse and to an awareness that alcohol had destructive aspects for both the individual and society. The influence set in motion by these two men -- a changed perspective of heavy drinking from normal, natural behavior to the context of health and sin -- became a movement

which eventually denounced not only intemperance but any use of alcoholic beverages (Keller 1976:17). Although morality remained as an important issue, the Temperance Era (which followed) was not entirely motivated by concerns of health and sin. This movement was also motivated by the social problems related to drunkenness and the complexities of an emerging, expanding, and proliferating nation. The disease theme and the notion that habitual drunkenness is hereditary[4] was included in the Temperance literature.

Gusfield (1962; 1963; 1967) discusses the Temperance Era as a social movement in various phases from its earliest development by the Federalists during the 1820s to its culmination in Prohibition legislation of 1920. The Federalists, a declining social elite, organized and promoted the temperance movement because they were alarmed by the increased political power of "the drinker, the ignorant, the secularist and the religious revivalist. ...If they could not control the politics of this country, they reasoned that they might at best control its morals" (Ibid. 1963:5). By 1840, abstinence and a religious-oriented lifestyle became the touchstone of middle-class respectability and a symbol of membership in that status level. Temperance was no longer related to health -- it was now totally a moral issue. Drinking was a threat to the character and values of hard work, obedience, and, of course, sobriety. Soon abstinence became a status symbol, and distinguished the middle class from the lower working class, most of whom were Catholic Irish and German immigrants. In this process the movement became dissociated with the New England upper class (Federalists). In the later 19th century the Temperance movement was a self-serving political mechanism by which American Protestantism deprived the immigrants of power -- primarily because of conflicting notions of values, ideology, and drinking behavior (Ibid. 1962). The indifference to the health

aspects of alcohol abuse is implicit in such statements as, "Keep the temperate people temperate: the drunkards will soon die, and the land will be free" (Maxwell 1950, in Glaser 1976).

The high point of the struggle to assert the old middle-class Protestant values over Catholic, rural over urban, tradition over modernity was in the passing of the 18th Amendment on Prohibition (Gusfield 1967:178). Clark (1976) views this ambiguous triumph as a revealation of the relationship between liquor control and the unique moral history of the American family. From a social perspective, the Protestant, Victorian, Classist culture was fighting for survival and the alcohol issue evolved as a political tool to attain that end. However, from a health perspective, the bigoted thinking of the early 20th century had a profound impact on that era's treatment of alcoholics as criminals, immoral, depraved, and/or insane persons (Ibid.). One serious health-related consequence of Prohibition was that the existing private medical institutions specializing in alcoholism went out of business; doctors no longer recognized alcoholism as a health problem (it was now a moral problem) and stopped treating identified alcoholic patients (Keller 1976:20).

In sum, from colonial times up until 1940, the dominant cultural viewpoint of regular and frequent alcohol consumption changed from natural behavior to unhealthy and vice-related behavior, then to addiction, and finally with the advent of the Temperance movement, to immoral behavior. The latter had the distinction of a later political, legislative sanction (Prohibition Ammendment). In relation to beliefs and attitudes the most important issue in this pre 1940 historical account is the transition of alcoholism from habituated status to addictive and from normal, natural behavior to a moral problem.

The Medical Model

The more recent tradition of scientific research on alcohol-related matters began after the repeal of the 18th Amendment (Prohibition) and at a

time when negative attitudes towards alcoholics prevailed to a degree that professional efforts to help them were almost non-existent. What few studies there were seemed to be limited to groups of alcoholic men who were in jails, in mental hospitals, and on skid row and alcoholism was explained in terms of characteristics of these groups. This fact, and the enduring Temperance ideology, caused the average person who drank excessively to deny the problem by disassociation with the established stereotype.

In the late 1930's and 1940's, a small, select group of medical personnel and behavioral scientists recognized the urgent need to redefine alcohol-related problems in more palatable terms and out of this movement emerged the so-called disease model of definition. This turn to a medical model was part of a calculated strategy to combat stigma and prejudice, to encourage alcoholics to seek help, and to change negative attitudes toward alcoholics which prevailed among physicians and the helping professions (Straus 1976). E.M. Jellinek (1946; 1952; 1960; 1962), leader[5] in this movement, recognized alcoholism as a progressive disease which could be divided into definable, symptomatic phases (1952). In his 1960 revision of the model he used Greek letters to identify a typology of "alcoholism." (See footnote #6 for an abbreviated form of Jellinek's typology of alcoholism.) Essentially, Jellinek put American alcoholics in two groups: addictive and non-addictive. The main differentiating criterion between the two categories is that the non-addictive alcoholic does not experience loss of control. The predisposition to loss of control for the addictive alcoholic is a chain reaction from (1) psychological conflict or social situation which initiates the drinking to (2) a physical demand for alcohol. Once started, the drinker undergoes a process which makes it impossible for him to control the quantity; he drinks until his body physically rejects the alcohol intake. For non-addictives, the effects of long-term drinking on the organism and on social life may be

the same as for the addictive, that is, the same symptoms appear for both (1962:356-368).

The implications of Jellinek's model were far-reaching in that both the World Health Organization's Committee on Mental Health (WHO: 1952) and The American Medical Association (1961) accepted the disease definition. The AMA justified this classification by placing alcoholism within the category of personality disorders without "clearly defined tangible cause or structural change" (AMA 1961). Both the AMA and WHO are clearly assuming that the loss of control factor is related to mental or physical disablements, or both. Alcoholics Anonymous, a highly successful self-help organization, also uses the disease concept as one component of its working model.

From the time of its inception until the present, there has been considerable discussion around the advantages and disadvantages of the disease model. The main problem is the many unknowns in relation to the etiology of alcoholism,7 and the problematic nature of connecting excessive drinking with certain bodily malfunctions. The pro's and con's as to whether alcoholism "fits" the working definition of disease is often debated. Arguments **for** the retention of the disease title are frequently centered around the practical and functional aspects of placing the problem within a medical framework; it facilitates better recognition, funding, and treatment in political, economic, legal, and medical areas. It also contributes to improved notions of individual personal dignity on the part of the alcoholic (Gitlow 1973; Keller 1977). On the negative side, the research and clinical implications of Jellinek's unidimensional model are not substantially validated (see Room 1970; Cahalan 1970; Albrecht 1973; Straus 1976). After summarizing the assumptions that underlie the disease model, Room concludes that past and current research does not support the universality of the phases and the symptoms therein. He

notes that the model of unilinear evolution (of disease) is based on underlying assumptions similar to those prevalent among 19th century social evolutionists(1970:7). Straus (1976) argued that Jellinek's phaseology, which was based on reports of 98 long time drinkers, all of whom had indeed progressed through the phases, subsequently became the self-fulfilling prophecy for the majority of studies of the drinking histories of alcoholics.

> Because all alcoholics had experienced at least some of Jellinek's phases, and the description of the phaseology was clearer in the minds of most alcoholics than their own actual experiences, they tended to recite the phaseology as their own (48).

In other words, researchers using Jellinek's formula "type" drinkers in one phase or another with no consideration for the possibility that they may belong in a category other than alcoholic.

One of the first major breaks in the growing consensus among researchers and clinicians in the United States that alcoholism problems be subsumed under "disease" came in the late '60s and early '70s when probability sampling of households were taken for the purpose of determining drinking patterns and drinking problems in the United States (Clark 1966, 1975; Cahalan 1970; Cahalan, Cisin, and Crossley 1969; Cahalan and Room 1974). These were the first efforts to give empirical attention to the complex, multidimensional nature of the behavior of problem drinkers. Using nationwide samples, these studies found that although there was a high prevalence of drinking problems among American men, there was no inevitability of progression from heavy, repetitive drinking to alcoholism, and that problem drinking (or predisposition to same) is influenced by an individual's environment and "learned attitudes" towards drinking in general.[8]

In sharp contrast to suggestions that the disease model improved personal dignity of the alcoholic, Cahalan (1970) presents an opposing view:

> It would appear that the concept of alcoholism as a disease may have the undesirable consequences of driving a wedge between the alcoholic and society, of providing the problem drinker with an alibi for failure to change his behavior, and of creating an atmosphere in which alcoholism becomes a stubborn disease to cure because it is perceived as possessing only the derelict or semiderelict or the incompetent who is incapable of control over his own behavior (10).

Cahalan goes on to say that Jellinek was strongly influenced by the Protestant ethic when he proposed his "phases of alcohol addiction with its orderly -- and inferentially irreversible progression of malign symptoms. ...a drunkard's progress on the downward path to perdition" (Cahalan 1970:4). Cahalan sees the word alcoholism itself as a value-laden label which reflects our culture's tendency to define things in absolutist's terms.

As for the clinical implications of Jellinek's model, studies and surveys cast doubts that the "functional" aspects of the disease concept are of a positive nature. As early as 1945, the redefinition of alcoholism as a medical problem created a dilemma for physicians, as more alcoholics and families turned to them for help with a condition to which in the past, they had usually given little serious medical regard (Haggard 1945:213). Besides their lack of training -- a situation that has persisted from the 1940's until today -- surveys show that health professionals and social workers reflect a negative attitude towards alcoholics in general (Riley and Marden 1945 and Middleton 1971, as reviewed in Straus 1976). Complaints focus on such factors as complexity of related problems, too great a demand on intensive care facilities and the futility of treating addicts and "degenerates" -- or those who have the potential to be such. Although professional associations recommended changes in medical school curriculums (AMA 1972) their practicing constituents seem to lag behind in actual efforts toward change. The pervasive fear is that those who become clearly identified as helpers of stigmatized persons will derive a stigma from

their patients -- thus the persistence of the moral model. Straus (1976) presents clear evidence that this "shadow of derived stigma" has delayed much needed interdisciplinary research efforts, deterred the brightest young scientists from becoming interested in alcohol research, and academic journals from publishing or even encouraging scholarly articles on alcohol-related subjects.

Psychological and Sociocultural Models

The changing conceptualizations of alcoholism over the past 40 years have included two other theoretical frameworks of explanation generally referred to as the psychological and sociocultural models. As both of these approaches have to date minimally influenced the ways in which people experience and respond to alcoholism, the following brief review is included as peripheral data to the purpose of this chapter.

The psychological model, as derived from the field of psychoanalysis and particularly Freudian theory, builds on the assumption that certain personality traits established in early childhood are the principal predispositions to alcoholism[9] (Zwerling 1959; Barry 1974). As in the disease model, this approach views the alcoholic as victimized. Drinking is a circumstance of pre-existing psychopathic personality and thereby precludes early recognition and treatment of the drinking problem. Although this approach in recent years has had minimal impact on prevention and treatment programs (and on the population at large), it is still utilized by many psychiatrists, and through the process of psychoanalysis, some alcoholic clients are introduced to such beliefs about alcoholism. (See Armor et al. 1978, for review of psychological models.)

The sociocultural model,[10] with its focus on the social and cultural patterns of beliefs and behaviors, covers broad areas of external factors in relation to alcohol use and alcoholism, ranging from consumption rates of whole societies to individual responses to a particular environmental situation, not

always to the exclusion of physiological and psychological factors. Where the large scale statistical studies have minimal implications for treatment, they are significantly relevant for prevention programs; the smaller, culture-specific explanations are most certainly of great value to both health professionals and to the general population should they ever be educated to such considerations. The sociocultural model empirically challenges -- either implicitly or explicitly -- the inevitability of the disease progression theory in its emphasis on the influence of an individual's environment, learned attitudes and beliefs on alcohol consumption rates, drinking behavior and problem drinking. Although a growing number of health professionals, scientists and concerned laymen recognize the significance of social and cultural factors in the cause and maintenance of alcoholism, overall responses of the general populace are more dominantly influenced by the medical and moral belief systems. Hopefully more studies from a sociocultural perspective (such as this one) will hasten the transformation from the prevailing tunnel-vision approach to a more holistic level of understanding. (See Bacon 1957; Heath 1978 for explanations and reviews of this approach).

Overlapping Belief Systems and Choice of Healers

This brief sketch of beliefs about the history of alcoholism in American culture tells us that deeply imbedded beliefs about matters of morals and health do not always change along with a dictum of medical science. The problem is one of cultural incompatibility; for reasons outlined in the following summary, the medical and moral models obviously cannot be integrated, but side by side, they do overlap, and the traditional moral view seems to have the influential edge.

The moral model or belief system about alcoholism perceives drunkenness as **primarily** immoral or irresponsible or derelict behavior (or all of those) and

secondarily as a health problem. A natural side effect of such "moral flaws" is loss of self-esteem and status position not only for the problem drinker, but in most cases, for the family of the drinker as well. In view of the fact that immoral behavior belongs in the realm of spiritual degeneracy, it logically follows that those affected by such beliefs assume that attempts to arrest the drinking problem -- or the healing process -- should be of a spiritual or religious nature. Those who are of the disposition to seek help from a spiritual source most often go to their priests, ministers or church-related counselors. Either directly or indirectly, spiritually-oriented healers utilize methods defined in terms of religious rather than medical institutions. In the case of American religions, the healing procedure would logically focus on abstinence from the instrument of evil (alcohol), possibly prayer or some form of pentinence and encouragement to resume expected role duties in relation to family, church, job and community. As the responsibility for the excessive drinking rests solely with the drinker, so does the responsibility for seeking out and completing the healing-cleansing process, although encouragement to do so may come from significant others.

The established medical model suggests a genetic predisposition to alcoholism, and a progressive disease process which if not arrested leads to death. In contrast to the moral view, the afflicted person is perceived as victimized rather than weak-willed, and therefore to some degree is relieved of the responsibility for excessive drinking and for becoming an alcoholic. In this view, responsibility for treatment rests with the established medical system and from among a variety of healers trained in the various physiological and psychological disciplines. Theoretically, diagnosis of the problem is in terms of the extent of the disease process or phaseology (see Jellinek's model in footnotes); for example, does the patient have delerium tremens, dependence

on alcohol, craving, withdrawal symptoms and so forth. If followed to a logical end, treatment would focus on the only means of arresting the disease -- total abstinence -- and when necessary on the physiological and psychological effects of long-term drinking. However, few physicians and treatment centers follow this pedantic course. Having no set formula for alcoholism, they often use an eclectic approach, moving beyond the genetic predisposition to a consideration of other aspects of a sociopsychological nature. In fact, in 1918 The American Medical Association published a "Manual of Alcoholism" in which physicians are encouraged to consider the "interplay of physiological, psychological and sociological factors which lead to the origin and development of alcoholism" (AMA 1968).

The paradox of these two opposing belief systems or models of explaining alcoholism is that in practice they are not mutually exclusive and there is overlapping between them. The "birth" of the medical model in the 1940's was not accompanied by an abrupt change in popular or medical beliefs about alcoholism. There are indications that the beliefs about alcoholism and drinking behavior that prevailed prior to 1940 have persisted in the general population and the immoral connotations formed in the Temperance Era are in fact subsumed within the medical model (Straus 1976). However, currently there seems to be a lag between the public's changing view of alcohol problems -- more realistic and accepting of humanistic and environmental considerations -- and the helping professions' view. As discussed earlier, the latter, or at least many who are working within the established health fields, are still inhibited by the derived stigma of working with alcoholics. As another example of overlapping belief systems, Alcoholics Anonymous, a highly successful self-help organization which utilizes the disease theory, is in a sense also a religious or spiritually oriented healing source. Their "treatment" includes

acknowledgment of a higher power (assume God) for purposes of gaining self-acceptance, strength and serenity. A.A. also uses coercive encouragement during meetings for members to give testimonials on past drinking experiences — a practice which can be viewed as a form of cleansing oneself of past sins or irresponsible alcohol-related behavior.

Of significance here is not the voluminous medical and scientific debates on the subject, but the existential reality of the people afflicted with a serious health problem of such an ambiguous nature. Other than the growing evidence that the success rate for treatment of problem drinking is disparagingly low, there is very little empirical evidence on how the aura of confusion which surrounds the phenomena called alcoholism affects the afflicted persons and their families. The following chapters describe and analyze behavioral manifestations of this dilemma.

Footnotes

1. Attitude surveys from various areas of the United States taken in 1951, (Cumming and Cumming 1957), 1961 (Mulford and Miller 1964), and 1975 (Orcutt 1976), show that while there is a growing acceptance of the disease concept of alcoholism, roughly three-quarters of the survey samples **also** define alcoholism as a sign of moral weakness. All of the above data is cited and reviewed in Robin Room's paper, "Sociology and the Disease Concept of Alcoholism" (forthcoming).

2. Since the 1980's, the stereotype that Jews were culturally protected from drinking problems has been questioned. The growing numbers of Jewish problem drinkers has been linked to sociocultural changes. These are: weakening of family ties and religious traditions, peer pressure to drink, and acculturation to gentile business and social patterns (Heath 1982).

3. William Penn was one of the first local manufacturers of alcoholic beverages (Glaser 1976).

4. However, their notion of heredity must be understood in terms of evolutionary theories of that era. Since 19th century Americans believed that acquired characteristics could be genetically passed on to later generations, the Temperance leaders preached that individuals' addiction to alcohol could be related to their ancestors (The Temperance Volume 1835, in Levine 1978).

5. Other significant leaders in the movement to explain alcohol-related problems in terms other than deviant behavior (but not necessarily in terms of disease) were H.W. Haggard, Selden Bacon and Mark Keller. Under Jellinek's leadership, they contributed to the founding of the first major Center for Alcohol Studies at Yale University. The Center has since moved to Rutgers University.

6. The following abbreviated formulation from Jellinek's 1960 model for alcoholism, is the revised view of the conception of phases set forth in his original 1946 model.

    1. Alpha alcoholism respresents a purely psychological and continual dependence on the effect of alcohol to relieve bodily or emotional pain. The drinking albeit "undisciplined" does not lead to loss of control, withdrawal symptoms, interference with personal life. (Dependence is **not** physical.) This is a developmental stage which can remain static for years. There are no signs of progression.

    2. Beta alcoholism: complications may occur as "polyneuropathy, gastritis, and cirrhosis of the liver." Incentive to heavy drinking may be social custom. Complications may come from poor nutritional habits. Transition to gamma or delta is less likely than in the instance of alpha alcoholism.

3. Gamma alcoholism: progression from psychological to physical dependence has occurred, e.g.:
   a. acquired tissue tolerance to alcoholism
   b. adaptive cell metabolism
   c. withdrawal symptoms and "craving"
   d. loss of control
   (This is recognized as the predominating species of alcoholism in the United States.)

4. Delta alcoholism has the first three characteristics of gamma. In place of fourth, loss of control, there is inability to abstain. Although drinker can still control amount of intake on any given occasion, he cannot go more than two days without withdrawal symptoms.

   (This kind of alcoholism predominates in France. It is sometimes referred to as an "endemic alcoholic condition." It differs from American alcoholics who go through gamma phase with its social and psychological experiences and behavioral changes.)

5. Epsilon alcoholism: periodic drinking bouts. Known in Europe and Latin America as "dipsomania" (Jellinek 1960:33-41).

7. The most striking feature about the voluminuous literature on etiological theories is the complexities of the problem. There is evidence that predispositions to alcoholism may be genetic, neurophysiological, developmental, physiological, psychological, socia-cultural, or the consequences of long-term drinking. For an excellent review of the range of possible cause and effect factors, see Kissin (1974) Biology of Alcoholism, Chapter on "The Pharmacodynamics and Natural History of Alcoholism."

8. Their results challenged the progression theory on several levels: (1) drinking problems are most prevalent among men ages 21-24, but problems decline with the majority of this group after age 25. There is a gap between the prevalence of younger heavy drinkers and heavy drinkers aged 40 and over; (2) many of their samples did manifest early warning signs which fit Jellinek's phase system, but these same men were able to alter their drinking patterns to a degree that they never progressed to the later stages. In other words, without complete abstinence, there were indications that remission of the problem drinking took place in the early stages. It was also established that in the United States most individuals are socialized in adolescence to drink for reasons of peer approval and preparation for roles in adult life. Problem drinking, then, when and if it evolved, was influenced by an individual's environment and "learned" attitudes towards drinking in general. Rates of alcoholism and/or problem drinking were differentiated among people by age, social, regional, and ethnic groupings.

9. The thrust of the psychological model(s) — there are three differing models — suggests there is an "alcoholic personality" that is, certain personality traits and structures cause a psychological vulnerability to alcoholism. From the Freudian, **psychoanalytical** perspective, alcoholism is seen as an outgrowth of disruptive childhood experiences; Zwerling (1959) stereotyped the alcoholic as schizoid, oral compulsive, anxious and depressed. Barry (1974) suggests alcohol functions as a means of regression and denial. The **personality** trait theorists, in their attempt to isolate clusters of personality traits that differentiate the alcoholic from other so-called normals, have failed to substantiate whether such traits preceded the alcoholic behavior or whether the cluster of traits is a consequence of the addiction that already exists (Armor et al. 1978:21). The **behavioral learning approach** (from the field of experimental learning psychology) assumes that alcohol consumption is both caused and maintained by the association of alcohol intake with positive rewarding experiences, thus individuals who are subjected to stressful situations may obtain relief from stress through alcohol use due to its pharmaceutic effects. The drinking habit is progressively strengthened by repetitive use of alcohol as a combatant to anxiety and stressful incidents (see Armor 1978 for review of psychological models).

10. "The sociocultural model focuses on patterns of belief and behavior that characterize various populations as one important factor in understanding how the substance ethanol and human beings interact, in ways that have long been recognized as culturally variant. ...This variation in patterns of belief and behavior appear to be related to differences in the relative frequency, or rate, with which problems are associated with drinking in those populations, and even to differences in the nature of alcohol-related problems when they do occur" (Heath 1978:55; see Heath 1978, Bacon 1957, for review of sociocultural approach).

CHAPTER 3: THE ANDREWS FAMILY

A Typical Middle Class American Family[1]

From all outward appearances, the Andrews family typifies an idealized normal middle-class lifestyle as many people know it or believe it to be in American society. From the very first visit to their comfortable suburban home, I came away with the firm impression that this is an intact, child-centered, religiously-involved and achievement-oriented household. Carl and Molly Andrews, an attractive couple in their late thirties, have been married for twenty years. They married young, when they both were still in college, and within four years had their three children Carol, Barbara and Ron. Carl, a tall, blonde, soft-spoken man, although non-aggressive and retiring in his self-presentation, works hard at his job as a real estate salesman. His work takes him away from the house most weekends and almost every evening during the week, a routine which is most upsetting to Molly. He has had a poor sales record during the past two years, and the family is struggling financially. Their income is supplemented by gifts of money, meat, clothes and automobiles from Molly's mother, and by assistance from the children, who all have part-time jobs to help pay for their clothes and for spending money. Carl's first priority in life is not his job. In terms of loyalty and emotional involvement, his employer ranks somewhere down the line after family, church and selected community affairs. His social activities center around his children's school, church and athletic events. Since the onset of Molly's drinking problem, Carl rarely takes her out or encourages social events in the home. He does escort

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1. Sections of this chapter will appear in "To All Appearances: An Ideal American Family," by J. Ablon, G. Ames and W. Cunningham, in, E. Kaufman, ed., The Power to Change: Case Studies in Alcoholism. New York: The Gardner Press, (forthcoming).

her to church services on Sundays and whenever she is able to go, takes her to early morning prayer service. Sensitive, warm, and personable, Carl displayed an anomalous, stoic resilience to Molly's excessive drinking habits and to their related humiliating and frustrating consequences.

Molly, a slight, fair-skinned, brunette, stays home to keep house and care for the family, a role she has maintained and enjoyed for most of the twenty years she and Carl have been together. She is a fastidious housekeeper, an excellent cook and seamstress, and a concerned, affectionate and fiercely protective mother. Twenty years of marriage have not diminished her love and admiration for Carl; she invariably speaks of him in supportive and affectionate terms.

At the time this study began, Carol, the oldest daughter, was nineteen. She was living at home, attending a local community college and working part-time. During her high school years, Carol was outgoing and aggressive; she was an outstanding scholar, a cheerleader, an elected leader in school government and the winner of a "beauty queen" contest. When in her home environment she presents a different image; she is a pensive, withdrawn and oftentimes visibly agitated young woman. Though ridiculed by her siblings and friends for "wasting" her scholarly talents in a local college, Carol chose to remain at home during her first year of college in an effort to avoid further financial pressure on her father -- and as was later observed -- out of concern for her mother's deterioratng health and well-being. When necessary, and in Molly's absence, Carol assumes the cook and housekeeper role, but for the most part, her crowded social, work and college schedule leave little time for domestic tasks. A pretty, likeable young woman, she is popular among her social peers; however, she rarely entertains friends or acquaintances in the home. Before the onset of the drinking problem, Carol and Molly had enjoyed

a close mother-daughter relationship. Through all the frustrating, disappointing months of Molly's alcoholism, Carol, more than any other family member, hung on to the memories of her mother's former self — that of a dependable, nurturing parent and companion.

Barbara, at age eighteen, and a senior in high school was, like her sister, an honor student, reigning high school beauty queen and leader among her social peers. Everyone in the Andrews family agreed that Barbara's personality was similar to the way they remembered Molly's to be — before she developed a drinking problem. According to Barbara, their similarities created conflict when she was growing up, and she never felt close to her mother. Barbara is disarmingly free of spirit, light-hearted, always laughing, a clever tease and in constant dramatic motion. No one except Molly seems to mind that among all the family members Barbara contributed the least towards the general maintenance of the household. Perhaps this fortunate exemption from menial tasks is related to the fact that she has unconsciously been allocated the much more important and vital role of family comedian. Barbara has a unique ability to clown around and see the humorous side of reoccurring, traumatic family episodes related to Molly's drinking behavior. She provides a comic relief in an otherwise tense, depressing and humorless household. To put it simply, Barbara knows how to make the family laugh, a natural attribute which they all recognize and value. Carl displays an open admiration and joyful affection for this daughter, and he is noticeably happier and more relaxed in her presence. He often and proudly speaks of her beauty, her "admirable" personality traits, her academic accomplishments and rising success as an aspiring actress. Molly is threatened by Carl's special relationship with Barbara, not in the sense that she suspects any incestuous or inappropriate inclinations, but from a growing realization that Barbara -- perhaps unconsciously perhaps

not — is replacing her as the flirtatious, feminine counterpart to her husband's serious, thoughtful nature.

Ron, seventeen, and a junior in high school, is also a high achiever in many areas of his life. He is handsome, popular among his peer group, a good student, an outstanding athlete and president of the student council. He is a religious, spiritually-oriented young man, who at the age of thirteen recognized a "call to the ministry." He is soft-spoken like his father, and remarkably articulate on a variety of current worldly issues. Always loyal and devoted to his mother, he is confused and noticeably saddened by the radical and frequent changes in her behavior. Still and in the face of repeating excessive drinking patterns, he remains optimistic that by use of spiritual counseling and prayer, he can bring about a satisfactory solution to Molly's drinking problem. With all the opportunities and valid reasons he has to reject his mother, Ron rarely argues with her or speaks to her (or of her) in a demeaning, accusatory manner. During the two-year research period, at those times when Carl withdrew from Molly, Ron progressively moved towards the role of surrogate companion and confidante to his mother.

Up until four years ago, the Andrews family lived in Centerville, a small town located in the heart of the same agricultural valley where Carl and Molly themselves spent their childhoods. During the years they lived there, Carl never made much money working in his mother-in-law's lumber business, but he and Molly and the children were happy in Centerville. They were leaders in community affairs and town organizations; Carl coached his son's baseball team, was active in Rotary Club and regularly volunteered to chaperone for school trips, outings, and teen dances. Molly was the leader of her daughter's "Blue Bird" and "Campfire Girl" groups, an officer in the PTA and an active member of various organizations in the Presbyterian Church. In their formative

years, Carl and Molly worshiped in the Presbyterian and Methodist religions and their family of procreation continues to be actively involved in the Presbyterian church.

There was no history of long-term alcohol misuse in either parents' family. Carl's parents are moderate social drinkers. Molly's father developed a drinking problem in his early sixties but stopped when he developed terminal cancer. Molly contends her father was an alcoholic, but her mother vehemently denies this diagnosis, explaining instead that his heavy drinking was a "temporary response" to a costly failure of a business venture. Neither Carl nor Molly have ever been heavy social drinkers. In fact, prior to the onset of Molly's drinking problem, they were moderate or at best occasional social drinkers. Carl can recall only one time in his life when he had too much to drink, and that was at a neighbor's New Year's Eve party years ago. Molly has never been intoxicated nor has she drunk heavily at a social event; she now drinks only at home, secretly and alone. Her serious problems with alcohol began four years ago, coincidentally, the family all agrees, with the time the family moved away from Centerville. Carl resettled his family in the rapidly growing urban sprawl where they now live in the hopes of finding a better job for himself, and a wider range of educational opportunities for his children. After fifteen years of working for his mother-in-law in Centerville, he wanted a change. While Molly reluctantly agrees with him that the change has been for the best, she misses her old friends and the "comfortableness" of small town life. She once mentioned that she knew by name almost everyone in that town of 2,000 people.

In the same year that they uprooted themselves from their lifetime home and social network, Molly's best friend, neighborhood cohort and confidante was murdered by an unknown assailant. Even now, four years later

during discussions of either their life in Centerville or the tragic death of her friend, Molly becomes visibly upset and often breaks into tears. Although Molly's secret drinking patterns were beginning to develop before they left Centerville, she considers the move and her friend's death as primary precipitating factors causing her drinking problem.

The Andrews family now lives in an affluent California suburban neighborhood, or better said, the external fringes of a large metropolitan area. Their housing development is miles from the city, and in fact, their house is on the end of a street which borders the adjoining and rapidly decreasing farm lands. There are few trees in their neighborhood, and for the greater part of the year the general atmosphere is hot, dry and smoggy. During the weekdays, when husbands and school children are not outside the houses for gardening and recreational activities, the streets are devoid of people, and neighborly interaction is at a minimum. These factors, plus the preponderance of waist-high weeds in the surrounding vacant fields create a kind of desolate and isolated environment for the houses on their street. Molly, who spends most of her days at home alone, often indicated in both words and action that she was lonely here. Because she has been a secret and heavy drinker since their move from Centerville, and is fearful of being found out, she has made no new friends or even casual relations among neighbors or in the community at large. Her social activities are limited to her Bible study group, Ron's school and sports activities, occasional sessions at the mental health center, and my frequent visits.

Carl bought the house before the family moved to the area, and without consulting Molly. He felt certain she would like the "space-saver" model which he decided upon, because though small in square footage, it boasted five bedrooms and three bathrooms, a feature which offered each of the children

their own room. The living room, which houses a baby grand piano and nothing else, and the large upstairs "family" room are used only on those rare occasions when the children have school or church related meetings. The center of activity in the Andrew's household is the large family kitchen, wherein there is a dining table and six high-back chairs, a sofa, a lounge chair for Carl and a television set. But the focal point of the room is the "family bulletin board" which extends almost the entire length of the room. This dominating feature of the house is, in effect, an historical account of the children's lives as illustrated through their many awards for various activities and high scholastic achievements. It is also a kind of symbolic display of the Andrew's family lifestyle -- of their value system, of their beliefs about parenting, family togetherness, mutual support, and community involvements; in effect, of what they perceive as the normal, everyday activities of a good life. There are pictures of their son in his little league uniform with his various teammates for every year he played baseball from ages 8 to 13, and then of his high school teams. There are pictures and ribbons and certificates of Ron's many awards for high achievement in wrestling, swimming, football, baseball, school government, Christian Youth Club leaderships and other church-related activities. There are sections for the girls: Carol is there as the queen of the Valentine's Day Ball, as valedictorian of a graduating class of 1500 students, as student government officer, and with numerous handsome young men at school dances and parties. Barbara, also an honor student and reigning high-school beauty queen is represented by pictures or documents for her achievements as a competitive tennis player, an outstanding actress, and honor student. She later won a full scholarship to a prestigious university on the basis of her scholarly and dramatic abilities. There are scattered pictures of Carl, mostly with their son, wherein he was scoutmaster, coach, chaperone,

and companion on fishing and hunting expeditions. Throughout the house, there are many more pictures of the children; the piano serves as a display for an array of pictures of the girls in their beauty queen pageants.

There are no pictures of Molly, which at first seemed a peculiar absence, since prior to the onset of her drinking problem, and less than four years ago when they lived in Centerville, she too was active in community and child-centered activities. As I became more familiar with the Andrews household, I discovered that Molly was also an accomplished seamstress and a creative cook. She made colorful curtains and bedspreads in the children's rooms; she also designed and hand-sewed the pretty dresses which adorned her daughters for their beauty pagents, school dances and graduation ceremonies. During her non-drinking periods, she prepared nutritional, tasty meals, desserts and snacks. In the summers, she picked the apricots from their backyard tree and preserved them into jellies or dried fruit. She would plan far in advance of special family events; for example at Barbara's graduaton party (which I attended), she prepared a variety of hors d'oeurves, hot dishes and decorative cookies and cakes. Molly never spoke of these things in the sense of accomplishments; she viewed sewing and cooking as ordinary, expected attributes of her maternal role duties. She was extremely sensitive about the housekeeping situation; for instance, if she had been "ill" (the word she always used for her drinking periods), she would request that I not go upstairs for fear it was "messy" or "dusty." From time to time I heard Carl and once Carol praising Molly's domestic accomplishments. However, the incentives to recognize her special talents were more often than not cancelled out by the family's preoccupation with her drinking problem. In their view, because of this failing, she did not deserve any praise.

The Andrews, a family of five, by the close of the research period had five automobiles and a house trailer in and about their driveway. Each child upon graduating from high school, in acknowledgment of this achievement, received from their maternal grandmother the gift of a brand new, medium-priced automobile of their choice. In his last year of high school, Ron requested, and received, a new truck instead of an automobile. Carl was also the recipient of this generous gift-giving practice. He received a new car "to assist him in his real estate business." Molly drives the 10-year old family station wagon; no family member seems aware, or even slightly disconcerted, by the glaring, obvious truism that the grandmother has "awarded" every family member with an expensive automobile with the exception of Molly, her daughter and only child.

After the children, the focal point of the Andrews family household is their church. Their weekly church-related activities include: Sunday morning services, Sunday evening prayer services, Tuesday afternoon Bible-study (Molly enjoys this group when she is "well"), Thursday morning 6:00 a.m. Bible readings (Carl attends this and sometimes Molly), the church choir (Ron), Christian Youth Club, and Campus Life. Ron, Carol and Barbara have all three participated in these latter high school organizations which teach and promote Christian principles. Ron, who is considering going into the ministry, is a leader in the Youth groups; in the past he has attended church-sponsored camps and now is preparing for missionary work in Africa.

The following letter was enclosed with the Andrews family Christmas card in their second year of participation in this study. In this note the mother is proudly displaying her greatest accomplishment in life -- and as she so often reminded me, perhaps her only one -- the success of her children. It documents the high achieving lifestyle of Carol, Barbara and Ron. But more than that,

she is describing her and Carl's deep commitment to the Protestant ethic and value system. In their view, the guiding principles of individualism, hard work, moralism and a God-centered life are most surely reflected in the cumulative achievements of the children. Another reason to include this idyllic description of the family is to establish a point of contrast between the normal, almost picture book image they present to the outside world and the existential reality of keeping up that image with an alcoholic mother. As will be described later on, the "inside" view of the Andrews family life presents a dramatic contradiction of their traditional beliefs, values and established norms for family life.

Dear Family and Friends,

I haven't written a Christmas letter for several years and when I think how fast they've passed it's just not believable. Carol is now 19, Barbara 17, and Ron 16. The Lord has greatly Blessed us. This will be a "Brag Letter." Not about us but what great things Our Savior is doing in all our lives. When Carol graduated she was Valedictorian & involved in just everything. She attended a Community College and worked at European Dance Studios at 1st as an instructress, and later adding training director duties. Her 1st evening home from school, she walked in the door and immediately a job was there for her 3 week break. She is now at Cal majoring in Chemistry and is planning to go into Dentistry. Barbara meantime was working very hard in student government at her high school and being very successful in chorus and drama. She also worked at a nearby amusement park, where her drama came in very handy. When she graduated she received a number of scholarships which enabled her to attend USC in Los Angeles where she is majoring in Communication & Business. Her biggest honor was being chosen to attend the American Academy of Scholars for 3 days. Only 2 students from this whole area were chosen & they had all expenses paid. They were later honored at a luncheon and presented with a complete set of Encyclopedia Britannica. It was a tremendous experience since she met many of the greats in all fields of work throughout the country. Ron meanwhile was elected Class President his Sophomore year, and Student Body president his Junior and Senior year. During that time, the Christian Youth Club was started and quickly it became the largest & strongest club on campus. They often meet here at our house and sometimes we have as many as 40 or 50. They are a real joy and are headed by a really great staff. If you are in the Channel 8 area, be sure & watch the Jimmy Dean special. Some of the segments were filmed right in our garage. Christian Youth Club started during Ron's term as President. This year they meet twice monthly with Ron leading and trying to get special speakers. He has also lettered in Soccer, Basketball, Baseball and was recently elected to the County Youth Hall of Fame. He works three days at a printing firm and some week-ends at our church where he is a member of our 120 member choir. After graduation he plans to attend State College and go on Christian Youth Club Staff. He will then transfer to a Bible college and go into the ministry.

Carl's new job is coming along just fine, and it is such a blessing. We praise the Lord for it. A few months back, it just fell into his lap, and we were very fortunate. It was very simply a prayer that was beautifully answered. As for me -- I've finally adjusted to the big city life, awaiting the start of a new ladies Bible study in January. It deals with Christian concepts of discipline & boy do I ever need that.

May God bless you each and every one throughout the year,

Carl-Molly-Carol-Barbara-Ron

Molly's Drinking Pattern

During the two years of this researcher's relationship with the Andrews family, Molly was a chronic alcoholic: she drank approximately 16 ounces of vodka a day during her drinking periods (this is her conservative estimate), and she drank it very fast in order to reach the immediate desired effects of semi- or total unconsciousness; Molly **never** drank for reasons of increased conviviality or social pleasure. The time of day for drinking varies between the early morning hours and later afternoon. Her usual pattern was to drink for four to five days and then not drink for two to seven days. The longest abstaining period she had over two years was one 14-day period of abstinence, and the month-long period she spent at a private hospital for treatment of alcoholics.

Molly was diagnosed by her physician as epileptic after what she describes as a "seizure" three years ago. Since that time -- when she remembers to take it -- she has taken the prescribed dosage of phenobarbital three times daily. Carl, the children and Molly's mother do not agree with this diagnosis, and object to the medication. Three times during the two-year study during the period when she was drinking, she swallowed a whole bottle of phenobarbital, twice in the presence of her family, in apparent attempts to take her life. In an effort to control her drinking, she occasionally takes antabuse (disulfiram), a sulfa compound which in the presence of alcohol causes nausea and vomiting. She took this in preparation for her infrequent visits to the county mental health center, and in anticipation of the researcher's visits the first few times she visited her home.

Molly is sometimes pretty, energetic, well-groomed and pleasant to be with; at other times, she is unattractive, puffy-skinned, sallowed, unwashed and generally speaking, very poor company to be around. The change of

appearance and moods are correlated to her non-drinking periods as opposed to her drinking and hangover periods. Whenever I was with Molly, whether she was drinking or abstaining, I was keenly aware of her sense of low self-esteem and of a smoldering anger, which could erupt with very little provocation. Both her immediate and extended family and her therapist from the county mental health center were puzzled by her frequent bouts with depression, her angry outbursts and her general unhappiness. Her family was puzzled, discouraged, sometimes disgusted and oftentimes humiliated by her drinking problem. Molly, as of the past four years, lives in a cyclical behavioral routine, moving from the role of affectionate, nurturing wife and mother when she is sober, to that of a screaming, disoriented, unpredictable stranger when she is drinking.

The Discovery of a Problem with No Name

Molly was a problem drinker for three years -- and perhaps a full-blown alcoholic -- before her husband, mother and children discovered her secret drinking patterns -- or that she drank at all, for that matter. There are several different versions of the discovery. Carl remembers that shortly before they left Centerville Molly told him "she was afraid she was becoming an alcoholic." At that time he and Molly drank socially on their rare evenings out and occasionally had a drink before dinner. He kidded her about her worries, assured her she was not an alcoholic, and then forgot about it. Carl goes on to say:

> But after that, things weren't exactly perfect. She started having afternoon sickness, she didn't feel good, and she couldn't do things in the afternoons or evening. And then, after we got here it got worse and so then we had many doctor's appointments and physicals and everything, but neither she nor the doctors ever brought out the problem. Whenever she would go to the doctor, she would be O.K. Then we finally had x-rays and found out she had kidney stones and she'd had these kidney stone attacks which were very painful. She refused to see a doctor about that. Then one day the kids called me from work and said she was having one of those deals -- a kidney stone attack -- and as I now know she was drunk too -- and finally between the four of us, the three kids and myself, we forced her to see a doctor. We put a mattress in the station wagon and forcibly put her in and I held her down while Carol drove. We got there, and she refused to cooperate with him, refused to take a blood test and was belligerent. He told her, I know you've been drinking, he says, but you'd have to drink an awful lot -- if this is a kidney stone -- to kill the pain. I asked her if this was true and she said Well, she's had maybe a half a beer for lunch. I later realized she was drinking vodka everyday. So that was kind of the beginning of my finding out.

Carl's father later told him he had known about Molly's problem for three years -- and the neighbor across the street said she knew about it also.

Barbara claims the family suspected something was amiss on a family vacation camping trip when Molly "suddenly began pestering Dad every other day to drive to some store to buy vodka for 'cocktails.'

Carol, perhaps the most sensitive and astute member of the family, says it was a gradual discovery process; she and her grandmother (Molly's mother) were firmly convinced that the afternoon sicknesses were related to diabetes:

> For a long time, every afternoon, Mom'd just all of a sudden freak out; she couldn't talk, she couldn't do anything. Grandma was here on a six-week visit and we thought it was her diabetes and we'd always try to make her eat this or that, and she's spit it out, and we'd get **so sick** that she could act like this. My grandma was really worried so she took her down to a private clinic for lots of tests and stuff for diabetes and epilepsy, but she was fine. We even had her checked for stomach tumors -- but they couldn't find any; it came out negative. And finally last summer Dad started finding bottles, and he said, I hope it's not what I think it is. And I said, What Dad, just tell me, tell me. He wouldn't and I made him tell me, you know. He said, well I think she's drinking. That just shattered me, it was inconceivable to me. I just cried and cried and cried. I kept thinking, I mean, I didn't think she'd be drinking because of us kids -- and her marriage seemed pretty good. We were so close to the situation and we were blinded by it. We had no idea it was this!

These and other discussions about the "discovery" left the researcher with the impression that the family would have preferred a diagnosis of advanced diabetes -- or epilepsy -- or even the hoped-for stomach tumor -- to the less-acceptable problem of "alcoholism." In fact they never once in the two-year research period referred to their mother as an "alcoholic" — or the condition as "alcoholism." It was referred to as her "deal" or "problem" or "screw-up" — it was not viewed as a health problem. Molly herself, even after having been diagnosed numerous times by various treatment modalities as alcoholic, never referred to herself in these terms. She did refer to her drinking as an illness, however.

More so than any of the others, the Andrews family explicitly and behaviorally manifested the impact of traditional ethnoreligious beliefs on whole family response to problem drinking. At the first level of analysis, wherein family behavior is viewed in terms of explanatory models for alcoholism, we can see that this family was more comfortable with a moralistic explanation. As Barbara so often reminded the researcher, "The Bible tells us drunkenness is

a sin -- so I guess Mom is a sinner." Ron rarely verbalized his viewpoints on the problem, but if action represents beliefs -- he too preferred moral over medical explanations. He frequently "prayed over" his mother when she was unconscious -- encouraged her to speak to their church minister, and brought counselors from the Christian Youth Organization to the home to talk with her or to "treat" her. He disliked and discouraged private and county mental health treatment. He disapproved of Alcoholics Anonymous. Ron was a strong-willed, decisive, and mature young man -- and because he was preparing for the ministry, the family held him in high esteem. Over a relatively short period of time, he took or was given the balance of power in the family, in the area of decision-making around Molly's care and treatment. In sum, the family's basic beliefs and attitudes about the problem never changed. Towards the end of the two-year relationship with the Andrews family, after Molly had conceded to try various medical, therapeutic, and self-help treatment modalities -- and when her deteriorating mental and physical condition was nearing an all-time critical state, Carl and the children were still preoccupied more with the stigma-related aspects of alcoholism than with Molly's health. They never viewed her "problem" as an illness or a disease.

Cultural Protection Against Alcoholism: A Coping Mechanism

In the episodes which follow I examine ways by which this family attempted to cope with the new experience of maternal alcoholism, and with the reoccurring crises, humiliation and guilt that accompanied the drinking behavior. Since they viewed their mother's behavior as deviant rather than illness related, great efforts were made to hide it from the outside world, and to solve the problem internally -- on a family level. This "cultural protection" against (female) alcoholism, when carried out at this level, imposed added constraints on both the problem drinker and the family. The mother was

forced into a double bind as she found it necessary to hide both the drinking and the fact that she was afflicted with alcoholism. The family as a group vacillated between anger and guilt over both the drinking behavior and their own demeaning and sometimes nearly cruel methods of dealing with the problem. The following examples of such family interaction, would have been inconceivable and inappropriate behavior for this family only a few years before and prior to the onset of the drinking problem.

Initially and immediately following the shocking discovery that Molly's frequent "illnesses" were related to alcohol, the family — individually and as a unit — developed strategies which they hoped would rectify the situation. Subsequent to the "kidney stone attack" incident wherein a physician informed a surprised albeit naive family that the patient was intoxicated, Molly found herself under careful surveillance in her own home. The family had determined, in a good-natured, but forceful spirit, to break her drinking habits. If she tried to have an evening drink, they poured it down the drain. If she tried to sneak drinks in her bedroom, and was discovered in the act, a kind of family court was held wherein she was gently, but openly and profusely reprimanded. At this stage, the ambience around her drinking pattern was still subdued and somewhat affectionate in nature. In response to this tactic Molly developed the routine of drinking more alcohol, more quickly in order to get the desired effects before being discovered and hasseled by the family. She bought an extra stock of alcohol during her non-drinking periods and then hid this surplus supply in many areas of the house, garage or yard, for the assurance that if one hidden stock was discovered, there would always be more somewhere on the premises. The family soon figured out her strategy, and in disbelief, disappointment and exasperation, abandoned their efforts to physically prohibit her from drinking.

The family then developed a strategy which might be viewed as the "withdrawal" method of coping with their mother's drinking behavior. Each and every family member began to physically avoid and emotionally abandon Molly when she drank. This pattern soon became an established routine. Upon arriving home, and discovering that Molly had been drinking, family members often refused to speak to her, or went elsewhere for the evening meal. On the first day she was abstaining the family reacted sullenly to her efforts to communicate and reestablish normal familial relations. Molly, confused and resentful of this alienating behavior, had bitter arguments with Carl for allowing the children to participate in what she considered disrespectful behavior. The children developed license to communicate sarcastically with Molly, to mock her, and in times of great stress to resort to name-calling. Molly often turned to Carl for disciplinary action when these incidents occurred -- and none came forth.

When attempts to cope with Molly's drinking by means of verbal abuse and emotional withdrawal failed, more physical and punitive measures were adopted. The family, most particularly Carl, sometimes "physically" forced Molly into uncomfortable and frightening situations. For reasons of propriety, respect and fear of reprimand, Molly made a concentrated effort to conceal the seriousness of her drinking problem from her mother. Knowing this, Carl often suggested to Molly that he might someday purposely expose her problem to her mother. On one occasion, when Molly was in a prolonged drinking period, he carried out his threat. With the solicited assistance of Ron, Molly was physically forced into the car and retained in the back seat while Carl drove the 20 or so miles to his mother-in-law's country home. Molly was then unceremoniously deposited at her mother's door, at midnight, in an unwashed, unkempt and still somewhat intoxicated condition. The surprised and reluctant

host was informed by Carl that her daughter had a serious problem; he promised to return for Molly once she had "talked out" her problems with her mother and reached some decision towards changing her behavior. Carl's plan was thwarted somewhat by Molly's persistent and stubborn refusal to confront her mother with the situation. When Carl resisted her telephoned requests to return for her that same night, she set out for home on foot. Acceding to his mother-in-law's frantic telephone pleas for help, Carl returned to find Molly on a country road, peacefully walking in a homeward direction at 4:00 in the morning. Where on the face of it, the "forceful" intimidation strategy failed, the punishment persevered. From that day forward, whenever Molly's mother telephoned or visited the family, she queried Molly about her daily routines and openly expressed her disapproval and shame of her daughter's drinking problem. Her mode of communication with Molly became accusatory and suspicious in nature. Where this cooperative effort to change Molly's drinking behavior strengthened the relationships between Carl, the children and the grandmother, it forced Molly, who had never communicated well with her mother into a placating, but yet even more alienated daughter-mother relationship.

And yet another "punishment" strategy occurred after an apparent suicide attempt. According to Carl, on this evening, when he and the children were assembled for dinner and the children were teasing him about his "rubber pancakes," Molly came out of her room with a glass of water and a bottle of phenobarbital. Leaning on the doorway for support, she said "Now you will believe me," and quickly swallowed the tablets remaining in the bottle. Knowing that the combination of alcohol and phenobarbital can be lethal, the family reacted matter of factly to a necessary course of action. Stating that he and Ron could handle the situation, Carl sent Barbara on to her dance lesson and

Carol on to her job. The ride to the hospital was violent; again Ron was designated as the person to physically retain Molly while Carl drove the car. Carl preferred not to enter the emergency room, but because the hospital required a family member present, Ron offered to witness the necessary processes. Following the emergency medical procedures Molly was then sent to the alcohol detoxification section of a large county medical complex, but as it was full, she was transferred to the only other psychiatric unit with available space -- the maximum security unit. When Molly realized where she was, and saw the condition of the people on that ward, she became hysterical and had to be physically retained. Two muscular male attendants strapped her to a bed. She pleaded with Carl to take her home - Ron was by now frightened and speechless. Carl said he would see what he could do. A few hours later, a psychiatrist who had spoken privately with Molly, informed Carl that he could release Molly, providing Carl signed a statement stating he believed Molly's promise that she would not attempt suicide again -- at least in the near future. Carl declined the offer, so Molly remained on that unit for seven days. Carl informed me later that day: "That is where the **real** crazies are: although it's not a nice place to be, it's the best place because it will teach her a lesson." The next day, Carl brought Molly the New Testament to read: Barbara and Carol accompanied him, but they were so shocked at the sight of a man relieving himself in the hall, and of the pornographic grafitti on the walls, they had to retreat to the waiting room. After one week, wherein the only "medical" service provided was two one-hour sessions with a hospital-assigned psychiatrist, Molly was released and sent home.

Here again, the punishment tactics were ineffective. For 7 days following her return home, she drank a pint of vodka every morning before the family awakened at 6:30 a.m. Knowing Carl had taken her car keys and money, I

inquired as to where she was getting the vodka. He had no answers, but suggested perhaps she rode her bicycle the 3 miles to the store, and stole it. I seriously doubted that Molly, in her weakened, debilitated condition could ride a bicycle. When days later I asked Molly about it, she said she couldn't remember, but she "guessed" that she bought it at the grocery store.

After the psychiatric ward experience, Molly's drinking behavior took a radical change from the more tranquil seclusion of her bedroom to aggressive, sometimes violent encounters with other family members. Two nights after she returned home, Carl and Ron threatened to tie her in bed and lock her door so she could not emerge while Ron was having his Christian Youth meeting upstairs. In response, Molly put her arm through the bedroom window and suffered abrasions that required medical attention. Nevertheless, the family went on with their planned meeting and Molly remained in her room. Within the next 10 months, Molly attempted suicide two more times, but was never again admitted to the County psychiatric unit; however, when she was at her worst, Carl often threatened to send her back to the maximum security unit.

The Andrews family was so firmly imbedded in a set value system -- in their "old way" before the drinking problem -- that it was difficult for them to adapt to the radical changes of the mother, and the implications which these changes had for whole family interaction. Overtime, they developed a sense of powerlessness to the degree that they could no longer fight or deal with the drinking behavior. But the family unit did not dissolve. They withdrew, without the mother's participation, into their own lives, their own ways of achieving and of continuing in the development and maintenance of "old ways." But again, the mother, formerly a principal guiding factor in their successful developmental process, was excluded. They set up means of

interactng as a unit without or around her, and all this was accomplished without destroying the family system.

Both the previous and following episodes provide examples of interactional processes by which this family moved from a normative lifestyle — in terms of their native cultural surroundings —towards an adaptive and radically altered way of doing things. While stll concerned with the effect of cultural pressures on whole family response to alcoholism, I have also examined the development and maintenance of interadtional patterns by which this altered organizational unit carries out the ordinary, routine activities of individual and family survival. This stage of analysis incorporates both the first and second level of the model.

A Pretense of Normality

Molly and I made an unspoken agreement at the onset of this study, that she would be home, in or about the house, during my visits. As such, whenever I planned to drive the distance from my house to the Andrews home, I first checked in with Molly. On one particular Saturday morning, my phone rang at 7:30 a.m., and there was Molly's cheerful voice asking me to "come on over" and spend the day with the family. She was ecstatic about her plans to play bridge with a church group that morning; since the rest of the family would be home that day, she requested that I come this once when she was away; she promised to return early afternoon. I accepted the invitation, and on arrival shortly after lunch, I noticed that Molly's old Plymouth wagon was in the driveway. Carol said very softly, "yes, she's here" and with a resigned wave of the hand motioned towards her parents' bedroom at the end of the hall off the kitchen, saying nothing more. This was typical of the family's unusual procedures for explaining Molly's absence from the family scene. On this morning, the wave of the hand was the signal that Molly had been drinking

and was already asleep and "out for the day," or that she was in her "drinking place" (as Carol once referred to her parents' bedroom), going through her private ritual of consuming a pint of vodka. I assumed the latter, because Carol whispered that she'd like me to accompany her upstairs where we could chat without disturbing her mother.

Since the onset of Molly's drinking problem, family members claim that no one in the Andrews family has ever seen, or has any desire to see, Molly drink. However, frequently -- often four days out of seven -- the children come home and find her in the bedroom. Carol explains the immediate cue: "When I look in, I can tell for sure cause she lays down on the bed and she rolls herself up in the bedspread and that's a for sure sign." On any given day that Molly is in her bedroom drinking, several family members or the whole family may be in the house also, going about their normal routines. For instance, on this Saturday morning when Molly never came out of her room, Carl was cheerfully raking leaves off the front lawn, Carol was doing her laundry with her wet hair wrapped up in a towel, Barbara was everywhere -- on the phone, trying to shock me with her latest risque jokes, teasing Ron about his new girlfriend or doing her dance routines on the stairway; and Ron, who laughs and comes to life when Barbara is around, was alternating between working on something in the garage and organizing a Christian Youth Meeting for that week. As I was chatting with one person or another, I too found myself forgetting or ignoring the fact that Molly was at that moment in the process of solitarily drinking in her bed. However, this happy, almost comic-relief ambience was frequently shattered by sporadic, frightful screams from the bedroom. These sounds always brought me back to the reality of what was going on here; at one point, knowing that it was "taboo" to open the bedroom door and physically check on Molly (no one ever did that) I couldn't

refrain from asking "do you think she is all right?" The family feigned unconcern, shrugging it off as distressing but normal behavioral routine for Molly's drinking periods. Carl walked outside, suggesting that if it bothered me, I should join him out in the house trailer in the driveway where he was having coffee; Carol's face turned pale, but she kept her eyes glued to the newspaper she was reading. Ron stood outside his mother's bedroom for a brief period, then went back to the garage. Later in the day, and in the course of a recorded conversation, Barbara finally addressed to my question, in an uncertain shaky voice:

> Yea, she's all right. She's just, I don't know. I guess she screams a lot. Like she'll get scared if she knows her door is unlocked or something. When she's sober, she doesn't care if the door's open. When she's drinking, then she gets into these big acts and stuff. Usually no one's home on weekends like today, so she drinks knowing no one will be watching her. Recently we've been here about 50 per cent of the time.
>
> I asked: So does your father stay home with her on weekends?
>
> No, she said, my Dad goes out and works on weekends.
>
> Does anybody stay with her?
>
> No, we just go and do our own thing, especially now, it's Christmas season you know, and we have to buy presents and stuff.

I was puzzled by the incongruity of the situation:

> Now Barbara, let's go over this again. Molly drinks during the week when she's alone. Sometimes you all leave her here on weekends alone. Are you telling me that if someone stayed here with her -- or if all of you did -- that she wouldn't drink on weekends?

Barbara was perturbed:

> Oh, she probably would if she knew we were staying just to watch her. Yea, she wouldn't like that at all. But like if our family's home and she's planning

> a big meal — you know, a real nice Sunday meal — and everybody's going to be home -- or like our birthdays or something like that — she doesn't get drunk on those kind of days. If there's something that she has to do, if there's a reason the family's all home -- like when you came to Sunday dinner that first night for example — and stuff like that — then she won't drink.

I suggested that maybe Molly took Antabuse on those days, to control her craving for alcohol, and Barbara said she didn't know "what antabuse was for." (This was unlikely, because we had discussed it in an earlier interview.) I replied,

> Well, it's a pill that you take — it makes you nauseous if you drink. It's supposed to be helpful in cutting off the drinking. It works for some people, for other's it doesn't.

She answered,

> Well, she's gone for a week without drinking, before she even had that Antabuse in the house, you know. Like when Carol got Valentine Queen, she sewed for a week on her dress, you know without even drinking anything cause, I mean, she knew she **had** to do it, so she did it. She didn't even drink in the evenings or anything. But as soon as it was done, back to the bottle!

There were other instances, similar to this episode, where the family went about their everyday routines under a pretense of normality — but in the all but visible presence of Molly's highly excessive drinking patterns and her distressing, abnormal behavior.

Disruption of Family Rituals

The stress and strain of living with an alcoholic parent was a constant irritant for all of the families of the study. It was most recognizeable in the context of the ordinary, taken-for-granted functions of nuclear family life. The periodic breakdown of the mother's role function created confusion and ambivalence over who should step into her role as provider of most necessities of basic family "survival." For example, during her frequent and sporadic absences decisions had to be made on heretofore taken-for-granted services;

for example, who buys the food, cooks the meals, does the laundry and cleaning, makes the dental or other routine appointments, and so forth. In the Andrews family, where the division of labor clearly allocated these duties to the mother, and where her drinking pattern all but removed her from family participation from two to five days a week, decision-making on role takeover was particularly problematic. Most of the stress was caused by Molly herself.

She was reluctant to turn over any of her maternal role duties -- especially to her daughters. Preparation for holidays, special birthdays, school and graduation celebrations and family rituals -- most particularly mealtime, were her domain of work. Whether drinking or not, she wanted everything to remain the same or as "normal" as it was before the onset of her drinking problem. But "normality" is impossible in families where maternal drinking is frequent and excessive. In this case, the attempts at role reversals and other adaptive measures for maintaining basic survival needs exacerbated the drinking problem -- in fact, supported and maintained it.

At this second level of analysis -- and from a microfunctional perspective on the alcoholic family system -- I examine family interaction using one important family ritual -- the evening meal. More so than any other, this important ritual was radically altered by both Molly's drinking behavior and the family's routinized adaptive measures.

Molly takes her role as cook and provider of nutritious foods seriously, and on her non-drinking days, she prepares thoughtful meals. On these days, Molly rises early, is in a cheerful mood, and makes sure every sleepy family member knows that she is planning a special evening meal; she expects her family to be there at the appointed dinner hour -- as they always were a few years back. But the family has by now, for the most part, scheduled themselves out of the house from early afternoon on. They have adapted their working

and social schedules to Molly's drinking patterns and the usual norm of "no hot meals." As a result, dinnertime at the Andrews household, on those few nights that everyone shows up for the appointed six p.m. meal, has disintegrated into a fighting, yelling battlefield of wills. Barbara calls it the "battle of insults" and Ron views it as "out and out warfare." From the perspective of the researcher, the plan of attack, defensive moves and rapid retreats were so predictable, the dinner conversation read like a Eugene O'Neill script.

After the family prayer, and sometimes an appropriate reading from the Bible, the family is immediately preoccupied with consuming the home-cooked food; hot meals are after all, increasingly rare in this household. The arguments are almost always instigated by Molly who takes the few opportunities when the family is together to complain about all the times they are not together. Carl then reprimands Molly for upsetting the children and tries to change the subject; Barbara unfailingly sides with Carl, ignores Molly's comments and purposely changes the subject. Ron, who is more sympathetic to his mother's viewpoint, makes at least a feeble attempt to acknowledge her complaints, if not in words, by concerned apprehensive glances or by patting Molly's shoulder. Carol, the quiet, more contemplative participant in these family confrontations, capriciously sides with the more vulnerable party of the evening. Molly gets more agitated, and insulting remarks ensue with rapid succession between any possible combination of dyads and triads. Ron, in his self-appointed role as family mediator, tries to calm the family, but ends up yelling at everybody. One by one, the wounded and angry members vacate first the dinner table, and then the house, leaving Molly home alone, usually to begin drinking.

Over the research period, meals remained a major problem, more so for Molly than for anyone else. No one in the family made a major move to take

over the cooking role in Molly's absence, although several feeble attempts were made. The family preferred to grab cold snacks from the refrigerator, or on those occasions when Molly had not shopped or prepared food in advance, buy fast foods. On one occasion, when Carl withheld grocery money from Molly, and took her car keys, Barbara took over the marketing and cooking duties. Molly became so threatened with this intrusion on what she viewed as her most vital maternal role duty, that she stopped drinking for two weeks, recovered her keys and grocery money privileges and resumed normal cooking and marketing routines. Then she started drinking again. When Barbara once again tried to step into that role, Molly threatened suicide, so the whole family gave up on meal preparation. Barbara and Carol deeply resented these "power games" as they so accurately called them, and were disappointed when their father backed down with Molly's tantrums and threats. Although they were sympathetic to the reasons for Carl's ambivalence, they felt he was dominated by their mother.

Adjustments of Convenience

At the third level of analysis, I examine Molly's alcoholic behavior in the context of family equilibrium and stability as a working human system. Overtime, certain family members -- or in some cases all members -- develop subconscious or implicit reciprocal "bargains" between themselves and the identified problem drinker which accommodate both their own material or psychic needs **and** the alcoholism. In unspoken words the intrapsychic message goes like this:

> You are the identified problem in this family, and we both know it. I can adapt to your drinking, if you in turn give me what I need. In that way, -- we can keep this family system together.

These "adjustments of convenience" are in a sense intrapsychic blackmail. After a time, they become integral parts of the family structure and function. As the following two sections illustrate, such maneuvering also helps maintain the mother's drinking problem.

Molly's early efforts to camouflage her growing addiction to alcohol over a three-year span were perhaps for good reason. After the family's "discovery" of her drinking, her life fell into a cycle of ongoing struggle -- between the polar opposites of the nurturing, affectionate and dedicated wife and mother and the cold, withdrawn, and malcontent problem drinker. Whenever she can maintain sobriety for any length of time beyond two days, the household regains some semblance of "the way it used to be" or the way she wants it to be, which is with Molly in full control of her designated housewife role. However, in the span of one year, the family gradually made certain adaptive adjustments to the drinking -- and for their own best interests, not Molly's. As illustrated in the problems around meals, Molly is often confused and irritated by these changes.

One morning, over coffee, Molly talked about the changes in her sexual relationship with Carl. She was unhappy with Carl's insistence that they have quick, early morning sex as opposed to their former, more satisfying pattern of relaxed, late evening romance.

> I know my drinking has changed the way he feels about me; our sex life isn't as good and it isn't as frequent. But his time schedule has something to do with that, too. He's pretty well decided that sex in the morning is the best time to have it and I don't agree with the kids running in and out and one thing and another. But that's the only time now when he's not tired -- it's funny, I used to be the one that was too tired. I do resent his job — and the times he's gone every evening when I need him most. The most difficult times for me are in the evening.

From Carl's perspective the early morning sex coincides best with Molly's drinking problem because she might be asleep by 6:00 p.m. Also, he frequently scheduled evening appointments to show houses. However, this schedule persisted even when Molly was not drinking, so whether abstaining or drinking, she now spends most evenings and weekends alone. Several times, when Carl could no longer tolerate Molly's behavior, he slept outside in the trailer. Once he spent the night at a friend's home. Since these were the first times in 20 years that Carl had purposefully removed himself from their bed, Molly was threatened, frightened and angry all at once. Each time that he did this, she made efforts to abstain for several days, to clean the house, to put on make-up and an attractive dress, and to plan a special meal; on one occasion she even bought Carl a new suit. Carl would always respond to these changes, return to their bedroom and resume sexual relations. On several occasions, they individually assured the researcher that their sex life -- albeit not always so good -- was stable, in spite of Molly's problem. In view of all the trauma, crises and degrading experiences between this couple, even occasional sexual relations seemed an anomalous constant.

In an effort to restrain Molly from buying alcohol, Carl often took the car keys away from her for days at a time. Because they live far out in the suburbs where there is no public transportation, this leaves Molly stranded; she has no means of getting to Church, Bible study, group counseling sessions

and of course shopping areas. Before Barbara graduated from high school and was given her own new car, Carl would often give the car to her on those days he was restricting Molly, much to Barbara's delight and Molly's disbelief. One morning, after Carl had left for work, a screaming battle ensued between Barbara and Molly over this issue. Barbara, who was fast becoming as volatile and verbally abusive as Molly, took the liberty of calling her mother a "bitch, who didn't deserve the right to drive a car and kill other people." Molly was so taken aback by this presumptuous behavior that she slapped Barbara, and — to everyone's surprise -- Barbara slapped her back. Molly, overwhelmed with anger, grabbed the first thing she could reach, which was the butcher knife on the kitchen counter. At this point, Ron stepped in and pushed Molly aside, took the knife, and called his father. Molly cried and Barbara ran upstairs. By the time Carl arrived home, Molly had taken several drinks from her hidden supply of vodka somewhere in the house, and was sobbing and shaking in a seemingly uncontrollable manner. After receiving an objective account of the story from Ron, Carl told Barbara she was to stay with a friend for awhile, making it clear to the other family members that Molly was becoming a dangerous person.

Barbara quietly moved out the next day; Molly was so guilt-ridden and shaken by this breakup in the family, that she stayed in her room for several days, coming out periodically to argue or "try to reason" as she put it, with Carl. During the three weeks Barbara was away, and between drinking periods, Molly began designing and sewing Barbara's graduation dress, and planning for her graduation celebration party, which was less than a month away. Barbara returned home several times to make choices on the fabric (an expensive white-on-white print) and for the fittings of the dress. She came and went in a pleasant, non-disruptive mode, with no apparent animosity towards her mother.

Molly had little to say to Barbara; she was more concerned with Carl's withdrawal since the knife episode. She scheduled Barbara's fitting sessions to those times when Carl was home, and kept him abreast of the party plans. He was pleased with Molly's efforts to remain sober, and in making appropriate preparations for his daughter's upcoming important event. Barbara moved back home two days before graduation.

The Graduation Party

The party began with a full buffet dinner at 3:00 p.m. and ended around six in time for everyone to attend the graduation ceremonies. The guests included: the paternal grandparents; Molly's mother; Carl's brother, his wife and three young children; two "special" neighbors who were friendly with Barbara; Kaye, an old friend of Molly's from Centerville; and several of Barbara's and Carol's friends. By the time I arrived all the other guests were already crowded into the family kitchen, sampling the array of foods; there was turkey, ham, salads, homemade breads, decorative cookies and cakes, fruit drinks, candies and nuts, all prepared by Molly and positioned on the long buffet table just beneath the bulletin board. I noticed that the family bulletin board displayed some new pictures of Barbara in her latest starring role in the school play.

Barbara, who like her sister was a strikingly beautiful young woman, was wearing the new hand-stitched graduation dress that Molly had finished just the day before. As she received gift checks from the grandparents, she tucked them into her bra, drawing laughter when she commented "oh well, it fills those out anyway." She was in a happy mood, joking facetiously about her struggle to graduate, when in fact she had just been awarded an $8,000 scholarship to a prestigious university.

Ron was very quiet, sitting next to his maternal grandmother who often held his hand. Kaye and Carl were acting as host and hostess, greeting guests, serving food and moving around the room. Molly was conspicuous by her absence. As Carol later told me, when the family awakened at 7 a.m. that morning, Molly had already consumed a pint of vodka and was out for the day. Although the family was angry and upset with her, they decided as a group that they would have the party anyway. Carol was upset because she had to take off work that morning and facilitate the laying out of the food. However, after Molly's careful preparation, there was little left to be done. Molly's mother, who arrived the day before, had, according to Carol, cried all morning, making such comments as:

> What am I going to do? This is my only daughter.
> How did this ever happen to me?

Once during the party, Molly came staggering out of her bedroom looking pale and dishevelled; her dress was wrinkled and her mascara smeared down over her cheeks. She said "hi everybody," went to the buffet, stirred the potato salad, and returned to her room. It was a strange, almost eerie three or four minutes: conversation stopped, no one moved to help her when she staggered, or to stop her from moving towards the food table. Everyone sat in silence, even the young children, staring at her as if she were some pitiful, afflicted stranger who had wandered in off the street. After she returned to her room, the party and conviviality were resumed; no one said a word about Molly or her condition.

That evening, when the family were all away at the graduation ceremonies, a former acquaintance of Molly and Carl's, a man who was himself a recovering alcoholic, came to the home with his girlfriend and took Molly to a private hospital for treatment of alcoholism. Molly began a month-long process of physical and therapeutic rehabilitation. Earlier that week, and with

Carl's knowledge, she had made arrangements to admit herself to this hospital, but at a later date. She never discussed this episode, that is, why she went into a drinking phase on Barbara's graduation day or how she managed to get to the hospital that particular evening. She may have called the friend from her room.

After a month's stay in that hospital, wherein several different approaches to alcoholism were attempted (private counseling sessions, group sessions, Alcoholics Anonymous meetings, and two sessions of couples therapy), Molly returned home, feeling stronger physically and mentally, and with great hopes that she would maintain abstinence from alcohol. After two weeks, she resumed her drinking patterns, and within a month she attempted suicide for the third time in two years.

Treatment History

Over a twenty-two month period, Molly attempted to get treatment or counseling, sometimes on her own instigation and at other times through her family's encouragement, from the following professional resources: the alcohol treatment center of the county mental health services, private detoxification and rehabilitation centers, the psychiatric unit of a large county hospital, a private hospital for treatment of alcoholism, Alcoholics Anonymous, and thereafter various meetings with ministers and church-related counselors. Additionally, she entered community hospitals for emergency treatment of injuries incurred during automobile accidents (twice) and apparent suicide attempts (three times). Although she did make progress with several of the treatment modalities on a short-term basis, overall she was unable to maintain abstinence or controlled drinking.

At the beginning of the field study, Molly was a client at a community mental health center in the alcohol treatment division (through which she was

recruited for this study). At this center she participated in individual, joint and group therapy. There were conflicting reports from Molly and Carl on the merits of this program. Molly enjoyed her weekly sessions at this center, primarily because it was "something for her to do," in an otherwise uneventful week. In anticipation of this event, she made efforts to abstain, usually with the use of antabuse. She preferred the individual therapy sessions to couple or group therapy and felt she was making progress with one particular therapist; she was discouraged on the days that this therapist was not in the center. Molly said that she responded positively to the "women's therapy group," wherein all of the members were problem drinkers; however, she herself was put off by the intimate nature of the topics some of the women discussed, and threatened when questioned about such matters in her own life. Carl's comments on this treatment regimen differed:

> Everytime in the past that she has gone to that center, she has come home in a very angry, resentful mood because they had dug up all sorts of things that had happened in the past and in fact, it usually triggered her off into a heavy drinking period. And the few times I've gone with her it has had the same effect on me. I find it to be an unpleasant environment.

In spite of her husband's protests, Molly continued to visit this center intermittently for a one-year period. Carl joined her for only the first several sessions, and then discontinued the joint therapy altogether. The children never attended a family therapy session, and neither Carl nor Molly ever encouraged them to do so.

At Carl's suggestion, Molly tried Alcoholics Anonymous; she attended her first meeting with the wife of a business acquaintance of Carl's. Molly took an immediate dislike to A.A. for a variety of reasons:

> They all chain smoke and the smoke bothers me; I don't like to drive at night; it's too impersonal and too big a group.

Ron was relieved when she abandoned the A.A. meetings, for no stated reasons other than he "did not want his mother at A.A. meetings." Carl agreed with Ron, commenting,

> A.A. can't handle Molly anyway; her problems are much too complex for them.

Several times, Molly admitted herself to five-day detoxification units wherein she also received short-term counseling sessions. These privately-owned "home-atmosphere" programs served no better purpose than to get Molly away from the house for a period of drying out and rest. On the positive side, these homes served as a kind of last-resort place for Molly when she was most desperate for help; in that respect, these "retreats" were an alternative or escape from the cold, disapproving responses of the family, bitter arguments with Carl, and the periodic compulsions to take her own life. Molly scheduled these sessions following a heavy drinking period during which there occurred a particularly stressful or humiliating alcohol-related episode.

The treatment at a large county hospital was not instigated by the family, but came about routinely after one of Molly's suicide attempts. As previously discussed, she was retained there on a maximum security unit for seven days when Carl refused to co-sign her statement that she would not attempt to take her life again. Fearful of her roommates, and appalled by the unusual behavior of some other patients, Molly at first became hysterical, and -- like any other patient on that ward -- was retained in her bed by force. This turned out to be a frightful, yet ineffective treatment method.

Molly's most singularly successful treatment process, in relation to abstinence from alcohol and a sense of well-being, was the month-long program at an expensive private hospital for treatment of alcoholics. The most obvious

reason for the positive results was that, in addition to receiving constant attention and care, she had no access to alcohol. This program offered seemingly everything: private therapy, group therapy, family therapy, Alcoholics Anonymous meetings, diet control, "alcohol education" classes, and a physical fitness program. The cost of this treatment was $6,000, and although Carl's insurance paid for most of it, he was resentful and skeptical of such high-dollar services for treatment of a drinking problem. The family visited her several times over the 30-day period, and though they were encouraged to participate in family therapy, they chose not to. These sessions, which met only once a week for a period of 2 hours, were not private. They were set up as multiple family-group sessions, that is, there were many families present. Their minister and his wife also visited Molly. Molly enjoyed this "retreat," as she called it, and returned home at the end of the month's stay in an improved physical and mental condition; she was happier, more relaxed and more positive-thinking than I had ever known her to be. The family was grateful for a sober, nurturing wife and mother, but they also were watchful and skeptical. After two weeks Molly once again began to get agitated and tense over "little things" such as the disorganized meal time schedules, Carl's absence in the evenings, her mother's daily calls and probing questions, the dirty dishes that the girls left in the sink after their late night meals and many other ordinary, but irritating (to her) mechanics of the Andrews household. After two weeks of abstinence, Molly returned to her former drinking pattern.

Spiritually-Centered Treatment

Attempts to get help for Molly from spiritual, church-related sources were a continuous process. Carl and Ron were the leaders in this effort. Carl regularly spoke to his minister about Molly's drinking and related problems, and from time to time he made arrangements for the minister to come to

their home to counsel Molly; at other times, he and Molly saw the minister together. From Carl's perspective, these were the most successful couple therapy sessions, yet Molly was embarrassed whenever radical elements of her behavior were discussed, such as suicide attempts and automobile accidents.

Ron arranged for a "christian counselor" through his Christian Youth Organization. After one such session when a family counselor came to the home Molly commented:

> I talked to him a bit, but I don't think one day's enough to tell about anything. Ron feels very strongly that I need christian counseling, not regular counseling. He objects very strongly to me going to see my therapist at the Community Mental Health Center, and my group — and I **need** to go there. Of course, since Carl has taken my car away, I can't go to my sessions anyway.

Each time Molly entered a hospital, the family brought her a Bible; Ron often prayed at her bedside when she was asleep after drinking. To some degree, the continuance of spiritually-centered treatment symbolized the family's rejection of disease or other physiological explanations for alcoholism. They maintained their unified belief that it was a moral problem. The conflict of belief systems was openly manifested in an encounter the family had with a counselor from an alcoholic treatment center who was called in to a hospital by Molly's attending physician after her third suicide attempt. In the course of conversation with the family, the doctor and the counselor explained that Molly had a disease and that she was "a very sick woman." This was after many months of attempted treatment from various established health resources, and at a point where Molly, had tired of ineffective professional help and conceded to her family's implicitly communicated belief that she was more morally than physically ill. Molly answered for the family: "I'm not sick, I'm a sinner." The counselor returned: "Sorry folks, the Bible hasn't done it for you." In the verbal interaction that followed, the physician and the counselor

responded firmly and negatively to the family's moral explanations for alcoholism. They repeatedly warned that without immediate and "proper" medical attention, Molly was going to die, and "neither the Bible nor prayers nor "christian counseling" were going to save her." To save face, and in deference to the medical profession, the family withdrew from the debate, feigning agreement with the medical diagnosis. However, after this incident, Ron, the spiritual spokesman of the family, discouraged Molly from any further participation in non-religious focused treatment attempts.

CHAPTER 4: THE BARKER FAMILY

Ralph and Joyce Barker, now in their early forties, have been married 15 years and have three children ages 12, 10, and 8. Together they own and maintain an equipment rental business which is located on the same one-acre property where they live. Ralph operates the business out of a mobile home which is just adjacent to their house. His equipment yard is open seven days a week throughout the year, closing only for three holidays: Thanksgiving, Christmas and New Year's. With three young children to care for, Joyce is primarily a housewife, but she also helps Ralph with customer service on busy days, and operates the rental yard alone during his infrequent absences.

A Not-So-Typical Middle Class Family

Ralph Barker, at six feet five inches and 300 pounds, is an imposing, powerful man in both size and personality. He projects the image of a jovial, carefree but hardy outdoorsman. In his colorful flannel shirts, khaki pants tucked into his boots and woodsman's cap, he often struck me as a Bunyanesque lumberjack, out of context and uncomfortable with his noisy, smoggy, heavily populated and suburban environment. In fact, in his younger, pre-marital days, Ralph regularly pursued recreational outdoorsman-type activities. He stream-fished, hunted deer, elk and wild boar, back-packed in the wilderness and skied as a member of a ski-patrol team. Following his marriage to Joyce, who had no penchant for sports or outdoors life, and the subsequent arrival of three children, Ralph regrettably found himself without adequate money or time to pursue these activities. However, he does manage to take several weekends a year alone or with friends, fishing and backpacking. Ralph often speaks of what he refers to as his "escape dream" -- a cabin of his own in the wilderness where survival depends only on and for himself.

In contrast to the father in the Andrews family, Ralph has little interest in activities which are centered around the church, community or children. Raised in the Catholic church, he obligingly and willingly switched to the Presbyterian religion after his marriage. He explained this transition in terms of convenience:

> Joyce was Presbyterian and I figured the woman generally handles the religion in the family and I thought well, we'll bring the kids up Presbyterian. I went along with the Church groups and it was sort of neat until the big squeeze play where they wanted a percentage of my money. When you take out a price tag for God, that lost it for me. Now I could care less about Church.

Ralph views his acre of land as "an island in the middle of a big city" and likes it that way. Exerting no overt attempts to socialize with his neighbors or to become involved in community events, he commented on the world outside of his island:

> Out there the husband gets up in the morning and goes to work and comes back in the afternoon to cut the grass or whatever else -- our lifestyle is 200% different. They can't grasp the difference between their life and mine and I don't want to. I'm different.

With regard to family life, Ralph tolerates the noise and confusion of three young children in near proximity to his workplace, but he is not happy with this arrangement. He stated:

> Joyce was raised to have babies -- I wasn't. If I hadn't done something about it, she would have had twelve kids....do I like my family -- I guess so, I'm still here anyway. But there are a lot of things I don't like about it. I wish Joyce could get organized and I wish she wouldn't let the kids walk all over her. ...Before we moved here, the business was my only escape from the family. I could tip my cap in the morning, walk out, and come home late at night. Now its all right here. Economically it's good, and I'm my own boss, but God, I'd like to go somewhere else sometime.

Ralph candidly describes himself as a kind of "possessive, thing person." He collects many kinds of mechanical devices -- machines, tools, connectors, wires, rope, vehicles, trailers and so forth. In fact, that's how he got into the equipment rental business. He stated: "After years of collecting and fixing up things, I decided to make money on my hobby. Some of my things I like so much, I want to keep nice, so I hide them from the customers." To emphasize the high priority of his "things" Ralph said, "A few times I've had in mind to split from Joyce and this whole mess, but see, that somehow would threaten my things, cause there's no way I could put all of my things in a couple of suitcases and disappear up North."

Joyce Barker

From our very first awkward meeting at a Sambo's restaurant, and throughout the 20 months of our acquaintance, Joyce Barker presented herself and her lifestyle in straightforward, unpretentious (in my perception) and truthful terms. She never apologized for her drinking behavior or her disorganized household, however; she did often express concern and embarrassment over these problems. Joyce is a realist who says it like it is. For example, when I asked her why she preferred we have our first meeting in a public restaurant rather than her own home she responded: "Because there is no privacy in my house, it is filthy dirty and I take any opportunity I can to get out of here." And when I asked how I would recognize her in the busy customer flow, she returned, "You can't miss me, I'm fat and my hair's turning grey." In fact, I had no problem spotting her in a busy parking lot as she climbed out of the family's service truck. A frowning, "pleasantly-plump" woman, she was wearing a brown polyester pant suit and an ill-fitting brown and white checked coat. Throughout the months I frequented her home, I never saw Joyce in a dress or adorned with make-up or jewelry. At home,

she always wore blue jeans, oversized button-down shirts and tennis shoes. On the rare occasions when she and Ralph went out for an evening, or to see the counselor at the alcohol treatment center, she wore the brown polyester pant-suit.

Joyce was raised in Northern Idaho, in what she described as a happy, loving family environment. After high school, she completed one year of college and three years working as a telephone operator before leaving her parents' home to live with friends in California. Shortly after her arrival in California she met Ralph in the sports shop where they both worked, and three months later, they were married. According to Joyce, the first 5 years of her marriage, wherein she had three pregnancies and three children, were her happiest years. Not one to join women's groups, church or community organizations, Joyce stated, in so many words, that she preferred the more solitary purposiveness of pregnancies and child-caring. As a couple the Barker's social activities were limited by the demands of caring for three small children. Other than her participation in the rental business, Joyce has not, since the birth of her first child, sought employment outside the home.

Joyce spends the greater part of her daylight hours in bed, napping, or dozing by the television between her favorite daytime shows. Her tiredness and lack of energy is due in part to her periodic drinking bouts, but also to her agreed-upon duties as night watchman for the equipment yard. With no protective fencing around the yard and the merchandise visible from three sides, the equipment is vulnerable to possible thievery. As a precautionary measure, Joyce and Ralph take turns watching the property from the living room window, which offers a vantage view of the yard -- Joyce from 10 p.m. to 3 a.m., and Ralph from 3 a.m. until 8 a.m., at which time he opens the office for business. As a result of this arrangement, they rarely, if ever, have

occasion to sleep together in the king-sized waterbed which fills up most of the master bedroom.

Joyce seemed to enjoy her maternal role, often stating that the best part of her life was being a mother. She is loving and affectionate to her children, often reaching out to touch or caress whichever child is in her near presence. She considers their needs and problems, in the sense that she takes time to listen when they need to talk to her; however, she rarely took action, beyond the act of listening, to correct or ameliorate their problems, of which, as we shall see later on, there are many. Aside from her role as a nurturing parent, and in part due to her drinking problem, certain other basic maternal role duties were often not attended to in the Barker household -- neither by Joyce nor anyone else. As examples: by normal standards for a healthy child-rearing environment, the sanitary, nutritional and certain other conditions of the household are most probably marginal. Joyce rarely cleans the house, and Ralph never participates in housework or meal preparation. Dishes are not washed for days, bed linens are rarely changed, and floors are littered with clothes, bits of food and discarded items; Joyce, the only person in the household who prepares food, provides a low-nutritional diet made up primarily of packaged snack food and frozen "t.v." dinners; two of the children's sleeping and study quarters are in the living room where the television is turned on all day and all night; outside of their school attendance, the children have, for all practical purposes, no peer group interaction because they rarely have opportunity or encouragement to leave the family property -- the parents never entertain in their home and rarely plan outings which include the children. Joyce was aware of these problems, frequently pointing them out to whoever was in earshot -- Ralph, the children or myself -- and she appeared to experience an enormous amount of guilt over the more obvious breakdowns in her maternal

role duties. In her straightforward manner, she often spoke of this guilt, her fears for her children's welfare and her frustration with the disorganized household. But still more distressing for her was the growing realization or belief that there were no immediate solutions to the existing and developing problems. During the first days of her non-drinking periods, she would resolve to accomplish specific goals and projects related to the house or needs of the children. These efforts never went beyond the "talking" stage, for the reason that Joyce simply did not know how or where to initiate changes in their routined pattern of living. She often asked Ralph for help, and when none was forthcoming, retreated to a drinking period: it was a repeating cycle.

Joyce is ambivalent about the depth of her emotional involvement with her husband. She once stated:

> There are too many problems between us for love, but we care for each other. There's a lot of days it's just like we put up with one another. We have discussed divorce, but then where would I go -- and I'd never let him raise the kids. He doesn't care for them that much and he calls them names, puts them down.

Joyce is intimidated by Ralph, but not in a physical sense because he has never abused her in that way. At many times when I observed them in one another's presence, I sensed a change in Joyce's self-presentation. Her mode of communication changed from refreshing forthright statements of fact to hesitant, guarded phrases. There was no doubt , at least from outward appearances, that Ralph was the dominant personality in this marital dyad. In fact, when Ralph walked into the house, everyone in the family was immediately aware of his presence. His bigness -- six foot five inches and 300 pounds -- his booming voice and his stream of sarcastic, sometimes humourous, oftentimes abusive comments on whatever anyone was doing or saying dominated the course of family interaction. Joyce resented his manner of verbally abusing

the children, for example referring to one daughter as a "lazy fat slob," or to his son as "useless," and she often complained to me about this problem. He controls all of the family finances: Ralph pays the house mortgage installments, while budgeting Joyce to $100.00 a week for food, clothes, house supplies and other such basic necessities of family subsistence. Joyce has problems stretching that amount to meet the needs of five people. However, and in lieu of a confrontation over the matter, she rarely asks him for money. The only times Joyce ever confronted Ralph, or put demands upon him, was when she was drinking. During those periods, he would allow her to vent her pent up anger for a given period of time -- once for an entire weekend -- and then explode into a rage of his own, until Joyce retreated from her position of power.

According to Joyce, she and Ralph go "six months and sometimes longer" without having sexual relations, primarily, she readily admits, because she does not enjoy it. Sometimes when she reflected on this problem, she expressed concern over their lack of sexual compatibility, but at other times, she dismissed it as a clear-cut case of frigidity. She stated: "I inherited this condition from my mother. She started talking to me in my teens already about the fact that she never enjoyed sex with my father. I guess I have the same problem." At another time she said "It's really weird, after a big fight with Ralph, or when I am angry with him and alone in the house, I get a picture of us having sex, and feel a repulsion for him." Joyce's apparent rejection of Ralph's sexual advances seemed inconsistent with certain other comments and natural behavioral mannerisms. Often when we were in the kitchen together, she would position herself by the window which offered the best view of Ralph moving about the equipment yard, and from time to time she would comment on his good looks and large, muscular physique. She once stated, "Whenever

he drives into the yard and jumps down from his truck, or when I hear him stomping towards the house, I get a special kick, a kind of thrill." Ralph never spoke of their sex life, but Joyce stated that he periodically made sexual advances, and if she refused, he accepted it with a quiet resignation, but always requesting that they "work on this problem."

The Barker Children

At the beginning of this study, Mary Ruth, the oldest of the Barker children was twelve years old and in the seventh grade. She held a striking resemblance to her mother in both her physical appearance and straightforward manner of verbal expression. From the perspective of herself, her family and her social peers, Mary Ruth was overweight. According to Joyce, Mary Ruth has consistently gained weight since the age of eight and in fact, by the end of our 20-month acquaintance, at age fourteen and with a height of 5'4", she weighed 250 pounds. A compulsive eater, she often consumed whole large packages of potato chips, cookies and 32-ounce bottles of Pepsi Cola at one sitting. When not in school, and especially during the summer vacation, Mary Ruth spent her days watching television, listening to records and eating. School proved to be an unpleasant environment as she was often teased about her rotund appearance or called demeaning names by her adolescent peers. When she entered junior high school, her grades dropped from above average in primary school to near failure. Her self-image suffered from the ongoing verbal abuse and attendant problems to the degree that sometimes when accompanying her mother for shopping, she would remain in the family car to avoid being spotted by schoolmates or stared upon by strangers. At other times she remained at home, feigning sickness or a "headache" rather than face what to her was a cold and unfriendly school and other social environments.

A quiet and sedentary young girl, she rarely instigated or encouraged conversation with other family members, except during those times when she was provoked into verbally (and physically) defending herself against sibling ridicule and teasing. She contributed little in the way of housework, cooking or babysitting of her younger siblings. Although they often rebuked her for apparent laziness, her parents rarely afforded her the opportunity to participate in normal household projects. Her father, when angered and frustrated by her eating habits and excessive weight problem, would strike out at her verbally, threatening punishment or withdrawal of privileges if she did not lose weight. He often, and in my presence, "jokingly" referred to her as the "family blob" or the "fat slob." Following his example, the younger children openly, and with only mild reprimand from their parents, teased and taunted Mary Ruth. Privately, Joyce spoke to me of these cruelties and of her apparent concern for Mary Ruth's suffering, but she never took measures to intervene in abusive family interaction around the issue. I often wondered to what degree Mary Ruth's weight problem benefited Joyce in the sense that it distracted attention from her drinking problem and frequent breakdown in maternal role behavior.

Jimmy, at age 10, was a sad-appearing, non-communicative, lonely little boy. Unable to cope academically and socially at school, he was already two years behind his grade level and struggling to keep up with his classmates. He had one playmate who lived two blocks from their home, but due to boundary restrictions he rarely obtained permission to see him. Jimmy distanced himself from the family emotionally, and whenever possible, physically. Sometimes he would sit alone for hours in a removed area of the yard, observing — more like glaring at — family and business interaction. At other times, when he was disturbed or teased by one of his sisters, he would angrily strike out at them both verbally and physically. When he wasn't sulking, or exhibiting

what appeared to be an unexpressed rage, Jimmy concentrated on attracting his father's attention. He would follow Ralph around the yard, but by at least a 10-foot distance, obviously waiting for an invitation to participate in some activity which would necessitate his touching the "off-limits" equipment and machinery. Occasionally, Ralph would allow Jimmy to sit on the tractor, or move a lawn mower, but more often than not, Jimmy was sent back to the house and out of the way of customers and the flow of business. When Ralph embarked on fishing, hunting or backpacking trips with friends, Jimmy in his disappointment at not being included, would sulk for days. To add insult to injury, both Joyce and Ralph teased him about his behavior, causing him to emotionally remove himself even further from the family. One time, during summer vacation, Ralph did take Jimmy surf fishing at a nearby beach area. When Jimmy became irritated and exasperated at his inability to properly handle the equipment, Ralph terminated the fishing activity and purchased some fresh ocean perch. On his return home Ralph announced to the family -- and myself -- that Jimmy was a "lousy fisherman."

The third and youngest child, Julie, at age eight was already showing signs of overeating and excessive weight problems. She was in the first grade and a poor academic achiever. Often referred to as the "baby," Julie had a habit of physically clinging to her mother, frequently reaching upwards, like a toddler begging to be picked up, or rubbing up against her with feline movements. Herself a sedentary person, Joyce sometimes sat holding Julie for hours, and when in the presence of her other children often touched them also, responding affectionately to their every word and movement.

Joyce's Drinking Pattern

The Community Mental Health Center from which I recruited the Barker family had categorized Joyce as an "impulse drinker." By their analytical

definitions for alcoholics, an impulse drinker is one who has irregular patterns of abstinence and drinking, can sustain long or shortened periods of abstinence or controlled drinking, and then, for no apparent reason other than the impulse to consume large amounts of alcohol, commence a period of heavy drinking. But this was not always the case for Joyce. For the first six years following the onset of her drinking problem -- now in its eighth year -- Joyce consumed a pint of brandy daily during her drinking periods. Her original regulated pattern was to drink for ten days or more, and then not drink from four days to two weeks. However, this pattern changed two years ago, following a six-week stay in a hospital wherein she almost died from "liver complications." Although her physician diagnosed her problem as hepatitis, Joyce was and still is firmly convinced that it was "liver failure due to my drinking." It was after this life-threatening episode that she entered the community alcohol treatment program. Over the past two years Joyce has tried to curtail the amount of alcohol she consumes and to sustain longer periods of abstinence. Ralph stated that she once went three months without drinking, but Joyce later on told me this was not exactly accurate. She explained that during her so-called non-drinking periods she often drinks small, measured amounts of brandy intermittently throughout a day or week, with sufficient moderation that she is able to conceal the drinking from the family. Since Ralph is almost always in near proximity to the house, she finds it necessary to destroy the evidence of alcohol on her breath by using mouthwash after each drink. Following these periods of sustained or controlled drinking, Joyce periodically goes into a heavier drinking period wherein she sips brandy and water slowly, beginning in the morning after the children leave for school and continuing all through the day into the late evening. The amount of alcohol consumed varies from 16 to 32 ounces daily and this pattern continues for irregular lengths of

time ranging from four days to two weeks. Joyce "sips" the brandy and water discreetly and in the natural course of her daily routine. During her drinking periods she makes no overt effort to conceal her drinking from Ralph, however she rarely drinks in view of her children. A two-hour nap in the afternoon enables Joyce to be fairly lucid when the children arrive home from school. She then resumes her drinking slowly and unobtrusively, until after dinner when she again "dozes" in front of the television. At 10 p.m., she rouses to begin her watchguard duties and to drink until 3 a.m. when she finally goes to bed. On those mornings when she is able to do so, she rises at 8:30 a.m. to prepare the younger children's breakfast (Mary Ruth leaves the house before she awakens) -- sends them off to school and resumes the drinking pattern. I noted that during the three-month summer school vacation period, Joyce either abstained altogether or carefully controlled her drinking.

There is a history of alcoholism in Joyce's family. Her father and sister both died of alcohol-related complications, and her mother, who rarely drank when Joyce was a child, developed a serious drinking problem in her later years. Joyce's brother abstained from alcohol by personal choice from his early teens. In her childhood recollections, Joyce stated she never saw either of her parents intoxicated, and was unaware until years after she had moved out of her parents' home that her father had a drinking problem. Ralph's parents were occasional, social drinkers, with no apparent problems with alcohol.

Both Joyce and Ralph pinpoint the onset of Joyce's drinking problem at exactly eight years ago, shortly after the birth of Julie, their third and youngest child. Both are equally vague and uncertain about precipitating factors causing her to change from a moderate and social drinker to heavier and problematic drinking patterns. Ralph hypothesized that it was related in some way to his

vasectomy, in the sense that this terminated Joyce's child-bearing possibilities. Joyce however, offered a different view:

> The biggest question of my life is why I have this problem. I remember my husband used to buy brandy by the case -- cause his Uncle is a cellar master at a winery -- and I can just see it sitting in the kitchen for months at a time and we'd have a drink at night. All of a sudden, I started to drink it by the bottle. And it was just seeing all these cases around.

For as long as he can remember in his adult life, Ralph daily consumed moderate amounts of alcohol. Occasionally on weekends and on holidays, he drinks heavily. His favorite alcohol beverage is brandy which, as Joyce stated, he buys by the case. He readily admits that he introduced Joyce to regular alcohol consumption, but is irritated that she cannot control her drinking like he does. He stated:

> When we met she drank very little and I was a brandy drinker and wine and everything else. I guess I introduced her to drinking. About 8 years ago she would you know, start drinking in the morning and keep on drinking all day long. I was at work, which kept me from drinking, but she'd drink and get beligerent drunk as opposed to when I get smashed I generally sit down in a chair and fall asleep.

In spite of this recognized relationship between Joyce's drinking problem and the easy availability of the alcohol, and even after her near death from liver complications, Ralph persisted in his pattern of buying brandy by the case and storing it in the family kitchen. During the second year of this study, this pattern changed. For several weeks, Joyce pestered Ralph to remove the brandy and store it elsewhere. When words failed to move him, she proceeded to empty one quart of brandy a day into the kitchen sink drain. Upon discovering this "wasteful" practice, Ralph moved the supply to a small mobile home in the equipment yard. After that apparent "victory," whenever she desired a bottle of brandy, Joyce retrieved one from the trailer. Towards

the end of the twenty-month research period, Ralph finally decided to lock the trailer.

An Island of Refuge

The Barker family home and working environment is indeed, as Ralph Barker earlier described it, "an island in the middle of a big city." Located in the center of an expansive and affluent suburban area, their one and one-fourth acre property is surrounded by a "sea" of modern ranch style homes. The house was built in 1907, and in terms of California's more recent developmental history, could qualify as an historical showpiece. As a family home, however, it has certain situational and structural problems. The property is bordered on one side by an overpass to a busy highway, on another by a trailer park, and on a third by a heavily trafficked city thoroughfare. Sometimes when large trucks pass through, not more than 200 yards from the kitchen window, the house shakes on its old and decaying foundation. The first time this occurred when I was present, and much to the children's delight, I jumped to my feet, announcing that we were experiencing an earthquake. The children have apparently adjusted to the shaking and noise, but Joyce complained that the trucks cause her tension and nervousness and when she is asleep they awaken her.

Another serious problem is the electrical system. The original wiring is still intact and operable, but Ralph and Joyce worry that faulty wiring will someday cause a fire. For that reason, and in fear that the children would not be able to get out in case of fire, they have closed off the large upstairs bedroom. This move prompted another inconvenience and special irritant to Joyce. The whole family sleeps downstairs in somewhat crowded quarters. The two girls have their beds in the small living room wherein there is also a sofa, two overstuffed chairs, the television set, and the house telephone.

The sofa serves as an imaginary wall between their sleeping and study quarters and the living room, where the television set is almost always turned on. Jimmy sleeps in a tiny room which, in addition to his bed, holds stacks of storage boxes, still unpacked since their move to the house four years ago.

The commanding view from every window in the house is equipment, because besides their place of abode, this acre-plus of land is where the Barkers sustain their livelihood. By their own surmisal, the Barkers are financially "secure and solvent." They estimated their equipment inventory value as "somewhere around 100,000 dollars." They own their property and house, which over the years has greatly increased in value, and enjoy an "adequate" income from their business. According to Joyce, Ralph can fix any kind of machinery, equipment or vehicle. As the owner of a rental equipment business, he regularly repairs broken and damaged merchandise. He never hires an outside repairman.

In spite of their apparent affluence and Ralph's repairing and mending skills, the Barker house is noticeably out of context with the well-kept, neat appearance of the nearby surrounding middleclass neighborhoods. From an objective, "outsider" viewpoint, both their home and property are in what might be considered in highly disorganized, unsanitary and broken down condition. A few of the more obvious problems are as follows: the kitchen plumbing has been out of commission for over a year, so dishes are washed in a bucket in an old sink on the closed-in back porch; the washing machine, dryer and portable dishwasher have not been operable for the four years they have lived in the house so Joyce hand washes the dirty laundry of five people in the deep sink on the back porch or "occasionally" uses a local Laundromat; the flourescent light fixture in the darkened, grease-marked kitchen had only one bulb which is always blinking -- Joyce explained that the other one had gone out a year before and she was waiting for Ralph to replace it; the house

always has an odor of gas about it due to a faulty pilot control in the gas range; the sofa (in the living room) has springs protruding through the dirty fabric covering; some of the doors have no knobs and one door hangs precariously on one loose hinge, needing only two or three wood screws to make it straight; the kitchen, with only one dim, blinking lightbulb and no plumbing, was always cluttered with two or more days of dirty dishes, piles of laundry, stale food in pots on the stove, open cartons of food -- dry cereals, cookies and potato chips -- and bags of garbage or refuse which often spill out onto the floor; the bathroom was rarely cleaned or deodorized and like the kitchen was a room which by normal standards by public health, would most probably be declared unsanitary and unfit for inhabitance of young and developing children; the floors were both "gritty" and sticky with food droppings and tracked in dust or mud from surrounding areas; and finally, lawns and shrubbery, which apparently were once well-established around the house, are in a dead or declining state from lack of water and care.

After the first of many guided tours of the equipment yard, it was apparent to me that much of the equipment was also in need of repair and organization. There were 50 hitch trailers assembled in 3 long rows behind the house; all were unrentable because they contained heavy rolls of steel fencing and iron pipes. Ralph stated that he had placed the materials in the trailers for storage four years ago, and saw no need to remove it until such time as he was ready to install the fencing around the property. Meanwhile, without the fencing in place, he and Joyce continued to take turns at all-night guard duty, and of course the trailers cannot be utilized for income purposes. The large family van, three of the rentable trucks and their three boats -- two in-board motor and one sailboat -- were in need of repairs. According to Joyce, the van, which needed new brakes, was highest on her priority list of

needed repairs. Their only other operable vehicle was a truck, and all six family members, three of whom weighed over 200 pounds, could not fit in the truck cab. Without adequate transportation, whole family outings were limited, if not impossible.

Pieces of the Puzzle

At first, the above described pecularities seemed to defy analysis, if not common sense. It was difficult to account for particular behavioral patterns which on the surface level appeared detrimental to certain basic functions of family life, not the least of which is the health and well-being of young children. Given that this couple had ample equity and income to improve on these problems, that they exhibited normal intelligence, and that moreover, Ralph was a "fix-it man," why, for example, did they prefer uncomfortable sleeping arrangements to fixing the unsafe electrical wiring, or broken sleeping patterns as opposed to putting up the fence, or storing 50 trailers (which Ralph appraised at $20,000) as opposed to selling some of them and then using those funds to fix the plumbing, gas leakage and service appliances -- basic necessities of urban life.

As was the case with all eight of the families studied, these structural and behavioral idiosyncrasies eventually made sense when viewed within the holistic context of a particular family culture. Like pieces of a puzzle, it all fell into a logical form. From the perspective of the family systems approach, that is, the family as an organized, functioning unit, these behavioral patterns emerged as necessary components to cohesive family unity within the Barker household. I suggest that the course of action by which the Barkers adjust to maternal alcoholism, and the factors which encourage the continuance of the drinking problems can be explained in relation to the **three level** analytical framework: 1) cultural beliefs and attitudes about alcoholism and drinking

behavior, 2) basic survival (or coping) techniques with an alcoholic mother and 3) interpsychic need fulfillment.

Boundaries of Refuge from a Disapproving World

In a sense, the Barkers can be viewed as refugees, fleeing from a world of normalcy, a world in which they can no longer compete. Between Ralph's proclaimed disdain for the scheduled, routine life of his neighbors and Joyce's cyclical periods of problem drinking and breakdown in role behavior, this family cannot, and in fact will not, adapt to the cultural norms of their surrounding environment, so they have blocked it out. They have learned to cope with the maternal alcoholism and attending problems by means of boundaries. In effect they have built physical, social and emotional boundaries around their "island" and their family life -- boundaries which not only separate them from the broader cultural environment, but also protects them from outside intervention to their own way of life.

Physical Boundaries

There was overt manifestation of physical boundaries and ongoing maintenance of those invisible lines. For one thing Joyce and Ralph sat up all night to guard the imaginary wall around their private refuge. While it was true that they are vulnerably positioned for robberies, it was also noted that all portable equipment was under lock at night, and over a four-year period, no robbery was ever attempted. Physical boundaries were further reinforced by the "nonconforming" condition of their house. In relation to cultural norms, for housekeeping, the Barker family was by no means oblivious or even cavalier about the unsightliness of their house. Joyce especially was ashamed and nervous about it to the point of barring entrance to all but a select few outsiders (non-family members). Other than an annual visit of her mother and the rare duty-type short visits of Ralph's parents, no one ever

entered the Barker home except myself and a therapist from the community alcohol treatment center who occasionally made home visits. Joyce stated that the few children who had in the past dropped by to play with the children were thereafter prohibited by their parents from ever returning for a second visit. She blamed Ralph for the state of disrepair of the house and the "lazy children" for the poor housekeeping situation. Ralph suggested that Joyce was the source of the whole family disorganization. Joyce often expressed guilt and concern that her children had few opportunities to establish childhood friendships and she was embarrassed that neighbors viewed their house and family as an unfit play environment for their children. Still, neither of the parents took steps to improve upon the physical appearance of their home. Instead, and in response to outside pressures for cultural conformity, they chose another solution. They simply discouraged all family members from inviting visitors into the home, and as much as possible restricted their own children to the property boundaries.

Social Boundaries

Social boundaries were established in many ways, most notably by their self-imposed isolation. Firstly, there was Ralph's philosophical stance on "outside" social interaction: as discussed earlier, he professed a dislike for the routine, scheduled lifestyle of his neighbors and other community members, and a disinterest in establishing any social relationships with them beyond that of customer and business proprietor. Never mind whether his disdain for the lifestyle of his surrounding cultural environment was a real or contrived stance. The fact is it existed , and to such a degree that it effectively supported their disorganized, alcoholic family lifestyle. Somewhere along the axis of events leading up to the present state of affairs, a pattern of social isolation was chosen or preferred over the ongoing struggle to arrange outside social

activities in the face of maternal alcoholism. As opposed to the Andrews family, who managed to carry on normal social activities with or without the mother's participation, the Barkers purposely avoided outside social intervention. As earlier discussed, other than Ralph's occasional trips to fishing and backpacking areas, and of course the daily contact with customers, he and Joyce, for all practical purposes, had no social life whatsoever.

In my earlier descriptions of the Barker family children I have already described how Mary Ruth was alienated from her social peers to a large degree, mainly because of her unusually heavy-weighted appearance. She was overweight when this study began, and consistently gained weight all the time I knew her. Where her parents could have helped her control her weight by providing lower caloried foods, they continued to buy fattening "junk" foods of questionable nutritional value. Along with her regular grocery items, Joyce purchased large volumes of doughnuts, potato chips, candy bars, cookies and soft drinks. This was "back-up" food for those times when the children were left to fend for themselves, which was more often than not. Between her drinking periods and daytime sleeping schedule, Joyce had little time and not much interest in cooking. Ralph never cooked meals, and Mary Ruth, though she made a few valiant efforts, did not know how to prepare meals.

But there was more to Mary Ruth's peer-group alienation than her eating and weight problems. She was ostracized for other factors even more beyond her control. She once remarked in a resigned manner of speaking that she "dressed different than the other kids." Neither of her parents were fashion conscious and all three of the children were dressed in mismatched, ill-fitting clothing usually purchased at the Goodwill Industries or other charitable organizations which sold second-hand clothing. Where these clothes were indeed

serviceable and inexpensive, it set the Barker children apart from the more chic appearances of their affluent schoolmates.

At times, Ralph and Joyce restricted Mary Ruth's social movements in a manner which seemed to purposely distance her even further from her peer group. Upon learning that Mary Ruth was occasionally teased on the school bus, Joyce demanded of school officials (by telephone) that her daughter be picked up first and seated in the front seat, next to the driver. Where on one level this mandated gesture protected Mary Ruth from verbal abuse on the bus, on another, it physically set her apart from the other children, leaving little or no opportunities to gain acceptance on merits other than her physical appearance or to build friendships or partake in normal conversations. And yet another pattern: whenever she requested a ride to school sports or other social activities, Ralph always refused. Once he stated "It takes too much gas to run back and forth to school all the time" and another time suggested she ride her bicycle, knowing that she was too large for a bicycle, and wouldn't risk being seen on one. Still at other times, and always on his own instigation or whim, Ralph escorted Mary Ruth to other outings such as two times to an amusement park some 20 miles from their home, once to a skating rink and on rare occasion a movie. But all of these outings were in company of only himself or other family members. In other words, his reluctance to provide his daughter with transportation to normal peer-group activities seemed to be related more to his and Joyce's efforts toward self-isolation and non-intervention from outsiders than actual inconvenience or cost.

On two different occasions, Joyce told me that the school psychologist had informed her that their son Jimmy had "serious problems" in school, and in particular seemed unable to cope socially with his peer group. According to Joyce he was described by school personnel as "sullen, angry and

uncommunicative." Jimmy was also unable to keep up with his grade level. To briefly review his academic problems, after repeating both the first and second grades, Jimmy was not advanced to the third grade, and after four years in primary school, at age ten, was technically still in second grade. In an effort to prevent additional stress and humiliation that this situation might incur, the school psychologist recommended he be advanced to third grade anyway, with supplemental assistance from a state-funded special education program. Through this program, Jimmy is scheduled into special classes at certain hours of the regular school day wherein he receives individualized assistance in reading and math. When routine testing indicated that Jimmy's intelligence level was slightly above average, school officials requested Joyce's assistance in isolating other possible causes for his apparent inability to cope and achieve in a normal classroom environment.

In one of many conversations with the Barkers on the subject of Jimmy, Joyce said the following:

> First the school was concerned about his eyes. So I took him to an eye specialist, and his eyes are fine. Then they said maybe he had low blood sugar, and after another trip to a doctor, I told them no, he doesn't have low blood sugar. I've come to my own conclusions and I told them that he has personality problems.

Interrupting her Ralph disagreed with her diagnosis:

> And then again (he said), Jimmy may be just a plain, old fashioned, lazy kid who doesn't try hard enough. What he needs is to get off his lazy butt.

Ignoring his remark, Joyce went on:

> I think his personality problems definitely have something to do with my being in the hospital for six weeks, three years ago. My leaving him alone (with Ralph) those six weeks had permanently damaged his personality. For one year after I got out of the hospital, he wouldn't let anyone touch him -- not even me. I will always think that my nearness to death, even though no one told him about it, had something to do with his problems today.

Joyce's reflections on one isolated incident as the primary cause of her son's serious social, psychological and educational problems may very well be at least in part a correct assumption. However, and as was their pattern, neither she nor Ralph viewed the problems of Jimmy and the other children in relation to ongoing stressful factors within the family home such as periodic maternal drinking behavior, the anti-social activities and boundary restrictions, or the condition of the household, which from all appearances was not conducive to a healthy environment for developing children. As I reflect on the many days we spent together, relaxed, comfortable in one another's company, speaking regularly and openly about these and other family problems, I find myself doubting that the Barkers were flagrantly avoiding obvious truisms which might negatively affect their children. Perhaps out of fear of self-condemnation or of facing up to painful realities of their situation, they unconsciously blocked out objective perspectives on such matters. But, overall, I sensed that they in truth did not see the relationship between the alcoholism and the children's problems. Another explanation for their apparent "blindness" to the source of the problems, is that over the years, their situational and interactional adjustments to the drinking behavior have emerged into a routine of life which by now is regularized to the degree that it is the "normal" and therefore natural routine. It is in effect, right or wrong, the Barker family culture.

Emotional Boundaries

I am not formally trained in psychology, and personality tests were not utilized in this study. However, after 20 months of periodic in-home observation and interaction with the Barker family, I feel reasonably comfortable in identifying certain more obvious emotional disturbances, and the behavior leading to those problems. In any case, any statements on apparent personality factors are supported by my own empirical observatons as described in the foregoing and forthcoming chapters.

The physical and social boundaries protecting the Barker family lifestyle, and the interactonal behavior by which such boundaries were developed and maintained had significant impact on the personalities of all individual family members, and especially on the children. Too young and vulnerable to direct the course of their own physical, social and emotional well-being, the Barker children were like prisoners behind invisible walls. The marked differences between the socialization processes within their particular private (family) and public social worlds left them confused and with many uncertainties. They suffered from lack of self-worth, poor self-presentation, a negative sense of difference from their social peers, lack of interest in normal childhood activities and feelings of frustration, anger and depression.

As negative and unhealthy as this situation may appear for the well-being of certain family members, from a systems perspective, it is supportive of the status quo and overall maintainence of this family's lifestyle. The children's emotional problems, in a remote but very real sense, serve the purpose of further alienating them from peer group members, thereby supporting the parent's preference for social isolation. In symbiotic relationship with the factors supporting the physical and social boundaries, emotional boundaries are created, maintained and continually reinforced by both individual family

members and the whole family unit. The children then, unconsciously and certainly helplessly, participate in the ongoing efforts at isolation thereby "protecting" this family culture from the disapproving and potentially intervening larger social and cultural environment. By the same turn of events, and as I have tried to demonstrate, certain structural and functional dynamics of the Barker family lifestyle support, if not enforce, the maintenance of the children's emotional boundaries.

One last word on alcoholic family boundaries. It is important to note that it is not the drinking problem in and of itself which sets up these boundaries between the family and the outer world. They are built, affected and maintained by the interactional behavior between individual family members, and of the family as a total unit and of the family with the "outside" world. In one form or another among all eight families, whole family interaction, in response to the parental alcoholism and to attitudinal pressures against drinking behavior, structured and maintained a self-ascribed, stigmatized kind of family culture and social organization.

Lethargy: A Practical Approach to Basic Family Survival

The general ambiance of the Barker family's daily pattern of life can be summed up in one word: lethargy. In striking difference to the Andrews family lifestyle, thriving on a flurry of social activities, active participation in community affairs, pursuit of academic, athletic and professional excellence and, continued efforts to maintain middle class normalcy, the Barkers did none of these things. They preferred -- or at least said they found it more convenient — or better said found it more convenient -- to maintain an indifferent, almost apathetic approach to outside activities and pressures of conformity. As was demonstrated in the Andrews case, high activity served as a useful coping mechanism to maternal alcoholism. Busy schedules, meetings and other

obligations offered a normal-appearing escape from the painful view and irrational behavior of a drunken mother. The Barker case, however, is situationally different, therefore, their response to the drinking behavior -- and for purposes of this chapter -- their means of coping with basic survival, that is how they carry on with basic elements of family subsistence with an alcoholic mother, differs as well.

Unlike Molly Andrews, Joyce did not always remove herself from the family's view when she drank. She drank slowly throughout the day and night with frequent and intermittent naps. As for performance of the more vital maternal role duties, Molly alternated between solicitious attention to normal cooking, cleaning and other needs of her family, and total breakdown in normal role behavior. Joyce, however, managed to remain quasi-functional, albeit with poor role performance, whether she was drinking or abstaining.

In the Barker family, escape or avoidance of the mother's drinking behavior is nearly impossible, where the father's place of business is on the family property and the children are far too young and dependent to willfully establish their own diversions outside the family compound. While the Andrews family purposively struggled to maintain some semblence of normalcy both in their external and at-home, day-to-day life style (they carried on with their activities in the home when Molly was in her room, drinking and out of sight), the Barkers made no overt efforts to avoid their mother's drinking problem or to conform to cultural norms of their surrounding environment. Over time they incorporated the drinking behavior into their daily pattern of living, and by the same token, adjusted their family lifestyle to the mother's drinking behavior. I have already discussed one obvious manifestation of such adjustments in the previous section on boundary establishment and maintenance. Here, I will present another relevant mode

of coping with maternal alcoholism in describing this family's progressive (or descending) journey into unit -- whole family -- lethargy and inertness. The following selected although typical episodes, either summarized or taken verbatim from among several hundred pages of field notes, illustrates these adaptive measures over an eighteen month period.

December 29, 1978 (Excerpts From Field Notes)

Today, on my third visit to the Barker Family, I finally had an opportunity to meet the children. For the first hour they all three settled themselves around the old table on the service porch where Joyce and I were drinking our coffee. They openly stared at me; they are curious, I suppose, as to what I wanted from them, as they well should be. Joyce offered that Mary Ruth, her oldest knew what an anthropologist was. After hearing of Margaret Mead's death on the evening news a few weeks ago, and in anticipation of my forthcoming visits to her home, she looked up the word "anthropology" in the encyclopedia. Mary Ruth did not comment on that. No doubt she is having difficulty comparing Margaret Mead and her exotic field work experiences with this anthropologist sitting in front of her at a suburban kitchen table.

Joyce was clucking around her children like a mother hen, touching this one, or urging another one to speak up. In apparent nervous exasperation with their silence, she sent the two younger ones out to play. Finally Mary Ruth spoke up: "I never go outside because I don't have anybody to play with." She waved her hands towards the window and in a wispy voice stated:

> When we moved here four years ago it was real pretty out there because we had a lot of trees. There was one peach tree which we played in all the time and a whole bunch of walnut trees, but my dad cut down all those trees for his equipment. I asked him not to but he did it anyway.

Satisfied that she had exposed this tragedy to an outsider, she said no more. At that moment, Ralph stomped into the house and immediately asked what we were talking about. Mary Ruth mechanically repeated word for word what she had just told me. Embarrassed, Ralph explained he needed that space for his business. Mother and daughter argued that point with him for a few minutes, half seriously, half jokingly and then dropped the subject.

No one made a move to prepare lunch today, that is not in a formal sense. Joyce and I had tea at lunchtime, and the children were foraging in the kitchen throughout the day, eating crackers, potato chips, some day-old doughnuts and dry cereal. Joyce remarked that she wasn't hungry today but Ralph came into the kitchen around 2 p.m. to fix himself a sandwich and a beer.

Joyce pointed to the mobile home park which borders the back side of their property. She said,

> Look at that, we have all those neighbors and not a one of them speak to us. What they do is regularly call the police to complain about the condition of the equipment yard. For one full year they griped about the high weeds and now just recently, when Ralph finally sprayed the weeds, they call the police to complain about the smell of the weed killer. And then there's the number one complaint -- our 50 trailers filled with fencing. I guess after four years, they're just tired of looking at all that stuff.

She giggled and Ralph made some comments about old ladies that have nothing better to do than look over fences and gripe.

Three or four times during the day, Joyce pointed out that she had cleaned the house in anticipation of my visit. However, the place had certain obvious earmarks of poor housekeeping, depending on one's standards of

cleanliness. For example, above the doors there were thick black lines of soot or perhaps it was the result of years of dust accumulation, and the windows were more opaque (dirt smeared) than clear. The kitchen and bathroom were "greasy," and malodorous.

The living quarters are quite crowded. The entry porch, rather than the small darkened kitchen, is the room wherein they have squeezed their long kitchen table with a wooden bench on each side of it. Alongside the eating area is a laundry sink which at the moment is piled high with dishes. A room in the back, right off the kitchen, is divided by an old sofa into both a living room and children's bedroom. The dominant feature of this room is the colored television for the reason that it is on, and quite loudly, all the day long. An artificial Christmas tree is still up in the living room, and around it are piles of used games, like Monopoly, Checkers and so forth. A counselor from the Mental Health Center gave Joyce this supply of used games, because, as Joyce said, "she wanted to be sure our kids had a Christmas." Ralph commented later on that day that "he didn't believe in spending money on junk toys that kids don't take care of anyway."

January 15, 1979

Joyce called this morning to cancel our plans to spend a day together in the Barker home. She was upset for several reasons. After a "terrible row" with Ralph last night -- over the disorganized condition of the house -- she had decided to discontinue her one-month abstinence period and start drinking again. She said, "I'm not feeing well, and besides my house is such a mess, I just don't want you to see it like this." She went on to say that she and Ralph had argued over Indian Guide meetings. Just recently, and at the strong suggestion of Jimmy's teacher, Ralph and Jimmy joined this father-son organization. The meetings are held bi-monthly, each time in a different

home, and it was their turn to host the group on Tuesday. Two weeks ago Joyce asked Ralph to help her fix up the house in preparation for this occasion, specifically, to paint the kitchen and living room. She didn't have the money to buy the paint -- her weekly allowance wouldn't stretch beyond the cost of groceries -- and he refused to give her additional funds. So last night, with the meeting only two days away, she gave him an ultimatum, "either buy the paint and fix this place up or cancel the meeting." Ralph happily chose the latter, stating that instead of buying paint -- and going to any more meetings -- he was going to take all three of the children to the skating rink "real soon." Joyce stated "I was so angry and frustrated, that I had a few drinks so I could talk back to him." She was proud that for the first time in many months she found the courage to refuse her late watchguard duty, thereby forcing Ralph to sit up all night.

The children heard the argument, as there are invisible walls in this small house. Joyce stated:

> For some reason, they really shaped up last night. I guess they heard me fussing about the dryer being broken and nobody doing the laundry around here, because last night, at 11 p.m. those three little ones were still in the kitchen washing clothes in the sink and hanging it all around the kitchen.

She didn't know why the children for the first time decided to help her on their own initiative. She stated:

> Maybe it's because they were frightened by our arguments, and maybe it's because they're afraid I'll die if I drink. They all know I almost died from liver problems two years ago.

After that conversation, she asked if I would take the girls out to pizza.

> They just have to talk to someone. They don't get a chance to say anything around here.

Later on that day as the two daughters were happily munching their pizza, I inquired as to how Joyce was feeling. Though I had not mentioned it, Mary Ruth reacted to my question defensively stating that their mother was not drinking. Looking me straight in the eye, she replied:

> Mother doesn't feel well, but she doesn't drink anymore. She hasn't done that for a long time. She just stopped one day and that was the end of it.

I felt sadness for these children as I recognized the fear they must be experiencing about their mother's health and the unspoken pressure put upon them to deny reality.

Febuary 9, 1979

It's becoming apparent that the Barkers are a rather slow-moving, perhaps a bit lethargic family. Although Joyce and Ralph spend hours planning major repairs and whole-house cleaning projects, nothing ever changes. It's not all Ralph's fault that nothing ever gets done around the house. Although Joyce repeatedly accuses him of neglecting household repairs, she appears to be equally remiss in her housekeeping duties. Because she stays up half the night alternating between watching television and scanning the property borders for intruders, she is too tired during the day to do any housework. She always takes a long nap in the afternoon. When she is in her drinking period, the situation worsens, because during those days she takes two naps.

Today, I found Joyce and Ralph, at ten in the morning, happily settled in their living room watching television and warming themselves by the portable floor heaters. During the winter months, when the rental business is practically at a standstill, they watch daytime television all day long, until the children return home from school at 2:30. Feet propped up on chairs, they remain in this cozy little room, dozing or napping off and on, taking breaks for coffee

and snacks which they always bring back into the television area, and as Joyce put it "doing a lot of talking together." In the course of this day, they talked about Mary Ruth, their oldest daughter, and how lazy she has become, and about their worries about how she "sits around the house from Friday until Sunday doing absolutely nothing." Ralph reviewed once again all the work that needs to be done in the equipment yard. Joyce said they are losing money because many pieces of rental merchandise are in need of repair and therefore unrentable. There was some discussion about the fencing still sitting in the trailers, waiting to be installed around the yard. Joyce talked about all her dreams and plans for fixing up the house; fixing the upstairs so the girls won't have to sleep in the living room, putting curtains on the windows, painting "everything," a new foundation so the house won't shake when the trucks go by, a kitchen sink that works, new appliances and new light fixtures. Ralph listens attentively when she runs through this list, nodding or verbally agreeing that they should do these things.

March 4, 1979

When I walked into the Barker house today, I was taken aback by an overwhelming sour, musty odor. I didn't have to look far to find at least one possible source of the problem (my problem only): dirty dishes and pots and pans -- at least two or three days worth -- were piled up in the laundry sink, spilling over onto the wooden counter which surrounded it; dirty laundry was piled six feet high in one corner of the service porch. It was Saturday morning and the children were home. Mary Ruth was sprawled on the bench by the kitchen with a Monopoly game spread out in front of her amongst the soiled dishes and bits of stale food. She and her father had been playing Monopoly all morning and whenever he had to leave to wait on customers, she sat and waited for his return. Jimmy was sitting on a box in the far corner of the

room, with his usual scowling expression and silent anger at being ignored and left out of things. Julie was dancing to records in the living room, and watching television all at the same time.

Joyce requested that I not go beyond the service porch today. She said: "It's just too filthy in there, you better stay out here for awhile." After a while the two younger children joined us and we all squeezed around the kitchen table which by now has been permanently moved out of the kitchen (where there is no light and no plumbing and an ongoing state of disarray) to the service porch. Joyce and the children agreed it didn't really matter where the kitchen table was situated because they took all of their meals in the living room around the television anyway. The last time they used the table for a whole family meal gathering was on Christmas day.

Joyce was upset. When she awakened at 10 a.m. there were seven cars waiting for rental equipment, and she knew that "she needed to get out there and help Ralph." However, when I entered the house at 11 a.m. four cars were still waiting for service and Joyce was watching television, leading me to believe that she was not overly concerned. From the eye level of my chair I could see that the housekeeping problem was getting out of control again. Under the old kitchen stove there were dust balls the size of baseballs along with opened boxes of crackers and dry cereals. Clothes seemed to be strewn everywhere, on the sofa, on the chairs, on the floor, even in a box on top of the stove. On the table, in between all the dirty dishes, there was a fresh box of fruit, a refreshing sight. Joyce and I talked; she said,

> Okay, I know it's a mess, but let me tell you the deal. Ralph and I made an arrangement that if I helped him outside, he would help me inside, well, he hasn't been helping me on the inside, so I'm not going to do it either. For example, yesterday it was Julie's and Jimmy's day to do the dishes, and since they didn't get to it yesterday, those dishes are going to sit there until they do them today.

The way the rules are set up in the Barker house, if the person designated to do a chore doesn't complete it, it doesn't get done at all. Dishes, laundry, dirt all pile up until somebody (infrequently) decides to do something about it.

Still, and in the midst of all the mess, there was a sense of calmness and relaxation in the tiny little service porch. Joyce complained about the Joyce was upset. When she awakened at 10 a.m. there were seven cars waiting for rental equipment, and she knew that "she needed to get out there and help Ralph." However, when I entered the house at 11 a.m. four cars were still waiting for service and Joyce was watching television, leading me to believe that she was not overly concerned. From the eye level of my chair I could see that the housekeeping problem was getting out of control again. Under the old kitchen stove there were dust balls the size of baseballs along with opened boxes of crackers and dry cereals. Clothes seemed to be strewn everywhere, on the sofa, on the chairs, on the floor, even in a box on top of the stove. On the table, in between all the dirty dishes, there was a fresh box of fruit, a refreshing sight. Joyce and I talked; she said,

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Still, and in the midst of all the mess, there was a sense of calmness and relaxation in the tiny little service porch. Joyce complained about the children's "laziness," but as she did so, she smiled at them, often affectionately patting their hand, or hugging Julie, ever present on her lap. These children are living in a dirty house under somewhat bizarre rules, but on this Saturday morning at least, they were calm and some were smiling in the presence of what appears to be a loving, and affectionate mother.

April 26, 1979

Joyce's mother is due to arrive in June for a month's visit, and once again, she is pleading with Ralph to help her get the house in order. She said,

> We're talking about it a lot, and we're getting along a lot better because we spend so much time talking about fixing up the house, but everytime I mention something, we come up against the same problem -- we just don't know where to start.

But there are other pressing decisions to be made -- like where will her mother sleep and where will they eat their meals. Joyce wants to start a routine of regular meals so the pattern can continue in the presence of her mother. Joyce said, "the children are not happy about mother's visit."

"Why not?" I asked.

She replied,

> Well, because they know that when grandmother is here I'm going to make them eat their meals at a regular table and eat as a family. They want to keep their normal routine of fixing a plate and sitting in the living room with Ralph in front of the t.v.

She continued,

> You see, there are only three days a year when we eat at the table as a family. These are Christmas, New Year's and Thanksgiving. At all other times, the family prefers to eat in front of the t.v., and usually in shifts.

May 6, 1979

When I drove into the equipment yard today, I noticed Ralph waving to me from the kitchen where he was eating a sandwich. As I went around to the back door, there, under the rack which holds all the rental ladder, were Joyce and Julie sitting on a blanket which had been uncermoniously plopped down upon dust and weeds. At Joyce's invitation, I joined them on the blanket. She explained,

> I'm taking my afternoon naps out here not that the weather is nice, the house is such a mess that I can't take it anymore, so I come out here for fresh air. Also I have a bad headache.

Julie, who had a hammer, nails and several boards, explained that she was making a "mother's day" present. Her consistent banging of large-sized nails into various-sized boards probably irritated Joyce's headache, but she said nothing about it. Ralph came out of the house to join us, and later on, Mary Ruth, who seems to be growing larger by the week, also squeezed onto the blanket between Joyce and me. Several times Julie ran in and out of the house retrieving various juvenile games of chance, each time cajoling her mother to play the game with her, and Joyce always complied. Ralph unfolded his newspaper and soon began reading out loud to us the more humorous news items and editorial comments. Joyce enjoyed this, stating, "he does this every Sunday, he always reads the paper to the family." Irritated with Julie's noisy

carpentry techniques, Ralph grabbed the hammer and said, "Here, let me show you how to do this. What are you doing anyway?" When Julie explained she was making a flower pot holder -- Ralph laughed and said, "Why don't we start with a lesson on how to hold a hammer and nail, my God, you'll never get it done this way." Joyce scolded him for expecting perfection from the children, but was obviously pleased that he was attentive to Julie -- and the other children.

The afternoon lazily moved along, with all of us leisurely chatting, and resting on a blanket in the dust under a ladder rack. At the moment, I found myself, like my hosts, ignoring the strangeness of the situation -- that is that we were huddled here on this blanket because the house was not fit for pleasant and comfortable habitation. Today, Joyce was not drinking, Ralph was in a jovial mood, the children were communicating (except for Jimmy who did not sit with us) and all was well.

August 1, 1979

As I drove into the equipment yard today, and after a month's absence (a much needed vacation), I immediately noticed several changes. A window has been broken out in the front of the house and behind the open space, the lining of the curtains are shredded from sun wear and perhaps from striking against the broken glass. All the drapes are drawn in the house and it is beginning to take on the appearance of a mysterious and abandoned old rundown building. Just when I parked the car, a flurry of people rushed out of the house going to the side behind one of the house trailers. It was Joyce, the three children and a few steps behind, Ralph. As I eased around the trailer, I found them sitting under a shade tree relaxing in chairs earlier transplanted from the house. Apparently upon seeing me drive into the yard, they all ran out of the house and behind the trailer to a makeshift living area, making it

appear as if they had been sitting there all afternoon. My assumption was that the house must be in such a state of disarray that they can't risk anyone viewing it, perhaps for reasons of embarrassment -- perhaps for fear that as a researcher of "health" problems I might be "obligated" or moved to intervene. I decided against discussion of these possibilities and went along with their pretence behavior.

A large table under the tree was covered with what appeared to be a display of items for sale. I asked Ralph if he was having a garage sale. Ralph laughed,

> No, nothing like that. . . I'm going on a four-day back-packing trip, and I have to decide which of this stuff I can carry with me. You see, I weigh 320 pounds and therefore have to get the weight of my backpack down. Usually you carry 75 pounds in a backpack, but I can only carry 40 because with my weight, I figure that's all I can handle.

So the afternoon project of the family was to weigh all the items, such as his sleeping bag, tent, various kinds of dried foods, insect repellents, knives, pans and many other items, and then reach a conclusion as to which and how many he could take. They asked if I cared to join in the project, to which I answered affirmatively; at the moment, and from their perspective, it was the most important thing that needed to be done, so that's how we spent the afternoon.

Towards the end of the day, and after we had all consumed great amounts of potato chips and soda pop, Ralph and Joyce announced it was time to show me a surprise -- "the highlight of our week" -- and the reason they had summoned me to the house today. It was the Barkers' 15th wedding anniversary, and they were about to show off Ralph's gift to Joyce. With everyone gathered close around and with delightful ceremonious gestures, Joyce pulled a chest from under her chair. She then opened it to display a beautiful

8-piece setting of sterling sliver. She proudly announced that Ralph had purchased it the day before, and it was paid for in cash. Then the daughters disappeared into the house, reappearing with the rest of her gifts: serving dishes, a pitcher and a coffee and tea service -- all silver plated. "Now," Joyce said, "I suppose we will have to get some nice china." In fact, the only dishes that they own are plastic -- some are cracked and stained. They rarely eat at a table and never entertain. But it didn't seem to matter that they may never use these items, or to wonder why they didn't spend the money on improving their living conditions. Ralph's gesture was successful and appreciated in the eyes of the family. Joyce, for one, was noticeably proud to have this set of sterling silver. She verbally fantasized an elaborate dinner party wherein she would show off her silver and fine china, forgetting for the moment all the unpleasantries of her lifestyle and drinking problem. As she fingered the silver, and spoke of passing it on to her girls some day, I sensed that the chest in her hands symbolized "normalcy" for the family, that is, normalcy in relation to the middle-class value structure of their own former lifestyle and present cultural environment outside the parameters of the yard. It was a token gift, a symbolic gesture which provided some semblance of cultural conformity and status. It also provided a distraction from the obvious and growing demands to get their "out of control" system in order.

November 11, 1979

The Barkers have their fence up. A six-foot high, steel-link fence now surrounds their property with two long swing-away gates positioned at the entrance. Joyce matter-of-factly explained the circumstances which precipitated this long awaited event:

> A few weeks ago we received a call from Ralph's uncle in Oregon. He said that his wife, Ralph's aunt, had heard about the fence thing, and about how Ralph's poor wife had to sit up all night and guard the place, so she wanted Ralph's uncle to come down here and put the damn thing in place. You see, Ralph's uncle is a huge, burly man who can do anything. He told us he and his wife would swing through here on their vacation, stay with us a week, and put up the fence. Well, Ralph may not care what this place looks like when my relatives come to visit, but his relatives, and especially his favorite uncle, well that was something else. He thought about it for a few days, and then remembered that there was this fence man who once offered to put up the fence in exchange for a cement mixer -- so that's what he did -- traded a cement mixer for labor to put up the fence -- and now after five years of talking about it, we finally have the fence up. Of course, he called his uncle and made up some excuses, but no way was he going to let them see this place.

There was more good news this day. Ralph pointed out the new clothesline strung from the corner of the house to a shiny new steel pole. "There's the dryer," he grinned, "see, I told you I'd fix it someday." Shrugging her shoulders, Joyce commented, "You know, I hung out four sets of sheets this morning, and must admit, I kind of enjoyed using a clothesline." Ralph pointed to the new kitchen sinks which were leaning against the back porch in the same spot where he had placed them two months before. "Those are next," he said. "Meanwhile," Joyce said, "I'm still washing dishes in a bucket." As we strolled around the yard they pointed out a pair of portable barbecue pits positioned under a tree. Joyce stated,

> The kitchen is such a mess, and the stove in there doesn't work right, so we cook most of our meals out here, and it's working out fine.

Since the weather has turned colder, and I no longer am allowed entry into the house, my visits are by necessity of a shorter time period. Today, after Joyce, Ralph and I completed our customary walk around the equipment yard, Joyce brought coffee out to the trailer office where we sat and talked.

They were both anxious to talk about new problems the children were encountering at their school, especially Mary Ruth who once again is suffering embarrassment and teasing about her weight problem. Over the summer vacation she gained almost 40 pounds, which, according to Ralph, brings her weight up to over 200 pounds. At age 13, and of relatively short stature, she is now noticeably displaying heavy rolls of flesh on her forearms, legs and other areas. Joyce stated that recently Mary Ruth has been breaking out in hives everytime she suits up for her physical education class, and that both she and Ralph were puzzled by this. I asked if they had considered the possibility that the hives were related to her fear of poor performance in P.E. or perhaps the requirements of wearing gym clothes was distressing for her. Joyce replied:

> No that problem has been taken care of. She has been transferred to a special education class, a smaller class than normal, so I don't see why she should be nervous. She's in this special class with others who have handicaps, emotional problems and such. One of them has a weight problem like Mary Ruth. All they have to do is suit up and run around the school yard a few times.

I had visions of Mary Ruth doing standardized physical education exercises, forced to expose her otherwise covered and excessive flesh to the mocking eyes of her schoolmates. Under such duress, it was no wonder she broke out in hives. At times like today, I feel anger, sadness and frustration that there is nothing I can do to change this situation.

June 15, 1980

The Barker children are just beginning their summer school vacation, and the family has already set up summer living quarters outside the house under the oak tree. The long picnic-type kitchen table is again in place on a carpet of dusty, loose dirt with benches and lawn chairs assembled around it. Kool-aid, soda pop and potato chips were in abundance when I arrived, just

in time for lunch. This year, the Barkers have added bedrooms to their summer headquarters. Ralph strung wire between two trees, placed a heavy canvas tarpaulin over the wire and then pinned it into the ground leaving an open-ended tent effect. Today, the children dragged mattresses, pillows and sleeping bags out of the house and into the tent where they intend to sleep until September. Ralph and Joyce are now sleeping in the smaller one-bedroom trailer. Joyce was upset by these changes, but Ralph, as always, made light of the situation. He explained:

> The idea got started when we discovered a hole in our waterbed several months ago. I drained it, but haven't gotten around to fixing it, so Joyce and I started sleeping in the trailer. Now the kids want to move out here too, so I put up a tent.

Joyce interrupted:

> Ralph's story is partially true. The whole truth is that the house is unliveable.

Shaking her finger at the children around the table she continued:

> No one will go to a movie or there will be no trips this summer or no other kind of entertainment until that house is cleaned.

The children were busy playing with eight recently-arrived baby kittens and not one of them acknowledged Joyce's ultimatum. I'm not sure they were listening. All the same the message which I had heard so many times before was clear. The house was "unliveable," Ralph and Joyce were not going to clean it, and the burden of housekeeping at least in theory had by now shifted to the children.

It's been seven months now since I've entered the house, and I can no longer envision its condition. Today when I inquired about the progress of certain basic problems such as the kitchen plumbing and washing machine, Joyce shrugged, took a deep drag off her cigarette, and said,

> It's worse than ever, it's unbelievable. I don't know what we'll do when mother arrives. Ralph and I were thinking we'd have her sleep in the trailer. Last time she was here, she smoked so heavily -- and sometimes she drinks too much -- we were afraid she'd burn the house down. Hope she doesn't burn the trailer up.

Joyce's mother will be the first "outside" person to enter the house, other than myself, for almost a year. Joyce said,

> Let me tell you some good news. I haven't done any real heavy drinking so far this month, and the bad news is that I'm eating instead. In fact, we all are. Ralph, Mary Ruth and I have all gained weight this spring. Even Julie is getting fat.

Even as she talked about her compulsive drinking and eating problem, Joyce poured herself another tall glass of cola, and as always she chained smoked all day. Neatly stacked on shelves under the ladder rack are rows of empty pepsi cola bottles. Julie said she had counted them, and they now have 200 half gallon pepsi bottles. Today, whenever a half gallon bottle was emptied, Joyce sent one of the children into the house to retrieve another one.

On this warm, balmy summer day the children spent their hours, as usual, clustered around their mother, sitting close, like a group of baby chicks around the mother hen. They played with their new baby kittens, drank Kool-aid, ate snacks, and napped, but other than these sedentary activities, they did nothing, absolutely nothing. Over the past year, and each time I visit when the children are home this seemingly lethargic pattern remains unchanged.

Mary Ruth is indeed, as her mother claimed, noticeably heavier of weight and recently, she has developed problems with severe acne. Repeatedly during the day her younger siblings taunted her about her weight. During lunch, Julie giggled out something like "did I know that Mary Ruth's favorite mammal is a whale?" and then asked if I knew why Mary Ruth's nickname was "zeppelin"

(a gas filled airship, sometimes referred to as a blimp). Even Jimmy, usually so quiet and non-communicative, blurted out:

> Mary Ruth maybe can't sleep in the tent. She can't fit into a sleeping bag.

Enjoying the lunch-time banter, and apparently oblivious to Mary Ruth's embarrassment, Ralph said:

> Well, it's just a fact of life that a small container will not contain something that is larger than it is.

Everyone laughed, including Joyce, although she mildly scolded the family for their indiscreet remarks. Mary Ruth remained with the family, one minute complacently enduring the verbal abuse, and at another displaying anger and pain by striking the sibling offenders with her fist. The interaction around the subject of Mary Ruth's weight problem took on the form of family entertainment, or an amusing diversion from an otherwise uneventful day, and it occurred to me that my presence provided them with an audience for their "humorous" but cruel banter. As I searched for ways to change the subject, I spotted Mary Ruth's new portable radio which she had recently purchased with funds earned while babysitting, and engaged her in a conversation on that subject. Later in the day, she confided in me that she was fearful of entering high school in the fall. She said:

> More than anything else, I want to be an oceanographer, you know how much I love the ocean. But I guess to do that I'll have to go to college, won't I? The trouble is I don't want to go to high school. I just don't like these schools around here, and I don't like the kids around here either.

She went on to say she would like to move to Oregon to live with her uncle, her mother's brother. Having visited there several summers before, she enjoyed the role of babysitter to his four small children, but more than that, I would suspect, she enjoyed the respite from the taunts and teasing of her family and social peers. I encouraged her to pursue that goal.

Summary of Lethargy as Convenient Coping Mechanism

From all appearances, this family **prefers** living in their disorganized, broken down house and under deteriorating conditions of health and sanitation, to initiating changes which might improve their situation. The condition of the house and household fixtures have progressively worsened over the 20 months that I have known the Barkers. For all practical purposes, and especially during the summer months, they now live around the periphery of the house, because it is by their own recognition unfit for human habitation. Again, this situation is not caused or sustained by lack of adequate funds. The Barkers enjoy a modest, but adequate income, and other than their first mortgage payments, have no outstanding debts or pressing bills. A quick glance around the yard displays a sizeable equity value in both land value and the rental equipment. In the past year, Ralph has spent several thousand dollars on sterling silver, fine china and recently expensive pots and pans (all of which are now "stored" in the house trailer). Ralph rarely complains about the household problems, and by the same token, never makes any attempts to change them. Joyce, however, regularly expresses concern and apparent frustration at the state of affairs. The blame for the chaos shifts back and forth between Joyce and Ralph and now more recently to the children. Never mind that the positioning of the fence should have provided Joyce with a full night's sleep so she could resume normal housekeeping duties, or that she can at will practice controlled drinking -- and in fact stops drinking altogether during the children's summer vacation, thereby regaining a higher energy level and better health. The fact is that drinking or not, with or without the watchguard duties, nothing changes. The normal, routine patterns of family life by which this family organizes the **basic** needs of day-to-day survival, their lack of clear-cut role duties and role behavior, and their ongoing

interactional behavior and family structure simply do not change except that these matters progressively become more firmly implanted in the adaptive mode they have chosen. For this particular family, that adaptive mode, or if you will, coping mechanism for maternal alcoholism, is what might be called the path of least resistance -- or the old adage, "if you can't fight it, join it."

As for the question of who looks to the needs of the basic necessities of family survival when the mother is not able to perform her role duties, no one did anything. Ralph refused to take over maternal role duties, and the children, quite frankly, never had the opportunity or the encouragement to learn about cooking meals, cleaning their rooms, picking up after themselves and the many other family household duties in which they could have participated. After years of fighting fatigue and energy-loss due to both her own drinking bouts and irregular sleeping patterns, Joyce became disillusioned with housework, then overwhelmed by it, finally rejecting certain important aspects of her housewife role altogether. Lethargy, inertness and a distinctive sedentary way of life became the established mode by which this family could survive as a cohesive, functioning unit with the least amount of struggle and disruptive behavior.

Tradeoffs for Individual Needs and Family Equilibrium

In the Barker family, and in all other case studies, there was evidence that maternal alcoholism sometimes served as a convenient vehicle for individual and/or whole family problem solving. There were allowances and tradeoffs of certain behavioral patterns, that is, individual family members accepted, tolerated or in some cases encouraged periodic drinking periods as compensation or license for pursuing personal, self-centered needs. In some cases, these behavioral exchanges were so obvious, that family members were able to identify the precipitating factors to the drinking problem. But on another

level, the level that views dyadic, triadic or whole family interaction in terms of a family system, we can see that the family is not always aware of the cyclical nature of repeating patterned behavior and the drinking periods.

Some of the behavioral manifestations by which intrapsychic problem solving occurred in the Barker family were vividly, if not blatantly portrayed. Several times, when Joyce was in the first day of a heavy drinking period, she explained to me the circumstances which, in her perception, led up to her decision to start drinking on that particular day. One of the reasons Joyce embarks on heavy drinking periods, after weeks of controlled drinking or complete abstinence through the use of antabuse, is to release pent-up aggression, resentment and frustration. Drinking provides her with what she refers to as "time-out" from the disorganized household, her children's problems at school and Ralph's continued dominance in family decision making and behavioral patterns. Drinking provides a psychic release from her out-of-control world, and Ralph allows her that time out, in fact, encourages it. His participation in the maintenance of her drinking patterns is evidenced by his stubborn refusal to remove his supply of brandy from first the kitchen and then an unlocked mobile home. Joyce never had to buy her favorite alcoholic beverage; Ralph not only provided an ample supply, he stored it where she would most often view it, the family kitchen. Even after he removed it to the trailer, he made little effort to discourage her from drinking. Once, after several weeks of abstinence and concentrated efforts to refrain from drinking, Joyce related the following:

> Well, I've had a mild setback. I hadn't had a drink for a number of days, and was thinking one day last week, 'I wish I could have just one drink to cheer me up.' So I went out to the trailer where I found Ralph having a brandy and water and told him how I felt. He didn't want to pour me a drink, so he just handed me the bottle. I was not able to stop with that one drink, and we had quite a few drinks together. Then after that, I had quite a few more setbacks, but nothing worth talking about now.

A good example of the trade-off processes around alcoholic behavior is the earlier mentioned episode of the "Indian Guide" meeting. Joyce viewed this upcoming event as a possible stimulus for getting the house in shape, and Ralph viewed it as a possible unpleasant experience wherein he would have to socially interact with neighbors. (Incidentally, a third party who suffered in this turn of events was Jimmy, who because of his father's loss of interest had to drop out of the organization.) In the following description of the episode, summarized from conversations with Ralph, Joyce, and Mary Ruth note the struggle between Ralph's dominating presence in this household and Joyce's efforts to initiate changes in their way of life. Also note that in fact it is all repeating, patterned exercise, and that neither of them, for vested interests of their own, have any real intentions of intiating change.

For a two-week period Joyce made daily requests of Ralph to buy some paint, paint the kitchen and living room, and then help her correct other major problems in the house. She reasoned that the deteriating condition of the house might be noticed by Jimmy's friends and their fathers, thereby creating embarrassment for both herself and her son. Right up to the last day Ralph procrastinated on the project, finally cancelling the meeting altogether, leaving Joyce in a state of anger and defeat. That evening, she began drinking heavily and a violent (verbal) argument ensued. Fearful of Ralph's rising anger, Joyce retreated to the bedroom to drink and later on to sleep. Ralph was left with the responsibility of preparing an evening meal for his three hungry children,

a chore for which he had little skill and less desire. In a show of rage, he began shaking Julie from the shoulders for no apparent reason other than she was in his path. Frightened and defenseless, Julie reacted by urinating on the floor. Pushing her aside, Ralph then picked up a glass tumbler and threw it against the refrigerator, causing a shattered fragment to strike and cut Mary Ruth's arm. Jimmy and Julie fled the room to hide behind the beds in the living room. Ralph then vacated the house for a cooling-off period, leaving the children to fend for themselves with dinner. Later on he returned, in a jovial mood and with no mention of the incident, to watch television. However, the three youngest children on their own initiative spent the entire evening, until eleven p.m., hand washing the family laundry and hanging it around the kitchen to dry. In reference to this episode, Joyce stated:

> I have to drink to get up the courage to fight with him. How else would I get up the nerve to ask for help around here -- and mean it. If you want to know the truth, I drink to feel better. The first few days I drink I feel a lot of relief. I actually feel happy. Then my liver starts to act up and I start feeling bad and I get depressed knowing I'm probably killing myself. But all the same, I have found out that when I have enough to drink, I get things done around here and the way I want it. I actually get some control of my life.

She continued:

> Like last night, after our fight -- after sitting in that chair for two weeks guarding this place, with a terrible backache, and never getting to sleep in my own bed, I finally had the nerve to say no and went to bed and made Ralph sit up for once. And those two little ones, they did the laundry. I guess they were afraid I'd drink if it didn't get done, they heard me complaining to Ralph about it. Look what drinking accomplished. Something actually got done around here and I got a full night's sleep.

Ralph and Joyce had ways other than violent arguments for accomplishing the tradeoffs necessary for maintaining the status quo. Often during the first few days of her drinking period, they spent hours, sometimes whole days,

sitting on the front porch or in the living room by the television set, talking over their problems. Joyce viewed these verbal marathons as therapeutic. She said:

> These are the only times when Ralph lets me say what I want. I complain and go through a whole list of problems between us, and about the house. He's really good about listening for awhile. Then, when he's had enough, we stop talking and he goes to the trailer or to his office.

In addition to the "pressure relief" aspects which periodic heavy drinking provides Joyce, it has certain long-term benefits for Ralph. In effect, the periodic drinking bouts support the continuance of Ralph's private world, his "island." It prohibits disruption of his island-like environment and preference for minimum interaction with outsiders. It allows him more license to spend family funds on his collection of what he refers to as his "things," i.e. machines, tools, gadgets and so forth, rather than on needed household improvements or other family-focused activities.

As for Joyce, her heavy drinking generates guilt to the degree that she is inhibited from challenging Ralph's self-centered behavior. When her rising tension and anger nears the confrontation level, Ralph allows her time out for a drinking period and sometimes a marathon session for voicing pent-up complaints. The positive productive effect on Ralph's world, along with the drinking patterns, are thereby maintained.

And yet another example of intrapsychic tradeoffs is the unusual sleeping arrangements of this husband and wife. Given that their problem of sexual incompatibility is a constant, they avoid confrontation over the problem by simply not sleeping together. A side issue of this convenient arrangement is that it provides Joyce with time and privacy for drinking when the family is out of view and asleep. After the installation of the fence, and when she no longer had a reason to sit up half the night for guard duty, Joyce complained

that she had difficulty adjusting to new schedules of sleeping (and most probably drinking). She said:

> Everytime I lie down in that bed, Ralph opens the window, and that aggravates my sinus problem. In fact, since I've gone back to a regular sleep routine, my sinus condition is worse than it has been in years. Also, I'm getting terrible headaches. In fact, half the time I just go back to my old chair and the television and spend the night there.

Another ongoing manifestation of family process and drinking maintenance was the stigma reinforcement behavior. As you may recall, in the Andrews family the stigma aspects of alcoholism and related extenuating circumstances were clearly focused on the mother. This is not the case in the Barker family. As demonstrated earlier in the discussion of boundaries, Joyce and Ralph are admittedly ashamed of their disorganized house and family lifestyle, and they take measures to remain hidden from public view. However, the drinking problem, per se is not signaled out as the "stigmatizing" source of their problems. In a sense, and by means of verbal and behavioral interaction, the "carrier" of the identified problem shifts back and forth between Joyce, Mary Ruth and the house. The family regularly criticizes Mary Ruth and in fact often verbally abuses her when they express open disdain and shame for her compulsive eating habits and large size. The parents support this abuse under the guise of good-natured family fun when they join in the laughter around the younger children's taunts and teasing. Ralph's stigmatizing labels for Mary Ruth, such as "fatso" and "fat slob" disturbed Joyce, or at least she complained to me about them, but she never intervened when they occurred. Mary Ruth's weight problem served a dual purpose: it detracted attention from the maternal alcoholism, thereby benefiting Joyce, and reinforced the family stigma syndrome thereby benefiting the Barker family system.

The tradeoffs, (which also may constitute comfortable traps), exist, and this family has little incentive, much less guidelines, for initiating change. Ralph openly admitted to me that divorce, separation, or relocation would threaten his world of things, and therefore he has never seriously considered such action as a practical solution to Joyce's drinking problem. As for Joyce, she has no job skills and is in a relatively poor state of health. She believes that she cannot survive without Ralph's financial support. She is further discouraged from separation for fear that in light of her drinking problem, the courts would award Ralph custody of the children, and she believes he would abuse them. All in all, the Barkers are caught up in a family-level economic, political and emotional bind, which for theoretical purposes, I will call a "functional" system. Without intervention by professionals who have an understanding of the complex processes outlined above, it is doubtful that they can achieve either successful treatment of the maternal alcoholism or a healthy, happy family environment.

Treatment History

During the early years of her alcoholism, Joyce was briefly in and out of Alcoholics Anonymous. Knowing that she was inhibited and fearful of participating in this self-help treatment program, Ralph at first escorted Joyce to two meetings a week. Although she liked the people in her group, and in fact, established friendships with other women in A.A., Joyce quickly discontinued this activity because of the requirement or occasional requests to speak out and share with the group personal and problematic experiences with alcohol. She was fearful both of being called upon and of the embarrassment she anticipated if she declined to speak.

Following the A.A. experience, Joyce immediately sought help from the alcohol treatment division of her community mental health center. Again, she

implored Ralph to accompany her for one hour a week. Although these sessions accomplished little or no changes in Joyce's heavy drinking patterns, both she and Ralph enjoyed the experience for reasons of conviviality. Every Wednesday, before their appointed hour of therapy, they had lunch at a nearby restaurant. The therapy sessions became their singularly most important weekly event. Reflecting on that period, Joyce stated:

> We had a whole Wednesday together, just the two of us went out to lunch and then saw her (the therapist) and that was good too, because it was the only time I can remember when we told each other what we felt without fighting -- and then, we'd go shopping together. Then when we moved here, there was no time for that, Ralph won't leave the business any more.

For a two-year period after their move to the equipment yard, Joyce had no treatment experiences until she became suddenly ill, and was hospitalized for six weeks for the "liver ailment" episode, as discussed earlier. On her first day home from the hospital, she was visited by a counselor from the community mental health center in her new neighborhood, and informed of the resources available to her for treatment of alcoholism. As she reflected on this incident, Joyce stated that she was still uncertain as to how or why this center was informed of her alcoholism, when her physician diagnosed her problem as hepititis and non-alcohol related. At the time Joyce and I met, two years following the near-death illness, she sporadically attended private, weekly sessions with a therapist from her neighborhood community alcohol treatment center. One day a week she attended group therapy sessions for women alcoholics. The dynamics of the women's group were always changing because most of the members were assigned there for brief periods by court order and as a result of drunk driving charges. Although she disliked the fact of continually changing membership, Joyce continued to attend these sessions primarily because it was her only outside social contact with women.

Upon request of her therapist, Joyce and Ralph began conjoint therapy in a group with other couples who were experiencing problems with alcoholism. This treatment experience terminated after only three sessions when Ralph was requested by the group leader to leave the group and never return. According to his account, it was a case of extreme mutual dislike (between himself and the therapist) He related:

> First of all, if you've ever been to an A.A. meeting or any kind of group therapy meetings -- like this one -- they all smoke two cigarettes at a time. One time this smoking therapist was shaking her finger at me, cigarette in hand, and she was saying 'Do you know Ralph, how dangerous it is to drink? do you know how bad alcohol is for you.' And I shook my finger right back at her and said -- 'do you know how bad cigarettes are for you. Do you know they could kill you.'

Laughing, Joyce interjected. "He was always doing things like that in sessions which irritated this young therapist."

Ralph went on:

> I don't think she was even a therapist. For all I know, she might have been some graduate school trainee. Anyway, one night she became so irritated she asked why I was there. I told her -- because Joyce asked me to be here. Then she said, 'well, I don't like you and want you to leave the group.' So we did -- we walked right out of there. By the way, that particular therapist is no longer at the center. Guess Proposition 13 knocked her out.

The Barker's never experienced family therapy which included the children, and never considered it as a viable treatment method. It was inconsistent with their present beliefs and explanatory model for alcoholism. Viewing the drinking problem as a stigma-related affliction, and as her own personal burden, Joyce saw no reason to subject the children to treatment or to illuminate further for them, the fact of her drinking problem. However, she did agree in the first year of this study to allow her therapist weekly visits to their home. The children enjoyed these visits, as the therapist was a

friendly, comfortable person. However, they were uncertain of her reasons for being there. These visits were more of a social event than formal family therapy sessions. Neither Joyce nor her therapist ever attempted discussion of family problems in the presence of the children. From Joyce's perspective, these sessions were important for the children because it brought a "safe" adult outsider into their home; other than myself, no one ever visited the Barker household. After a three-month period and due to mutual agreement, these sessions were terminated. Joyce stated that in terms of treatment, these sessions were important, because it promoted a closer understanding between herself and her therapist.

Periodically, and when the various physical effects of ethanol caused Joyce an aggravated degree of discomfort, she would seek help from their family physician. These visits were unpleasant experiences for she sensed that her physician disliked her and was disgusted with the fact of her uncontrolled drinking habits. Once during a heavy drinking period and when she was experiencing abdominal pains, she requested, and was granted, immediate attention from the physician, who had also been the attending physician during her hospitalization for the "hepatitis" problem. In a routine examination, he informed Joyce of a high blood pressure reading. Gathering up courage, Joyce told him she feared that many of her physical ailments were probably related to a drinking problem, and that in fact, she had been drinking heavily for several days. She matter-of-factly and with an accepting resignation related to me the physician's response:

> He gave me a look of disgust and led me to believe there was nothing that he could do for me. In fact, I could tell he never wants to see me again -- or never wants me to walk into that office again. Well, I don't blame him. I mean, what can you do with an alcoholic.

After this episode, and building on a history of humiliating experiences with health care-takers, Joyce was inhibited from talking to physicians. In view of her high blood pressure, overweight condition and apparent liver damage, I often urged her on those days when she was feeling poorly or suffering pain, to find a new doctor and have regular physical check-ups. She refused, stating that this course of action would only tell her what she already knew (or believed), that her health problems were related to her drinking. In a sense, she believed that she did not deserve or warrant medical attention for the physiological, symptomatic affects of alcoholism. Unfortunately, she has been implicitly denied proper treatment, and inherently inhibited from seeking it, by the ignorance and bigoted actions of her attending physician.

During the last months of this study, primarily due to Ralph's confrontation with the group therapist at the community mental health center, the Barkers terminated all ties with that center. At our last meeting, Joyce stated that she had decided to "try to work her problems out by herself," and for the present, would not attempt to seek treatment from her physician, the mental health center, or self-help groups.

CHAPTER 5: THE CARTER FAMILY

From the beginning and throughout the months of our relationship, Steve and Donna Carter were open and receptive to my presence in their home and to the frequent impromptu questions or interviews about specific areas of their private family life. They were supportive of the purposes of this study and genuinely sincere in the hope that their participatory role would somehow benefit not only themselves, but also others who experienced drinking problems in the context of family life. On our second meeting they informed me that Steve's long hoped-for transfer to another area might become a reality in a matter of months, therefore we agreed to a shorter but more intense research experience. From March 1 through the month of May, I spent many days in their home, remaining four to ten hours for each visit. Additionally, there were visits of shorter time periods, plus occasional meals and snacks in restaurants, shopping trips, errands and many telephone conversations. For three months after the transfer, which occurred in mid-June of 1979, Donna and I communicated by telephone and letters.

The Family Setting

The Carters were living in a California tract house in an average middle-class suburban neighborhood. They had relocated to their present neighborhood and rental house nine months before, for the specific purpose of removing their two older daughters from what Donna believed to be a "wild, drug-oriented" high school and neighborhood. She had wanted a larger house, but with the high rental rates, had to settle on their present small three bedroom home. When they converted the living room into a bedroom for the two older daughters, all flow of traffic and family gatherings were redirected to the tiny kitchen, open dining area and small, oblong-shaped family room. The

house usually appeared to be neat, clean and well-cared for. Off the family room is a small patio where during warmer weather Steve sometimes barbecues meat for their evening meals. Beyond that is a lawn area bounded by a six-foot high redwood fence, where Sharon, their seven year old daughter, and their huge German shepherd dog often exercise and play. They also have two Siamese cats which roam freely about the house.

One peculiarity about the house is that the heavy curtains across the front of it, facing a sunny, private cul-de-sac street, always remain closed. Over a three-month period, I never saw the curtains opened, and this practice noticeably darkened the house, especially the kitchen, which had no other opening for air or light. The drawn curtains seemed to symbolically suggest a demand for privacy and separateness from the surrounding active neighborhood environment.

Profile of a "Nice" Middle Class Couple

Steve and Donna Carter, both in their late thirties, have been married ten years and between their present and previous marriages have five children. The children living with them are Susan, age 17, and Sandy age 14, from Donna's first marriage and Sharon, age 7, who is their daughter. Steve has a son and a daughter who live with their mother, his ex-wife.

Both Steve and Donna were raised in the Protestant faith, he Baptist and she Presbyterian. Steve's first wife was a religious abstainer from alcohol, and his children by that marriage attend private Baptist schools. Since their marriage, he and Donna infrequently attend church services, but off and on through the years, Donna enrolled the children in Baptist Sunday School.

Steve is employed by a large department store chain as a service technician for major household appliances. His take-home pay of $1500 per month barely supports the living expenses of his family plus child-support

payments to his ex-wife. He and Donna struggle to pay their monthly bills and make ends meet for the most basic needs of day-to-day survival. Donna works at home as a housewife, but periodically, and when she is in the state of mind and health to do so, she supplements their income with funds received for daytime babysitting in her home and ironing for selected customers. With his shock of black hair, moustache and full beard, and at an imposing six feet, three inches in height, Steve Carter is a strikingly handsome man. However, his darkly forceful appearance does not fit his personality which is of a quiet, retiring and almost complacent nature. He is more of a listener than a talker, but when he does speak out on family matters, he expects his word to be law in the Carter household. Steve considers himself a family man, in that he enjoys being at home and in the company of his wife and children. However, he contributes little toward the role of parenting, once stating "that's Donna's job." When he does discipline the children, it is extremely punitive in nature, and several times during our acquaintance, he was provoked into explosive displays of anger and vigorously spanked -- or beat -- the older girls with a belt.

Donna's drinking problem creates an ongoing level of stress in their marriage, but not enough to diminish Steve's most obvious fascination with his pretty and effervescent wife. Sometimes he rationalizes and diminishes the seriousness of her drinking problem by sharing the blame for the onset of her heavy drinking practices, and identifying himself as also being a problem drinker.

Where most of the other women participants of this study showed in varying degrees the physical effects of long-term heavy alcohol consumption, Donna Carter's attractiveness, well-formed figure and generally healthy appearance belied her diagnosed condition of alcoholism. Her deep brown eyes, reddish brunette hair and clear, ivory-colored complexion were complemented by a pleasant, fun-loving personality. When she was not drinking or depressed,

Donna could spark lively, meaningful conversations about many subjects -- herself, her family or world affairs. On first impression, she appeared to be a happy person, one who was in constant motion and who delighted others in her presence with her dry sense of humor. However, after several hours of drinking or when she was suffering from a hangover, Donna was cross, acid-tongued, easily angered and always depressed. Like most of the women in this study, she fluctuated in her housewife role behavior between the role of a caring, affectionate and conscientious wife and mother and that of a cynical, unloving and careless stranger.

The Carters are affable people, and in the early years of their marriage they developed friendships with neighbors and among Steve's coworkers. However, since the birth of Sharon, seven years ago, and more so after the onset of Donna's heavier drinking patterns two years later, they rarely do anything social together or as a family group. Steve is disillusioned with the high cost of living in their present suburban environment and lack of funds for anything beyond basic survival needs. He is often depressed that at age 38, he has not reached his goal of owning his own home. Because of economic pressures and multiple family problems, he requested a transfer to a sparsely populated area on the far northern California coast, which was in near proximity to his parents, many relatives and former boyhood acquaintances. Steve could talk about nothing else but this hoped-for move. He foresaw it as the turning point in their lives, a kind of utopia wherein problems with money, alcohol, drugs and runaway, juvenile delinquent children would somehow disappear.

The Development of a Drinking Problem

Cultural beliefs and attitudes about alcoholism and drinking behavior weigh heavily on Donna. Her early life socialization to alcohol impressed upon her the belief that social drinking is a normal and pleasurable activity, but

problem drinking or alcoholism is unacceptable and immoral conduct. When I first met her, she was seeking private and weekly therapy at a community alcohol treatment center. One focused issue of her sessions was her inner struggle to accept her recently diagnosed condition of alcoholism as unhealthy rather than immoral behavior. The origins and consequences of this belief conflict are implicitly scattered throughout the following historical account of her early life and the development of her drinking problem.

Problem drinking has had a disruptive influence on Donna's life since her early childhood. Her father, when he was a newly married young man, was a heavy social drinker. Shortly before her third birthday, her parents divorced, and she never saw her father again until 27 years later when he paid her an unexpected visit. She recalled that as a young child, whenever she asked her mother about her father, she received mixed messages about a man who was exceptionally "handsome and kind, but who drank too much to be a good father."

After the divorce, her mother left her native Kentucky and moved with Donna to a rural California area where Donna's mother entered nursing school. Donna remembers these early years as "lonely, boring and unhappy" because she spent more time with numerous babysitters than with her mother. When she was eight, her mother remarried, and that marriage also ended in an alcohol-related divorce when Donna was fourteen. Her stepfather, whom she remembers as a "kind man and a good father" was of the firm belief that the drinking of alcohol was an "evil act." He considered her mother's penchant for having an evening cocktail and occasional social drinking as unacceptable behavior. On those occasions when he caught his wife sneaking a drink, Donna recalled the following:

> He would rant, rave and preach on the evils of drink for days on end. The more he preached, the more determined my mother was to have her drink -- she particularly enjoyed a beer or two after work. Over the years, she started drinking more and more until they got divorced over this drinking thing. Her drinking continued after that, and in fact, now she has a problem with her drinking.

Steve and Donna have known each other since childhood, and in fact during their teenage years they infrequently dated. But at age seventeen, Donna became pregnant by another high school friend, who was at the time her "steady boyfriend," and in defiance of her parents' wishes they were married. Donna recalls that the young man's father had his revenge when he "forced him" to join the Air Force thereby also "forcing" them out of their home-town community. During their second year in the service, the young couple became immersed in a social environment where frequent heavy drinking was almost a nightly occurrence. Very quickly, Donna's first husband developed a drinking problem. Often during heavy drinking bouts, he became physically abusive and flagrantly promiscuous to the degree that he brought women acquaintances into their home. When he once threatened to harm their baby (first-born, Susan), Donna left him, and with her young daughter moved to a small apartment near her mother's home where she took a job as a waitress. Soon thereafter, when her husband was "kicked out" of the Air Force, he visited her with the announced intent of reconciling. However, after a week of binge drinking, and during the course of a violent argument, he struck Donna with his fists, leaving her badly cut and bruised. She immediately moved into her mother's home and filed for divorce. Shortly thereafter, she discovered that during the week of her husband's visit she had become pregnant. In a state of high emotional stress and humiliation, Donna slashed her wrists in an attempted suicide. Following three weeks of hospitalization in a psychiatric ward, and with her mother's help, she went through with the divorce, and

shortly thereafter obtained a good job as a hospital ward secretary. After a full-term pregnancy she delivered Sandy, her second daughter. Donna's first husband, who for many years was unable to hold a job, never gave financial assistance for the support of his daughters. He at first occasionally requested visits with Susan, his older daughter, but after moving to another state broke all ties with his children and with Donna.

Several nurses who were coworkers encouraged Donna to enter nurses training and offered to use their influence towards gaining acceptance in a university-based nursing school. At that time, Donna recalls that her poor self-image and uncertainties as to how she could cope with two young daughters and a rigorous academic schedule inhibited her pursuit of that career. Now she deeply regrets this missed opportunity, and often speaks of her unfulfilled dream of being a nurse.

For four years following her divorce, Donna rarely, if ever, dated, and her social life was limited to drinking in bars in the company of her nursing coworkers after late-shift hours at the hospital. She frequently drank beer at home with her mother. During these years, she experienced periods of guilt and fear that she was a negligent mother, and worried that her children with their long hours at babysitting services or in various homes of babysitters were experiencing the boredom and loneliness that she remembered from her own childhood. Donna began experiencing periodic states of depression and often contemplated suicide. In retrospect, she expressed belief that depression during that difficult period of her life affected her physically to the degree that she experienced frequent vomiting.

Through a mutual friend, Donna, at age 26, became reacquainted with Steve Carter, a friend from high school day. Steve too by then was also divorced and living in a city some miles away. He visited her twice a month

on those weekends when he traveled to her area to visit his two children. They both recalled that their courtship was almost always "chaperoned" by their four small children. Following their marriage Donna quit her job and upon moving to the large urban area where Steve was employed, took up the role of housewife. Two years later their daughter Sharon was born.

In the early years of their marriage, Steve and Donna were occasional and moderate social drinkers. Steve recalls:

> I didn't drink much in my first marriage. I mean, my first wife, she just didn't live that way. But I love to drink beer -- I do love the taste of beer, and I guess one of the things I enjoyed about Donna is that we could sit around and have a beer together. We'd talk and sip a few relaxing beers -- that was it.

Over a period of two years, their solitary and moderate drinking as a couple changed to heavy social drinking and partying with friends. Donna recalls the social context of her developing drinking problems:

> Steve and I both had come out of a divorce and we sort of clung to each other, cause he was going through a lot of things I went through as far as depression. Both of us drank before we were married, but after our marriage we hardly drank at all. And then little by little it started building up and friends coming over -- we'd get all wound up. Any old excuse to go out and buy a couple of cases. We've discovered that drinking was really, for us, a social thing. Friends come over on weekends, we'd barbecue and drink cases of beer -- **every** weekend. It was fun, and all we could afford on our salary. But all of a sudden, here I was, right back to heavy partying and drinking like in my first marriage -- with the difference of course, that Steve never gets physical like Ron (first husband) did.

In an effort to avoid a decrease in his job efficiency Steve tried to limit his alcohol intake on Sundays and weeknights to six beers or less. He stated that he preferred an "early to bed, early to rise" routine. Donna, however, enjoyed the quiet solitude of the late evenings, and often long after Steve had retired for the night, she continued watching television or doing household projects

and drinking beer. When Steve at first gently objected to her steadily increasing drinking patterns, and more forcefully to the fact that drinking preempted their normal routines, Donna began to hide a surplus beer supply and to drink alone, earlier in the day. Donna stated that it was at this point, when she sensed her husband's disapproval of her drinking behavior, that she first questioned whether she drank for social reasons or to relieve stress. Where before she had taken her first drink of the day with Steve, and in "celebration" of his return home from work, she now began drinking in mid-afternoon to "relax her nerves." Her former pattern of buying one or two six packs of beer each day, now changed to three: one or two for her and Steve to share and her own reserve supply for afternoon or late night drinking.

Donna's Present Drinking Pattern

The foregoing history of Donna's alcohol-related experiences reflect that she has been a heavy social drinker off and on since age nineteen. However, and from her own perspective on her drinking history, she has been a problem drinker and identified "alcoholic" for the past five years. She cannot be classified as an impulse, binge or periodic drinker, because her drinking patterns persisted on a continuum over months and sometimes several years without a noticeable break or change in the amount she daily consumed. She drinks from one to three six-packs of sixteen ounce beers almost every day. There were a few periods during the course of the research when she abstained from one to three days. The context of her drinking varied from alleged sociability with her husband and with friends to celebration of an important event, such as job promotions or salary increases for Steve, self-rewards for completion of a project or a job well done, to ritualized holiday drinking and always, as Donna described it, "to settle my nerves." Sometimes Donna drank alone and secretly but at other times she drank in the presence of the family. For the

six months prior to the time I met the Carter family, and during the period of this study, Donna almost always drank alone. On two separate occasions over the preceding five years, through the use of antabuse and with the support of one particularly competent therapist at her community alcohol treatment center, Donna was able to totally abstain from drinking for long periods of time -- once for nine months and again for three months. Many other attempts to drink infrequently and in lesser amounts were unsuccessful.

Donna's routine of drinking rarely varies. Everyday after her noon-day meal, she drives to the supermarket to buy supplies for the evening meal and to buy beer. At exactly 4 p.m., just when she begins to prepare dinner, she opens her first beer. By 6 p.m., when the family sits down to dinner, she has already consumed six cans or 96 ounces of beer. She continues "sipping" beer after dinner and often late into the night, sometimes, she stated, until four in the morning. On those evenings when Steve drinks with her, he either buys beer on his way home from work, or Donna makes what she calls a "beer run" after dinner, that is she buys more beer for him so her supply will not be depleted. By the time I knew them, Steve and Donna had withdrawn from social activities wherein heavy drinking was the norm, but in previous years, both of them drank heavily on weekends. It was understood that guests of weekend barbecues always bring with them their own supply of two or more six-packs of beer per couple. Often, Steve recalled, couples brought a case of beer (24 cans or bottles) and consumed it all in the course of one social event.

Donna maintained a sociable, albeit altered, demeanor when drinking in the company of friends, but when she drank at home, she often became aggressively argumentative and cynical. Sometimes she experienced blackouts. She suffered daily hangovers and other effects of alcohol, such as sleeping

until late morning, bloating, headaches, high irritability, tenseness and depression. On most days, however, she managed to carry out basic housewife routines, most notably shopping for food, cooking the evening meal, surface housecleaning and laundering the family's clothes. Several days a week she babysat with a working-neighbor's child and ironed clothes for the three or four regular customers. In mid-afternoon, she showered, put on makeup and fresh clothes in preparation for Steve's arrival home from work, and for the beginning of her evening drinking ritual.

At the community alcohol treatment center where Donna sought treatment for her alcoholism, a consulting psychiatrist diagnosed her as manic-depressive. Donna stated: "the psychiatrist feels that the manic-depressive syndrome is hereditary. She (her doctor) says my grandmother had it, my mother has it, I have it and my daughters have it." Donna conscientiously follows the prescribed medications for this condition: Lithium, 300mg. thrice daily (an anti-depressant) and desipramine 50mg., four times daily (an anti-depressant). She rarely uses antabuse due to the uncomfortable nausea it causes when mixed with alcohol, but during several short-term periods over the years of her drinking, she has achieved controlled drinking or abstinence with this medication. Donna takes multiple vitamins, and in fact proudly displays her seven bottles of vitamins in a prominent place in the kitchen.

The Carter Children

Susan, the oldest of the Carter children, was not living at home during the early months of my association with this family. She was confined at the county Juvenile Rehabilitation Ranch where she was serving a one year sentence for "assault with intent to harm" on another teenage girl. Primarily through Donna's efforts and her weeks of negotiations with county juvenile authorities

and probation officers, Susan was granted an early parole in the fourth month of her sentence and released to the custody of her parents. She returned to the Carter household during the 12th week of their participation in this study.

Beginning at age 13 and since her freshman year in high school, Susan has lived in a world of drugs, truancy, runaways, and petty thievery. At age 17, she is a high school drop-out, has been arrested ten times, served four short sentences in juvenile hall (not including her most recent one) and is continually on probation. She has also experienced serious problems with both alcohol and drugs. She sometimes drinks excessive amounts of hard liquor (excessive in the sense that she experiences blackouts) and, according to both her own and her mother's accounts, has used virtually "every drug that's out there." It was during the course of a marathon alcohol and drug-taking session, wherein she took a combination of LSD, alcohol and marijuana, that Susan and another teenage girl tied up a third member of their party who was also under the influence of drugs, and over a period of hours repeatedly beat her and burned her feet with cigarettes. When the effects of the drugs wore off and the injured girl returned home, her parents pressed charges. It was for this offense that Susan was undergoing therapy and rehabilitation at the County Juvenile Ranch, by order of the Juvenile Court. Other arrests were related to public drunkenness, possession of illegal drugs, repeated truancy and petty theft.

Over the past year and preceding her most recent arrest, Susan has kept steady company with "Duke," a 32 year old transient "biker" who is a member of a well-known motorcycle gang. Twice when she ran away from home for month-long periods of time, Susan traveled or stayed with this man, also a heavy user of drugs and alcohol. Susan spoke affectionately of Duke, but Donna stated that twice he had physically abused Susan and once she

returned home with a black eye and a cut on her forehead that required immediate medical attention. Donna and Steve despised this man, and Donna described him as follows: "a filthy, dirty scum of the earth type who has the mentality of an immature teenager." They bitterly disapprove of this relationship, but have never taken legal steps to prohibit him from keeping company with their minor daughter. When I inquired as to why they did not, Donna stated that it would serve no purpose, other than to encourage Susan to see him more often. She said: "Sometimes I feel if we would pretend we liked Duke, Susan would drop him right away. Whenever we forbid her to see him, she climbs out the bedroom window and meets him anyway or runs away, so what can I do?"

In person, Susan has neither the looks nor apparent attributes of a hardened, street-wise person who has served four sentences in juvenile hall. When I first met her on the day after she was paroled, I was taken aback by her soft and well-groomed appearance. With her shoulder length blond hair, wearing blue jeans and madras shirt, she looked like a typical teenager, as she sprawled in front of the television set, sipping pepsi colas and holding her seven year old sister on her lap. She proved to be a soft-spoken, shy and relatively unaggressive young woman, who had a strong resemblance to her attractive mother. Following her four-month confinement, she had returned home in good health and with much introspection on her problematic life experiences. She never used so-called foul or offensive language, but beneath the veneer of softness, her vocabulary and matter-of-fact way of discussing her use of drugs, relationships with men, and proficiency in shoplifting techniques suggested a worldly value system that was out of context with both her youthful, innocent appearance and the seemingly, protective environment of her comfortable family home.

In spite of all the worry and grief Susan has caused her mother, when together they project a close and affectionate mother-daughter relationship. On her third day home and when the three of us were having lunch in a quiet suburban restaurant, I was struck by the joy they shared in one another's company. As they talked and giggled over events and trivia of the preceding four months, I thought of how much they looked like two reunited old friends rather than concerned mother and delinquent child.

Sandy Carter, at barely five feet in height and weighing less than 100 pounds, is an exceptionally pretty girl with appealing blue eyes, long blond hair pulled back in a pony tail and an impish expression. At age thirteen, she is experiencing serious academic, social and emotional problems, and from all appearances, following in the footsteps of her older and troubled sister. During her freshman year in high school, she missed more days of classes than she attended. Many of those days were spent "hanging out" around the campus or in a bowling alley, some five miles across town, which was a popular gathering place for truants from several large high schools. She had run away four times in one year for short periods, once during the months that I was acquainted with the family, and was awaiting a hearing in juvenile hall for petty theft. Although an honor student in primary school, Sandy, at the time that I knew her, displayed little interest in her studies and in fact did not pass the ninth grade.

At home, Sandy is quiet, sometimes sullen and always inactive, spending her after school hours and evenings watching television, listening to records in her room or sleeping. Steve and Donna rarely plan social events which include the whole family, and of recent years, never allow guests in the home, so Sandy, like many of the children among all eight of the families who participated in this study, was bored, lonely and in a sense, socially isolated.

Sandy once told me she loved her mother for the reason, she said: "She's my real mother you know, so of course I love her. Steve is not my father, and he's okay, but I don't like the way he spanks me. I wish my real dad would come around sometime. Once he wrote to Susan when he got married, but he's never written to me." (Donna's first husband does not recognize Sandy as his child.) In any case, like Susan, Sandy enjoys an affectionate and close relationship with her mother. Whenever they get into trouble, no matter how serious or trivial, Donna expresses frustration rather than anger or hurt feelings, and never, no matter how serious the infraction, withdraws affection or communication. Steve, however, can on provocation explode into anger and severe physical punishment, and for this reason Donna often witholds from him facts about the girls' abberrant behavior.

When Donna is unable to get out of bed in time for breakfast, which is usually the case, Sandy fixes her own and her younger sister's breakfast, as she has been doing since she was eight. She is expected to come straight home after school and look after her younger sister. The hour she returns home from school coincides with the beginning of her mother's drinking ritual, allowing limited time for normal or expected mother-daughter conversations and activities. Sandy has never been allowed the opportunity to take ballet or dance lessons, to learn how to play a musical instrument, to take part in after school or community sponsored sports, to take part in the school band or a school play, or to have friends regularly visit her home although they reside in a cultural environment where other girls in Sandy's age group take these things for granted. There is limited parent participation in Sandy's (and her sisters') school work and a limited time span, when her mother is still lucid enough to engage in pleasant conversation, wherein Sandy is encouraged to share problems or achievements -- her daily happenings. Basically, Sandy, like

most of the children in this study comes home to a non-responsive household wherein normal and necessary parental feedback is minimal.

During her most recent arrest, Sandy was caught stealing a skirt and blouse from a large discount department store which she passes each day on her route home from school. She explained to me that she had stopped at the store after school "just to look around for a new outfit, and I really only meant to take it home to show Mom." Donna and Steve were fearful that Sandy was imitating her older sister's behavior, and expressed belief that the Juvenile Court experience would "teach her a lesson."

Although Sandy had been well-liked and popular among the students of her former neighborhood school, since moving to the new school district she had become involved in fights with other girl schoolmates. When Donna talked to the school principal about this problem, he dismissed it as a case of a new girl "hanging around with the wrong crowd." After checking her school records, and noting the radical change in grades (from A's to F's), he suggested to Donna that Sandy should be put into private therapy. Steve said they could not afford therapy, and he would handle the situation. Each time the school reported that Sandy had been in fights or missed a day of classes, Steve would step into the parenting role and punish her with one or both of two methods: spankings with a belt or "groundings" -- meaning she was restricted to the boundaries of the house for several weeks during after-school hours and on weekends. It was always during such periods of restriction that Sandy ran away from home, only to be grounded once again when she returned. It may be noted that earlier this also was Susan's pattern.

The youngest member of the family, seven year old Sharon, is a smallish, fine-boned girl with a whiny voice, ever present runny nose and fretful disposition. She wears an owlish and distanced expression behind her thick

glasses which seem far too large for her petite features. She suffers from a condition of chronic and unspecified allergies and has a serious speech impediment. The kindergarten teacher from her former school (where they lived before the move) informed Donna that Sharon was retarded and did not belong in a normal classroom environment. Donna had the following to say about this diagnosis:

> This cranky old woman did Sharon a lot of damage. She not only labeled her retarded, she also saw her movements as spastic and thought something more was wrong with her. In short, she just didn't want her in her classroom.

Donna was relieved when, after a series of tests, professionals at their present school district found Sharon to have an above average I.Q. As Donna explained it:

> She was just severely handicapped -- educationally handicapped -- but not retarded.

In addition to her educational and physical problems, Sharon has been unsuccessful in gaining social acceptance both at her new school and among neighborhood children. According to Donna "kids just don't like her." From my observation, one of the problems was the recurring pattern where the parents restricted the children's movements to the house or in near proximity to the mother. In this case, although the Carter home is situated on a quiet, tree-lined and cul-de-sac street, relatively free of traffic and wherein neighborhood children daily gather for play on the front lawns and sidewalks, Sharon was never allowed to play in that area. She was restricted to the fenced-in backyard -- where of course there were no other children playmates -- and prohibited from interacting with neighborhood children unless an older member of the family accompanied her -- which rarely, if ever occurred. The existence of boundaries separating alcoholic family life from the eyes of a real or imagined disapproving broader culture are in evidence. I will not

repeat here the analysis of boundary maintenance as was presented for the Barker family, but the threads of that theme may be recognized throughout the Carter family case.

Identified Family Problem: Children or Mother?

There are similarities between the Barker and Carter children. In both families children exhibit serious physical, social and educational problems with underlying and developing emotional disturbances. In both cases, children unknowingly and again, helplessly, contribute to the maintenance of a system which perpetuates both the drinking problem and whole family stigma syndrome. Their regulatory behaviorisms reinforce protective boundaries of a problem and alcoholic family culture. In this case study, I give particular and comprehensive attention to the children for the reason that the situation demands it. The behavioral patterns of the Carter children were of such a serious and disruptive nature that they emerged analytically on an equal footing with the mother as the "identified family problem." When viewed along a continuum -- from inception to the present state of things -- the children's problematic lives proved to be locked in, step by developmental step, with the situation of maternal alcoholism and the alcoholic family system. In descriptions and explanations which follow, this symbiotic relationship unfolds in terms of covert and subtle cultural factors.

Socialization to an Alcoholic Family Life

Susan and Sandy Carter have undergone radical life changes in a relatively short period of time. There are no specific and definitive answers as to why they have so early chosen a fugitive, derelict lifestyle and one that is obviously out of context and incompatible with the norms of their broader cultural environment. However, the **meanings** of their self-destructive behavioral

patterns are illuminated somewhat when we view them historically in the context of the Carter family experience with maternal alcoholism.

During their primary school years, both Susan and Sandy were above-average students and neither exhibited unusual behavioral problems. Susan's problems began in Junior High School, and in a time period which coincides with the year her mother experienced the turning point in her drinking patterns. (She began drinking greater amounts of beer and more often.) Apparently, Donna saw no clear-cut connection between her daughters' delinquencies and her own drinking. For example, in the following statement, she suggests that her oldest daughter's early problems with drugs and truancy were caused by premature body development:

> Susan was always super attractive with a build like -- well, she had a build at eleven years old that a lot of women wished for at sixteen. For this reason -- or it's my feelings, that girls were jealous of her and kids raised a lot of hell with her. She started gettng in fights with girls and coming home playing sick and she experimented a little with pot, but I didn't worry about that so much, because I don't think pot's such a big deal, you know.

The summer before she was to enter high school, Donna recalled that Susan "hung around the house a lot" and fretted about the upcoming school term. She said:

> For some reason, she didn't want to go to high school. After her first few days in high school I guess she couldn't cope with comments or how high school kids are, you know, so she quit going. She hung around the parking lot a lot, and of course, the parking lot crowd's the drinking and dope crowd. I'd go over to that school and talk with the principal -- or whatever -- and I'd see those kids hanging around stoned -- and I'd tell him, I thought this was supposed to be a good high school. Well, little by little it was no school, truancy and I'm suddenly taking her all over town first for counseling, then to family planning so she wouldn't get pregnant. By then she'd gotten into running away and she would be gone six to eight weeks at a time.

At first Donna and Steve were shocked at Susan's strange behavior, but after a period of time, though they feared for her safety, they accepted her runaways as the with resignation. Donna recalled the first time at age 14, Susan climbed out her bedroom window and disappeared for a week.

> That night, about 12:30, I checked her room and she was gone. Both Steve and I had been drinking a lot that night, and Steve really got upset. In fact, he started to cry and said 'well why wouldn't she — look at us.' That made me think a lot, but I still didn't know what to do about it all. From time to time I'd go to that alcohol treatment center in my old neighborhood and get into a group. The problem there was I'd just get going in a group, and a therapist would quit or get fired, and lo and behold, the group would be gone. Finally, I said to hell with it.

Since their early and formative years, Sandy and Sharon and since her early teens, Susan have experienced a home environment where heavy and frequent parental drinking was the norm. As such, they view their mother's cyclical and changing behavioral patterns, her mood swings and frequent periods of blackouts or absence from the family scene as the normal course of their family life. As was the case in the Barker family, the Carter children never connected their own personal problems or the evolution of those problems to their mother's alcoholism. However, the relationships did exist, and in spite of the children's naive and self-flagellating perceptions of their own behavior, the impact of maternal alcoholism on their lives surfaced in both their past and present family experiences. That is not to say that Susan and Sandy were unaware of their parents nightly patterns of heavy drinking, the morning hangovers and the many afternoons when their mother's drinking ritual preempted parental attention to their homework, choice of friends and after school activities. But the Carter children never discussed such matters in exactly those terms. The following excerpts of conversations with Susan, taken

directly from my field notes, typifies this attitude of acceptance and resignation to the way things are and have always been.

May 9, 1979

> Susan, according to your mother you were an above average student in primary school, what changed for you in Junior High?
>
> Yeh, I did well until the seventh grade, and then I started hanging around with the wrong kind of people, I guess, and I started smoking a lot of pot and I just really didn't care anymore and I guess I was just trying to act like everybody else, you know, cut school, and get stoned. And then I went to high school and I thought my parents were really strict because everybody else got to go out and do things on weekends and they wouldn't let me do anything. So I started running away.
>
> That first time you ran away, why did you do it Susan, what were you thinking?
>
> I did it because I felt they were like -- what do you call it -- I don't know. It's just that they were like locking the doors every night and keeping me locked in the house with them and stuff. Some nights I'd hear them fighting and I'd try to talk to them. I'd say things like 'you two just sit down for a minute and talk this thing out' but they never would. Then, you know, with their fighting and everything, they wouldn't let me do anything -- I didn't do anything that most other kids my age did. Steve was always afraid something would happen, so I'd just stay home, all the time.
>
> Tell me more about your high school experience, what happened there.
>
> Well, I started out high school and did okay. I went for the first six months off and on cutting classes now and then, getting stoned. Then in my sophomore year, they put me in this special class where you go three hours a day. My best friend Sharon, we were both in that class, both screwups, you know, and we'd say, well we'll just have a cigarette before class and then we'll go and then we'd see somebody and they'd say 'hey, let's go get stoned,' so we'd go. Then I realized school just wasn't for me, so I quit. People influenced me a lot -- and I wanted to do what they were doing -- which was getting stoned, cutting classes and running away.

> When you ran away, did you have a place to go or was someone with you?
>
> Not the first night. I just knew that night I had to get out of this house, and I'd been thinking about it for a long time, so I just snuck out the window and went over to my boyfriend's -- a guy from school -- and stayed in his parent's camper. I was scared -- really, I was so scared. But my Mom, I guess she somehow knew where I was because she came over later that night and picked me up. You know, I can't remember if we ever really even talked about it. They did ground me for 3 weeks though.

After her first runaway experience at age fourteen, the interactive patterns around that event became routine: Susan was grounded during non-school hours and restricted to the boundaries of the house. After a period of a few weeks, she would run away again, each time staying out for longer periods, during which time she established new relationships in her own private social network, one which had no connections to family, school or local community. She returned home when she ran out of funds or felt a strong need to see her family. Often during these runaway periods, she returned at night to leave gifts on the front porch for her younger sisters. Susan stated that she did this first of all because "I missed my little sisters" and secondly to let her mother know she was okay.

Once when Susan returned home after a month's absence and at two a.m., Steve in a fit of rage ordered her to take off her clothes and whipped her with a belt, stopping only when Donna, pleading and crying for him to stop, wrestled him to the floor. For several days after that event, Susan, with two blackened eyes, was unable to walk and was in great pain. As this was an unusual and traumatic event, all three persons involved related to me similar accounts of this particular interaction, but with very different emotional

reactions to what appeared to this observer as flagrant child abuse. Steve reported ambivalent feelings:

> I lost my head, but dammit, she deserved it -- hurting her mother like that. If she wanted to come home after a month, she had no business coming in at two in the morning.

Donna expressed shame, humiliation and guilt over this incident. Each time she spoke of it, she became teary-eyed. She tried to take the blame:

> We'd been drinking and fighting all night. Susan had called me earlier to say she was coming home. I was so happy; then she didn't come and didn't come until so late. Steve got madder and madder, and then when he heard her come in, he went crazy. My God, he might have killed her.

Susan said very little, but she did state:

> I don't like him and I don't like the way he tries to run my life, but I guess under the circumstances, I had it coming to me.

Susan's self-identification as a "screw-up," her acknowledgement that her friends were undesirable types, that she is the easily-influenced follower and finally that she deserved the physical beating at the hands of her stepfather implicitly suggest a sense of low self-esteem, poor self-worth, guilt and self-flagellation. Ironically, in the context of these same conversations and reflections on past events, Susan is describing a household where she almost daily returns home to a drinking, unpredictable mother, a frustrated and volatile father, parental fighting and always enforced restrictions on her social life.

In so many words, it is possible to see how the strictly imposed boundaries are, in effect, a built-in coping mechanism. Where parents are unwilling to regulate and chaperone their children's social activities, as was the case with Steve, or unable to participate in that aspect of their lives, as was the case with Donna, they have to choose between releasing their children to experience outside social activities without parental supervision, or as in this case, maintain

protective and all-confining boundaries. During school hours, Donna and Steve shifted responsibility for their daughters' activities to that institution, assuming that within those boundaries, they would perform adequately and within the normal guidelines of educational procedures. They were wrong. Susan and later Sandy and Sharon were all three unable to make the emotional transition from home to school, and therefore failed in their attempts to achieve along normal lines of the educational process or to establish social relationships with anyone other than students who, like themselves, assumed a lowered sense of self-worth.

It was during one of her frequently occurring "groundings" that I got to know Sandy, and what I saw did not fit her developing behavioral patterns of truant, fighter, thief and street-wise kid. One day, when she was bored beyond all other possible forms of self-entertainment, she reluctantly invited me into her room for the purpose, she warned, of "just hanging around." For the reason that her room faced the street, her window blinds, like all others on that side of the house, were drawn tightly closed, blocking out the warm, sunny California day. There were two beds in the spotlessly clean room (one was for her sister, by then serving her fourth month in juvenile hall), a portable record player, a small chest of drawers positioned between the beds, two posters and nothing else. The dark red carpet and bedspreads in this dimly-lit room projected a cell-like environment. As we talked, she sat cross-legged in the center of her bed smiling frequently and wearing a huge cowboy hat. I wondered as I looked at her why this typical-looking American teenager was so unpopular in an almost all-white, affluent and middle-class school. I pondered over who these girls were at her school who apparently wanted to physically hurt her, and for what reason. And if she did in fact engage in actual exchange of blows, how did she, with her small stature, manage to protect herself. When

I asked her about this problem, she refused to discuss it beyond such statements as "the kids are weird at that school and pick fights" and "everytime I get into trouble the principal spanks me with a paddle that has big holes in it and that's because my parents signed some kind of paper so he could have permission to spank me." As can be expected, the spankings were a source of embarrassment for Sandy, and she was teased about them by other students.

On that day, Sandy did not want to say much about her problems at school, or lonely periods of running away from home, beyond that during those periods she hung around bowling alleys, begging or stealing for food, and spent nights sleeping at homes of other children her age whom she met at the bowling alley or on the street. She wanted to tell me about happier dimensions of her life, and in particular her two most memorable experiences, which were the time she was elected to the Junior High School cheerleading squad, and her first communion day.

Unfortunately, the honor of being a cheerleader never went beyond the first week of practice because as Sandy explained:

> I made it (the cheerleading squad), but then I didn't really make it either because we had to do our own uniforms and pom poms and stuff, and my Mom doesn't sew and stuff, you know, she said maybe I'd just better forget it for that year. So I don't know, it just didn't work out. I was good though and I bet I could have been a cheerleader this year. I should have tried out again.

The "First Communion Day" occurred when Sandy was 10 and her sister Susan was thirteen. Their grandmother, Donna's mother, a recent convert to Catholicism, enrolled her granddaughters in Catechism classes, and after a period of time, they were baptized and received their first communion. At that time, Donna, and to some degree Steve, were drinking heavily and they did not participate in either the christening or the communion event. A couple in the neighborhood who had befriended the girls acted as their godparents for

the christening, paid for the communion dresses, took pictures at the church, and after the ceremony, celebrated at their home with a barbecue and party. Sandy proudly showed me her white communion dress which still hangs front and center in her closet. I was taken aback when she said that each time she runs away, she visits the church in her former neighborhood wherein she made her first communion. When I asked what she does there, she replied "I sit... and sometimes I pray." As soon as these words were out, Sandy covered her face with her hands in apparent embarrassment. It crossed my mind that she was deceiving me possibly for the sake of creating a more positive impression and in an effort to divert my attention from all the negative and troubled parts of her young life, but I don't think so. In any case, the topics of that afternoon's conversation indicated that from Sandy's perspective cheerleading and church activities might be more acceptable and pleasurable behavioral patterns than truancy, stealing or running away -- if she were given the opportunity to pursue them.

Summary of First and Second Levels of Analysis

In terms of the family-level cultural model, and on the first level of analysis, it may be seen how conflicting cultural prescriptions for alcohol use and drinking behavior supported the evolution of Donna's drinking problem, inhibited early recognitionof her alcoholism and finally influenced the development of family boundaries and whole family stigma syndrome. The consequences of these factors for family life and the health and well-being of its members have been quite clearly demonstrated.

On the second level of analysis, wherein I address the issue of whole family survival techniques, we have seen that maternal drinking minimally affected the most basic functions of this family in terms of physical sustenance. In other words, the mother's drinking pattern allowed enough hours in her day

for meal preparation, provision and laundering of clothes and surface maintainence of the house. The role breakdown for this family occurred in other, equally vital functions of family life -- that of adequate and consistent parental nurturance and developmental guidance. As evidenced in the foregoing inside perspective on their troubled lives, these children were deprived of these basic human needs (as defined in their socioeconomic category) and as a result were retarded in their emotional, social and academic development. This is not to say that Donna Carter was a surface, or uncaring parent, lacking emotional involvement with her children's lives and welfare. During her more lucid intervals, she openly and naturally displayed her affection for her daughters, and when made aware of their most serious problems, consulted with school, law and community mental health professionals for help and guidance. The breakdown in role function occurred because of the fact that her drinking and recuperative hours fell during the prime family time of early evening to noon the following day, and on a continuing, ongoing basis. Additionally, her husband, who displayed little interest and capacity for parenting, did not step into the nurturing role in her absence. When he did try to give guidance, it was in the form of angry and sometimes physically abusive outbursts. As was the case for every family in this study, where there is clear-cut and traditional division of labor, that is the wife in the home and husband as the principal provider, fathers step into the wife-mother role reluctantly and with half-hearted performance or not at all.

The children of this family system survived in this disruptive and oppressive environment by withdrawal from the home. Their search for recognition and human nourishment put them in contact with environments which from the perception of their own established culture were undesirable and unhealthy. Their need to escape was critical. Neither the older daughters

nor their seven year old sister could be expected to sanely and emotionally cope with a family system where on the one hand, and in the light of their broader cultural surroundings, there was an ongoing pretense of normality, and on the other no hope of meeting those expectations, and in fact, restrictions forbidding it. As young children, and never having experienced any other perspective on family life, they accepted their parents' world, their home environment, without criticism or blame. Likewise as intelligent, attractive and potentially high achieving individuals, they were denied parental involvement and support in the most basic school, church and neighborhood activities. Even more frustrating to them, most of their peers in their natural cultural environment, having these advantages, moved beyond them academically, socially and certainly emotionally. Unfortunately, their sense of low self-esteem as repeatedly reinforced in their home and school is now continued in their truant, runaway and new found worldly environment.

Ambivalent Rule Systems and Manipulative Interaction

Ambivalent rule systems emerged as a common and reoccurring theme for all eight families. Due to the fluctuating nature of family structure and parental role functioning, established notions of appropriate rules and behavior in the case of parents and children alike were periodically relaxed, bent or in some instances turned upside down. As earlier discussed, when mothers were drinking and thereby unable to carry out their maternal role duties, the fathers wer reluctant to compensate for her absence. Out of frustration and resentment for the wife's radically changed behavior, fathers often exacerbated the situaton by verbal and physical outbursts of anger, or by withdrawing from the home altogether. The children, being aware of the cyclical nature of things often manipulated these periodic parental voids to their own best interests and needs. That is to say, children became adept, either consciously or unconsciously, at

maneuvering family interaction towards the coexisting results of self-serving interests and the maintenance of the mother's alcoholism. They learned over time to take a kind of vicarious pleasure in their mother's drinking periods, for the simple reason that it allowed for temporary freedom of movement and unlicensed behavior.

Once again, in my analysis of alcoholic family dynamics in terms of a family systems perspective, I have come to the third level of analysis, wherein the locked-in relationship between the drinking problem and problem solving of individual family members is explained in terms of interactional behavior. In the Carter family, the children, like children from either normal or problem families, were particularly adept at behavioral maneuvers which supported their own needs. Like most children, they were for the most part aware of their manipulative powers. What they were not aware of was the ultimate and harmful consequences of such "powers" for themselves, their mother and the whole family unit. The following statements and episodes are but a few of many examples which demonstrated how interactional processes supported this family's problematic way of life.

Susan Carter often stated that she remembers well when she was younger, being awakened in the night by the sounds of her parents' arguments during their frequent drinking bouts. It distressed her then and it distresses her now, but as she grew older and the pattern of drinking and fighting became routine, she learned to cope with parental drinking behavior by using it to her own advantage. Her explanation of such manipulative processes suggest firstly and from her perspective, that such actions were justified, secondly that she felt guilty about it, and thirdly, that she experienced some element of recognition and concern for the extenuating circumstances of her actions (i.e., that she ended up in juvenile hall and that her mother was drinking more than ever).

> My Mom and Dad would drink all night sometime, and then, late at night, I could hear them fighting and stuff and that used to really bother me. And then the next morning, Mom'd be a real bitch, you know, and I'd have to fix breakfast for everybody, and Steve, he'd come down real hard on me for anything. He wouldn't let me leave the house if it was a weekend. But when I got older, I liked it better when they drank. I mean when they were feeling good from drinking, they left me alone and wouldn't be so strict. I'd ask them if I could do something and I usually lied to them when they were drinking, because they let me do anything when they were drunk. Then I started thinking about this when I was in juvenile hall, and it bothered me a lot. Now that I'm home, I worry about Mom's drinking. I never thought about it that much before. But I wouldn't want to say anything to her you know, and hurt her feelings and stuff.

Susan attributed the inconsistency in rules and parental demeanor to alcohol, but Donna spoke of these same issues in terms of guilt. In other words, the disinhibiting nature of her drinking behavior was from her view less related to the effect of alcohol than to the knowledge or belief that she was an alcoholic. Her own analysis of the problem speaks for itself:

> You know, the problem between me and my daughters, especially Sandy right now, is that she doesn't take me at my word. The reason for that is that I am ambivalent. All of Steve and my problems with the kids revolve around my being so inconsistent. All my threats are made when I have a hangover, because when I have a hangover, I'm not feeling well and I'm in a very dark, angry mood. So I'm very strict with the children during that time and I tell them that they cannot do things and that when they do them, I swear that I am going to punish them and I'm laying out what the punishment's going to be. Like grounding them, taking away privileges like using the stereo or something like having friends over. Then as soon as I've had a few drinks, they come and ask me if they can do something, and I let them go, even though I have just that day grounded them. I know that I do this not because the drinking has changed me that much. It's that when I drink I realize that I am an alcoholic -- that I drink too much, too often, and I feel so guilty about it all that I try to make it up to my kids by relaxing on all the rules and punishments that I've worked so hard to build up.

In both of the foregoing statements, there is evidence that the breakdown in family rule systems is directly hooked into maternal drinking behavior; however, the manipulative interaction and role inconsistencies are not always limited to the mother's drinking periods. Ambivalent rule systems can also be recognized in the conflict between the ongoing and daily struggle of the mother to maintain maternal role status and the complex guilt syndrome of maternal alcoholism. Children recognized this discrepancy, and acted upon it. In light of their conforming middle class environment, the Carter children, and for that matter, all of the children who participated in this study, sensed or in some cases knew for a fact that their mother's behavior often deviated radically from the culturally accepted norm for maternal comportment. As was earlier discussed, children often shared in varying degrees the stigma and guilt syndrome of alcoholic family life. However, over time, they learned how and when to shift the burden of that guilt to their mother for purposes of personal self-interests and needs. This was accomplished by means of interactional and interpsychic manipulation during periods when the mother was **not** drinking. In the Andrews family, Barbara, the second daughter, was particularly adept at getting special privileges during the mother's non-drinking periods. Recognizing the mother's deep guilt and weakened status position during the periods immediately following heavy drinking bouts, she often manipulated conflicting parental decision-making on family rules in her own favor. In the example given, Barbara encouraged and facilitated her father's decision to restrict the mother's right to drive her own automobile during her abstaining periods, and in the process obtained the heretofore forbidden use of a family automobile -- her mother's -- for transporting herself and friends to school. Where at other times the mother's parental rights would have prevailed,

in this instance, and because of diminished status and the guilt burden syndrome, she was overruled.

The following episode, taken directly from my field notes on the Carter family, is another example of trade-offs between rules and guilt in the context of a total family system, and when the mother is **not** drinking.

March 27, 1979 (Excerpt From Field Notes)

Steve came home from work briefly and unexpectedly today, this was about 3:30 p.m. I was in Sandy's room, talking about her fight at school the day before, but we could hear his voice. He only stayed a few minutes, and knocked on our window to wave at us as he left. Then he came back in, poked his head in the room to say he had gotten his new job and transfer. We talked for a minute or two and he left again. He never spoke to Sandy. Then Donna called out that the coffee was ready, so I went out to the kitchen to talk with her. She said Steve had come home for the singular purpose of checking up on Sandy. He left orders that she was not to leave the house under any circumstances. Sandy has just recently returned home from a ten-day runaway period. Then yesterday, her first day back at school, she was in a gang fight, or as she told me, "a bunch of girls beat me up." She has bruises on her arms, and one of her eyes is puffy and blackened. I still find it inconceivable that this petite, pretty thirteen year old girl gets herself involved in all of these aberrant activities. After no more than five minutes, Sandy came out of her room with her coat on and announced that she was leaving. Donna seemed tense and nervous. She said: "I don't want you to leave the house." Sandy replied, "I'm just going over to Mike's house." Donna said: "I don't want you to go to your boyfriend's house." Sandy replied: "I'm not going there. I'm just going down to the Seven-Eleven store." At that time it was 3:45 and Donna said, "You must be back in the house in 30 minutes." To

which Sandy replied "I can't possibly be back before 4:30. How about 5:00?" Then there was a negotiation that went on between the calm, quiet-spoken and slightly battered little girl and the nervous, trembling mother over a matter of a fifteen minute time differential. Sandy promised to return in one hour, and left the house. Donna, who by now was near tears, poured herself a full glass of water and drank it down. I said, "Donna, are you all right?" She answered "yes, I'm just so nervous. I never know when she walks out of the door if she's going to come back." She paused to light a cigarette,

> What I'm really going to be in trouble about is if she doesn't come back. Steve is going to kill both me and Sandy because he just left orders that she is not to leave the house. And look, I just did it. I just let her leave the house.

In answer to my unspoken question of why she let Sandy go, she went on:

> She manipulated me I guess, knowing you were here. I guess she thought I wouldn't put up a fuss. But even if I had told her Steve had grounded her again -- and forbid her to leave the house -- what if she runs away again, knowing that. I mean -- look at her she's already half sick. And I know she is upset about this upcoming move and God knows what else, but she is so secretive that I have no way of knowing what is going on in that head of hers. I just don't want her to run away right now.

At 5:15 p.m., Sandy returned home, just minutes before Steve arrived. Donna was greatly relieved, and nothing was said about the incident.

The foregoing scenario typified the dyadic interaction of these two family members. Donna and Sandy, who in previous years had enjoyed a trusting and affectionate relationship, now interacted in a web of fear, guilt and not-so-idle threats. What on the surface may appear to be a typical teenager-parent negotiation for special privileges and rule-bending, was in fact a confrontive challenge of maternal role status and authority. When Sandy walked out of her room, with coat in hand, both she and Donna knew that

nothing short of physical restraints could stop her from leaving the house. Donna had already shed her tears over the state of her daughter's life, and had ceased pleading with her to change. The facts were now clearly established: Mother sees before her a sick, abused and emotionally disturbed child. She daily fears for her daughter's health and safety, and in this instance cannot chance a confrontation which might trigger another runaway incident, or worse, further physical abuse, this time from an angry and unpredictable father. This mother is immobilized by fear and guilt. Her placating behavior was on the one hand compensatory (for alcoholic behavior and guilt) but more than that, it was in accordance with manipulative processes which by now were too regulatory for resistance or change. The daughter sees before her a mother who due to an addiction to alcohol, is repeatedly weakened in health, parental capacity and role status. The child's own sense of poor self-worth and confusion drives her, like her sister before her, towards a radically different social and cultural environment. Neither parent can help her and she knows it. As a result, she forcefully manipulates interpsychic and behavioral dynamics in accordance with her own material interests and psychic needs. This episode is a good example of the complex dynamics by which a dysfunctional -- in terms of a healthy environment -- yet functional system -- in terms of an individual child -- is developed and maintained.

What's To Be Done For The Carter Children

Donna attempted to get help for her troubled children during her brief non-drinking periods and particularly during the one nine-month long period of abstinence. Diagnosis and suggested solutions differed by the perspectives of the agencies she contacted.

All three of the Carter children were unable to perform -- perhaps cope is a better word -- in the public school environment. Sometimes on her own initiative and at other times by request of teachers, principals or student counselors, Donna searched for answers to this dilemma. School officials had no way of knowing that the pleasant, pretty and concerned parent who came to them for help had a serious drinking problem. They, like Donna herself, related Susan and Sandy's problems at school to isolated factors such as early body development or use of marijuana or stubborn unwillingness to adapt to a high school environment. It was suggested that Sharon (the youngest daughter) was retarded; her learning and other problems were related to physiological dysfunctions caused by birth trauma. In the case of the older daughters, school officials recommended individualized, private therapy as one possible corrective process.

Following this advice, Donna took her older daughters to the community mental health center where they were interviewed by a consulting psychiatrist. Based on this one interview, and on Donna's own history of depression and attempted suicide and after taking appropriate blood tests, both girls were diagnosed as manic-depressive. Medication was prescribed and both took it for a short period of time. On advice of her pediatrician, Donna admitted the seven-year old to a major university medical center for a complete testing program against birth defects. Except for a slight coordination problem, Sharon checked out as normal in every category tested.

The judicial agencies, who were responsible for correcting the girls' "illegal" behavior, viewed them as juvenile delinquents. They followed routine and institutionalized procedures for corrective action. During the course of Susan's four periods of confinement at juvenile hall, she each time underwent rehabilitation and therapeutic procedures designated appropriate for her

individualized problem. Parents were not included in these programs. After short periods of confinement Sandy was two times released to the custody of her parents. Susan talked about her youth counseling experiences in juvenile hall:

> At first I didn't hear the message, in fact it took two months before I let it all sink in. I began to listen to them and realized what terrible things I was doing to my body, my life to my whole self -- but mostly I heard them say what terrible things I was doing to other people, most especially, my parents.

Upon returning home from her four-month confinement, Susan let her parents know that she accepted the responsibility for her deviant behavior. She was determined and positively inclined to make changes in her life. She talked about pursuing a career in nursing. While this self-flagellating approach to counseling was on the face of it a "noble" and productive approach to youth therapy, in Susan's case it widely missed the mark. Self blame and guilt, which were already part of the problem before she entered her world of drugs and runaways, now were increased to the degree that she was even further alienated from her family. Within two weeks after her return home, Susan was right back to her former behavioral patterns. To illustrate how far-removed the outside interventionists were from the reality of Susan's family life, on the night she returned home, Donna, who had been abstaining for one week, bought 3 six-packs of beer and shared them with Susan in "celebration" of her return home. The next morning, Susan related to me that while she appreciated this gesture of good will, she was distressed that her mother stayed up half the night drinking. She never expressed her feelings to her mother, she said, "because I wouldn't want to hurt her."

Of the three social agencies contacted, none had the opportunity, much less incentive, to diagnose these children's problems in the context of their

family life. Certainly routine questions were asked about their home environment; however, both Donna's and her daughters' accounts of such inquiries indicated that information obtained by this method was peripheral to the core of the Carter family problems. Add to this omission the fact that children who have always lived with alcoholism, as in the case of the Carter children, are not likely to recognize it as a significant factor affecting their troubled lives. For them, the drinking is integrated within the troubled family system to the degree that it is almost nonrecognizable to the younger participating members, and therefore not revealed in routine interviews and admitting questionnaires.

Based on my observations and experiences with the two older Carter daughters, I must suggest that the isolated instances of diagnosis and treatment by public agencies tended to do little more than increase their sense of poor self-esteem and diminished self-worth. They are in a sense caught in the classic double-bind. If they remain in their present home environment, and without competent intervention, they will continue to experience emotional disturbances; if they continue to run, and attempt survival in the street culture, they risk harm and self-destruction in multiple other ways. Unless this family has an opportunity to see and understand their own family culture in its cyclical form their present predicament will persist.

Treatment History

Over a ten-year period, and beginning with the break-up of her first marriage, Donna has periodically sought treatment for nervous tension, depression and more recently, alcoholism. Her primary source for treatment has always been her local community mental health center.

Her first and much earlier treatment experiences included one three-week stay in a hospital psychiatric division after an apparent suicide attempt,

and after that, six months of follow-up therapy with a psychiatric social worker. Donna remembers that these sessions, which took place during her pregnancy and continuing on after the birth of Sandy, were unpleasant and counter-productive. She commented on that experience.

> After I made an attempt on my life and when I got out of the hospital, I started seeing this psychiatric social worker at a community mental health center. He told me I was a dangerous person capable of physically hurting myself and my children and that I should commit myself to a mental institution. He threatened that if I didn't, somebody else would. Well for some time after that I was a wreck, because I believed what he told me. Finally I got up the nerve to tell my doctor about this and he actually saved my life. He said no one could just commit me to a mental institution, and that I didn't need to be in one. I think that this was a trick -- a scare tactic that the therapist used on me. I remember he used to do other things like pull his chair up really close to see what I would do and then put his face very close to mine to see if I would break under the pressure -- and of course I did. Now I know that his tactics were strange, but at the time, I was so young and naive, I thought that's what all therapists did.

After her marriage to Steve and when she first became concerned about her drinking, Donna contacted her community based alcohol treatment center for help. Upon their recommendation, she and Steve joined a couples therapy group at the center. Steve disliked this treatment method, but continued to attend sessions for several months in deference to Donna's needs and wishes. He said:

> I actually hated those sessions. It was my weekly bad experience. I didn't particularly like the people in our group and I resented having to listen week after week to somebody else drone on and on about their own little petty problems. I wanted to talk about our problems -- I mean about drinking problems. But the subject of drinking was never talked about.

Three years after the onset of her drinking problem, Donna sustained nine months of abstinence through the use of antabuse and while regularly

attending individual and group (women only) counseling sessions at this same alcohol treatment center. Their treatment "tactic," she stated, centered on increasing her sense of self-esteem. She said:

> I had been so wrapped up in Susan's problems and my problems that I forgot about myself. They kept encouraging me to take pains with my looks, my hair, my makeup and my clothes. And it worked for awhile; everyone, especially Steve, was thrilled with the new me. He said I was a totally different person when I didn't drink -- my body, my face, my personality -- everything. It was quite an ego trip for me.

Throughout these nine months and especially during periods of heightened tension or depression, Donna visited the center more frequently, sometimes five days a week. She would attend anything that was available, group session, private sessions, or sometimes brief conversations with her therapist between her scheduled appointments. While the self-improvement tactic and frequent therapeutic contact helped to improve her immediate and personal condition, it did not touch upon the pre-set regulatory conditions of her family life. Her account of the events leading to her return to heavy drinking implicitly but poignantly explain how the scales were tipped away from the personal and towards the family involvement with her alcoholism.

March 5, 1979 **(Excerpts From Field Notes)**

> Continuing Conversation: "Donna, getting back to when you stopped drinking for almost a year, how were things then with you and your daughters -- or with your family life?"
>
> Well, the main thing I can remember, I was able to cope with just about anything that came my way. And that's when the biggest part of Susan's problems were going on like being picked up by the police. And we'd get calls in the middle of the night of different things going on, probation officers and stuff. And I was able -- if I had to get up in the middle of the night I could go down there and talk sensibly to them and I would point out to Steve that there was a time when we wouldn't have been able to drive down there to see about anything much less

even answer the phone, we'd have been so zonked with drinking. That part made me feel so good. At least I was trying to be more understanding of both Susan and Sandy.

But Steve was still drinking then; did he encourage you to drink with him?

No, No, he really wouldn't have wanted me to. He'd always ask, 'does it bother you?' And I said not a bit. I used to buy his beer for him, and it didn't bother me. I remember we went to this New Year's Party, and I drank Dr. Pepper all night and watched everybody get drunk. And the next day I didn't have a hangover. I couldn't believe it.

Why did you start drinking again Donna?

Well, I almost made it a year, and it was just a super ego trip for me. I was so smug, so pleased with myself. This plus Steve's positive comments about how good I looked kept me going. Then I'd get depressed. Something would happen with Susan at school, or she'd run away or o.d. on drugs and things got really bad around our house. Steve would go crazy. Then I'd run right over to the treatment center and the people there would boost my ego up again.

They gave you the support you needed?

Yes, but then things got really bad. We started having relatives visiting and it was summer, and while they were there, Susan got beaten up by that creep that she goes around with. We had to take her to the hospital to get her head stitched up. And Sandy was just beginning to smoke and she was so boy-crazy. And just, it all just hit me at a vulnerable time or something. Too much. I thought, well, I'm going to try just a few beers to calm me down. It was hot too. And I kept telling myself. Now watch it, if you can just make it through this summer and meet all these little tests, you can make it forever. And I didn't make it.

Immediately following her return to drinking, and in hopes that a change would benefit the whole family situation, the Carter's moved to their present neighborhood. At the new community alcohol treatment center, where Donna again sought treatment for alcoholism, a consulting psychiatrist diagnosed her

as manic-depressive. Donna stated that this psychiatrist suggested her manic-depressive syndrome was hereditary. Based on her remarks about other family members, he said her grandmother, mother and daughters were also manic-depressives.

At this same center, Donna has for most of the nine months since the move, sought individual therapy. Thus far, and after fifteen consecutive sessions with the same therapist, she learned two important things about herself and her alcoholism. She said:

> Joan (name of therapist) has encouraged me to be more open about my drinking problem. I'm trying to treat it as a health problem and stop thinking of myself as an immoral person. Also, I've learned that I'm not wierd or always wrong. Joan actually listens to me without judging me or all those shoulds -- you should have done this, you shouldn't have done that -- I think I'm begnning to see some answers with her.

On the advice of this same therapist, Steve and Donna began joint therapy sessions. When I met them they had attended only a few sessions with Joan, Donna's therapist and they both agreed the results were positive. When Steve's transfer came through, he dropped treatment for the reason, he stated that he was "too busy planning the move and couldn't spare the time." He promised to start therapy again after they were relocated.

The Carter family has never attended a therapy session as a group. One reason for this omission in their treatment procedures is that their community alcohol treatment center does not offer total family therapy. Although some individual therapists who were treating clients for alcohol problems brought in whole families for sessions, this was the exception rather than the rule. Throughout the five years that Donna has been regularly seeking treatment, no mental health professional or for that matter anyone from the

school or judicial agencies, has as yet, requested a visit to the Carter family home.

CHAPTER 6: PROFILES OF FIVE REMAINING FAMILIES

In the preceding chapters, I have presented in-depth description and analysis of three of the family case studies. Now I want to share in profile form the experiences of the other five families as I observed them over the research period. The following brief sketches are preliminary to the final discussion of the model and concluding observations.

FAMILY D

Husband and wife in Family D have been married two years; second marriage for both. They have four children, ages 12, 10, 9 and 7, three from her first marriage and one from his. Their income, neighborhood and economic and social lifestyle are upper middle class. Husband is a manager-engineer and wife is a housewife. They own their large and thoughtfully decorated ranch-style home.

Mother: Age 34, Mormon religious upbringing, English-Irish descent, some college. Attractive, well-groomed, former model and high school homecoming queen. Conscientious and affectionate mother, creative cook, fastidious housekeeper. Stated she dislikes social gatherings due to feelings of low self-esteem and feelings of "social inadequacies." Relationship with husband is sometimes good, at other times antagonistic and tense. She is often placating in his presence, then later harbors feelings of anger and resentment. Heavy drinking pattern began in first marriage; accelerated during period of divorce and remarriage. Based on diagnosis of alcohol-related symptoms — hepatitis and pancreatitis -- wife accepts condition as "alcoholism"; husband does not. Though he is willing to support her treatment efforts in terms of time and money, he believes it is "her problem" and is not interesteed in co-therapy or support groups, etc. On weekends and every evening he drinks beer, and always has wine with dinner — in her presence.

Circumstances of drinking patterns and behavior extend back to first marriage. First husband (introduced to researcher) is handsome, dominating, first generation Greek-immigrant. Wife was reluctantly co-opted into his large, extended family for frequent and volatile family gatherings which were not to her liking. Heavy drinking took place at these and all other social and ritual gatherings. Relationship with first husband was platonic; sexual activity, after the first few years, was limited to two or three times a year. Husband (according to informant) was dominating to the degree that he told her what clothes to wear, gave daily instructions on household and child care and arranged all social activities. This 11-year marriage ended when she met and fell in love with a neighbor and

widower, her present husband. Guilt and shame over circumstances surrounding her divorce and remarriage contributed to the acceleration of heavy drinking patterns. Religious upbringing taught that "marriage institution is sacred and eternal." Parents verbalized concern over her "immoral" comportment in relation to drinking patterns and divorce.

Father: Age 38, Protestant (Congregational) religious upbringing, mixed European ethnic descent, post-graduate education, successful career in engineering management. Intelligent, good conversationalist, friendly, and by his own admittance, a loner. Dislikes neighborhood or work-related social events; prefers weekend camping and fishing trips with family. Stated he is still struggling with change from one child to four, with transition of wife who suffered lingering death with cancer to wife who is suffering with drinking problem, with the new relationship and marriage. Does not share wife's guilt over their secret courtship or the dissolution of her marriage; stated she was in a "bad marriage and unhappy." Strict disciplinarian with children, but relationship there is stable and relatively free of undue tension. Tolerates wife's drinking -- but adamant in his belief that it is her choice to drink or not -- and therefore it is her choice to continue or stop. Makes little or no effort to control his own drinking habits, to keep liquor out of the house or to participate in her treatment efforts. From his perception, alcoholism is a personal problem, and not in the realm of illness or disease related health problems.

Children: Son, age 12 (hers); natural ability for music and sports. Studies piano. Confused over events of last two years -- spends much time with father. Average student, enjoys several stable peer group friendships. Outgoing like his father. Personality clash with stepfather promotes a distant, but tolerable relationship. Protective of his mother. Mother and teachers claim he lacks motivation and is emotionally unstable.

Daughter, age 10 (hers); appears to enjoy whatever she is doing -- but does nothing well. Beginnings of academic/learning problems at school; inability to concentrate or carry through with projects and learning procedures. Overeacts to slightest irritating or disagreeable stimulus. Often sullen, weepy, tense, withdrawn. Spends long hours in her room alone, reading or sleeping.

Daughter, age 9 (his); strives to be personable, agreeable and amenable to everyone. Good rapport with stepmother and new siblings. Enjoys special relationship with her father. Talented in jazz and tap dance. A high achiever -- perfectionist.

Son, age 7 (hers); average, exploring child. Minor learning problems in school.

Drinking and Treatment History

Identified Problem Drinker has been heavy social drinker for ten years, and an alcoholic for three years. A daily drinker, she usually consumes 32

ounces of vodka a day, beginning early in the morning with vodka and orange juice, then vodka and other mixtures throughout the day. Sometimes she drinks coffee with brandy for breakfast, vodka in the afternoon, wine in the evening. Husband is not aware of the exact amount she daily consumes; he was upset by her slurred speech at dinner table and early bedtime ritual. Housework, laundry, social telephoning, appointments, shopping and planning of evening meal are all accomplished before noon, and prior to her afternoon nap or diminished role performance of late afternoon. Drinks to reduce tension and ongoing "uptight" feelings; also, she stated, to relieve guilt and feelings of remorse over dissolution of her first marriage. No drinking history in her family. Parents were light social drinkers. Both first and present husbands were heavy social drinkers, but neither had a drinking problem.

Treatment resources included her personal physician (who prescribed Valium), a hospital for treatment and rehabilitation of alcoholics (she completed 30-day treatment program), follow-up group therapy with counselor and from patients from the treatment hospital, six sessions with a psychiatrist, Alcoholics Anonymous, and the community mental health center from which was recruited for this study. She also attended courses on alcoholism at a nearby commmunity college in her search for guidance on how to stop drinking. During the course of this research, the mother successfully began abstaining from alcohol. This was after the one-month stay at the hospital, group therapy, individual therapy at the community center and two Alcoholics Anonymous meetings a week. Her husband refused her requests for his participation in couples sessions at the hospital, joint therapy at the community center or Al-Anon (a support group for spouses of alcoholics). He advised the children against mentioning their mother's "problem" at school or in the neighborhood. He was reluctant to converse with his wife on her treatment experiences, A.A. meetings or the issue of the children's confusion over their mother's frequent absences and "problem." As she became stronger, she openly challenged him on this issue; finally and against his wishes, explaining to the children about the nature of alcoholism. She used the disease concept as a model of explanation.

Comments

In this case, the development and maintenance of the early stages of the alcoholism clearly occurred during the first marriage. Unresolved and culturally-related differences of husband and wife (Idaho Mormon and first generation Greek), sexual incompatibility and an explicitly manifested dominant-submissive relationship, were all contributing factors which supported the mother's first seven years of heavy drinking patterns. When the marital changes occurred, and in the face of culturally based guilt and shame, the mother "naturally" used alcohol as an emotional lubricant. Her second husband's willful ignoring of her changing drinking patterns (she began drinking more and on a daily routine) and later on "hands off" attitude towards her efforts to get help set the stage for another dominant-submissive role set-up. Her efforts to maintain "super mom" image while struggling with value conflicts in her most intimate relationship, the moralizing comments of her parents, a new family and the condition of alcoholism -- all converged into a "nervous breakdown," and the maintenance of the drinking problem. Through the efforts of a concerned neighbor and multiple treatment resources, she was able to stop drinking on her own. Hopefully, and if her husband eventually accedes to family therapy/intervention, this family will attain a system which more securely and predictably supports her effort to **not** drink.

FAMILY E

Husband and wife of family E have been married 22 years. They have no children. Their income, neighborhood and social lifestyle are upper middle class. Husband is a stock broker; wife is an elementary school teacher. This is the only family in the study without children.

Wife: Age 46; Methodist religious upbringing, German-Scotch descent, post graduate education. Attractive, sophisticated, soft-spoken with genteel mannerisms. Enjoyed compatible relationship with husband up until 4 years ago, when she began an intimate relationship with a long-time coworker and close friend. Has separated from husband twice during the past two years over the triangle love-marriage relationship. She is sexually "faithful" to her friend-lover; has not had sexual relationships with husband for 2 years; they occupy separate bedrooms. States she loves her husband for reasons of intellectual, social and religious compatibility. Both are practicing members of the Methodist religion; entertain lavishly with parties for 150 to 200 people, and share like interests in art, literature and the performing arts. States her deeper emotional attachment is with her lover. Over a period of four years, she has maintained the triangle by means of deceit, ongoing rescheduling of her daily and weekend routines, withdrawing from and later reinstating one or the other of the relationships. She has twice been requested to take sick leave-of-absence from her teaching duties due to diminished ability and alcohol-related illnesses. Another reason for staying in marriage is related to economic need. This couple built their "dream house," and without both incomes, it cannot be maintained or afforded. Neither is willing to give it up.

Husband: Age 55; Methodist-German background, college degree, successful career experiences. Handsome, energetic, poised, commanding but warm personality, stimulating and attentive conversationalist; sportsman, student of the fine arts. Enigma in this case; why did he stay in the marriage. He stated he did so because both he and his wife believed in the "sanctity of their marriage vows" and that they had been socialized against divorce. Also, by what this researcher observed, he is devoted to his wife to the degree that he can tolerate what appears to be demeaning and demasculating behavior. He is a daily social drinker; on occasion drinks heavily, but that is the exception. Other than occasional weekend golf and tennis tournaments, and rare late evening business appointments, he spends most of his free time at home, gardening, swimming and up to two years ago, frequent entertaining of friends and neighbors. When his wife is ill or suffering from hangovers, he nurses her back to health; often invents excuses for her absence from work; never questions or derides her about her excessive drinking patterns. Dominating feature of their house is a large leather bar, which he always keeps stocked with various kinds of alcoholic beverages. Even after her first stay in an alcoholic hospital, he still shared evening cocktails with her, and served alcoholic beverages at parties and, in fact, at all social occasions.

Drinking and Treatment History

This woman has been a problem drinker for ten years. At the first sign of developing symptoms of alcoholism -- nervous shaking and dry heaves in the morning she contacted her physician. He prescribed Lithium, and she has taken this off and on for ten years. She first drank for pleasure; daytime drinking pattern started to escalate when she moved into an administrative position where lunch time drinking was the norm. After work drinking steadily increased until she reached a daily consumption of 16 to 24 ounces of vodka. Her pattern was to drink for several months to a year without a period of abstinence; when pressure from superiors over competence, quality of work increased, she went through slacking off period and abstained from one to three months. Her decision to start drinking again -- in all cases -- was in the context of a social activity with husband, usually in the home. Two sisters -- both who live in the Eastern United States -- are alcoholics.

Twice in the past two years she has admitted herself to an alcoholic treatment hospital for one-month period of detoxification and rehabilitation. Her lover also has a drinking problem, and he often visited her during these periods. Over the past year, she has been attending A.A. meetings frequently; during the study period, she attended seven days a week. Her lover was also a member of A.A. She participated in follow-up group therapy with a counselor and other patients from the treatment hospital. She and her husband were invited to attend group couples therapy at the hospital; she declined, for fear of loss of face if her personal situation were disclosed to fellow patients. Second hospital stay occurred during the study; 9 months later, when study period ended, wife in Family E had returned to her daily drinking pattern.

Comments

In this case, the drinking cycle and maintenance of the alcoholism is so obviously integrated into this family system -- and the love triangle -- that it is difficult to believe that the members involved did not see the connection. The husband, the lover and the wife all three seemed to be skirting the issue of her alcoholism. The love triangle became a more identifiable and "bigger" problem than the drinking to the degree that it took precedence and for the most part, diminished attention on the drinking behavior. Circular behavior supporting the problem can be found in a personal needs assessment. Husband and wife have opted to maintain a marriage for reasons of shared and traditional beliefs, values and complementary interests. Also for economic and social necessity. From the husband's perspective, it was a "perfect" marriage before the love affair began, and can be again. Meanwhile, he is willing to live in the relationship without only one component -- a sexual relationship. He believes this will eventually be reinstated. Her drinking problem supports his "need" in that it keeps her dependent upon him for care and financial security, thereby diminishing incentive for divorce. The wife uses alcohol as a lubricant for her guilt, tension and perhaps self-punishment. For emotional support she turns to her lover, and is firmly entrenched in that need. The lover, himself a recovering alcoholic, devotes time and energy to escorting her to A.A. meetings (7 nights a week -- they meet secretly). He enjoys her emotional dependency. She offers him a greater purpose than drinking -- and in light of her attractiveness and higher economic and social status, a sense of dignity, propriety and stability. (His marriage dissolved and job status was diminished when he was a problem drinker.) This stormy triangle has endured for four

years, and through trial and error has emerged as a stable, homeostatic system in its own right. Without intervention the system -- and the alcoholism -- will most probably endure for four more years.

FAMILY F

Husband and wife in Family F have been married 24 years and they have three children, ages 23, 21 and 12. They own their home which is located on a pleasant, shaded street in a middle class neighborhood. Husband is a salesman for a heavy construction equipment manufacturer, and the wife works weekends as an electronic assembly inspector. During the week, she works in the role of housewife.

Mother: Age 55, Presbyterian religious background, Canadian-English descent, high school education. Pleasant, matronly appearance, of good humor and with matter-of-fact, accepting approach to life. When drinking, she becomes whiny, aggressive and nagging. She is particularly affectionate and doting on her 12 year old daughter. She speaks fondly of her sons, and of their years spent at home. But she recalls the family as a whole was not a happy environment. Has embittered relationship with husband; they argue and bicker almost daily. No sexual relationship with husband. Never considers divorce (she stated) for financial reasons. Feels great sorrow, remorse and guilt over the loss of her sons. Both have for all practical purposes rejected their parents and have little or no contact with them.

Father: Age 52, New England-Methodist upbringing, some college, career salesman; some business travel. Rigid, conservative personality; appears to be the dominating member of this marital dyad. He shows affection and focused attention on daughter; admits he was rigid and controlling of his sons; feels no remorse over their rejection of family. He does not recognize wife's "problem" as serious, refers to it as "an irritating response to a few too many drinks." A heavy drinker, but rarely drinks to the point of drunkenness. He takes over care of daughter when wife is drinking, but does no cooking or housework or shopping for food.

Children: Son, age 23, left home at age 21; has no contact with family; has "disowned" himself from all family ties. A brilliant, high achieving student in high school; an excellent performing musician; dropped out of college, resisted any organizational activities and most sports; now lives with girlfriend in a neighboring community. Emotionally unstable; unsuccessful at maintaining friendships (with males) in late teenage and early adult life.

Son, age 21; good student, dropped out of college, has high-paying job as programmer with electronics firm; lives with girlfriend; has only formal, obligatory contact with parents. Harbors resentments for the years of unhappiness, fighting, frustrating lifestyle of his teenage years. Feels some guilt for "abandoning" his young sister. Frequently ill with flu, colds and sinusitis.

Daughter, educated in expensive private school at great financial strain of parents (mother works on weekends to help pay the tuition). Good student, athletic. Friends not permitted to visit in the home; spends free time playing with much younger children on neighborhood street. A quiet, pensive, accepting personality. Has abnormal fear of entering high school; wants to attend a small, private school. Good rapport with both parents; sadness at loss of brothers; spends weekends and most nights alone, at home (mother at bar -- father working).

Drinking and Treatment History

Onset of problem at age 49; problem drinker for past six years. Drinks gin or brandy; diagnosed as "binge" drinker; when in drinking period, drinks daily and usually in a neighborhood bar, consumes up to 15 drinks in one "sitting." On weekends, if not working, drinks with husband at home or in bar. Non-drinking periods last from one to three months. Drinks to relieve tension, resentments, sexual frustration. Prefers bars for reasons of social conviviality. Husband often joins her in evenings for first few drinks, then returns home without her. This woman has been in three serious automobile accidents; hospitalized with serious injuries after two of them (and after she had been drinking). Aggressiveness always accompanies drinking; depression is most notable symptom of hangover periods. Controls or stops drinking altogether in preparation for "special events."

Once admitted self to a detoxification center (privately owned); for past two years has been seeking ongoing treatment from community mental health center (alcohol division), where she has periodic sessions with a consulting psychiatrist and regular, weekly sessions with a therapist. Husband attended two sessions of joint-therapy, then refused to participate in treatment. Children have never participated in therapy -- and at the time of the study, had not been urged by either treatment personnel or parents, to do so. One year after this field study, the mother entered Alcoholics Anonymous and through this support group, has maintained sobriety. However, she spends seven nights a week at the A.A. meetings; situation at home has not changed.

Comments

In this case, the mother began drinking heavily as a means of coping with the reality of her life. For years, prior to the drinking, the family life and all major decisions revolved around the husband. He enforced rigid schedules for all family members, directed the routine of family life, and used strict and physically disciplinary tactics, all of which produced fear, tension and unhappiness in the wife and children alike. He regularly beat the children for normal childhood behavior, such as soiling their clothes, spilling their milk, wandering too far from the family home. When the mother recognized or admitted what was happening, it was too late; the children were already (according to her) emotionally disturbed. When she failed to change her husband's beliefs and methods for child rearing, she used alcohol as a relief valve for pressure and tension. When her drinking and role breakdown failed to budge him, she started drinking in bars, both for reasons of social conviviality and to "punish" him.

It appears that the husband has not moved from his position as supreme authority figure, though one son has threatened to kill him and left home in a rage, another refuses to speak to him and rarely visits the family, and the wife has become an alcoholic. It also appears that he tolerates the drinking in lieu of changing his position, or even negotiating on it. The mother drinks at a bar, so he does not have to witness the drinking, and she comes home late at night after he and the daughter have retired for the night. He shows little or no emotion towards his wife -- although they are friendly when she is not drinking and he has refused to have sexual intercourse with her for 10 years. Perhaps, the drinking is supportive of some other covert relationships in his life. However on the face of it, he seems to be punishing her for her resistance to his set beliefs and mode of behavior -- and drinking is one part of that punishment procedure. Her discomfort with alcohol seems to please him. He remains, to the end, definitely the power figure in the family.

FAMILY G

Husband and wife in Family G have been married three years. It is the third marriage for both, and they each have three children. Two of the children live at home. Income, neighborhood and economic and social conditions are upper middle class. Husband is self employed; wife stays at home as housewife. They own their home business.

Mother: Age 40, Episcopal religious upbringing, English-German descent, some college. Attractive woman, dresses in high fashion. No outward signs of physical effects of alcoholism. Softspoken and noticeably feminine in her mannerisms, dress and general comportment. Considers herself a good mother and wife -- however has had problems adjusting to husband's daughters (one lives with them). Present husband was her high school sweetheart. Except for drinking problem, they are compatible. Have "fair" sexual relationship; both are intellectually stimulating, physically attractive, share an appreciation for the fine arts. Their home reflects their love of books, music and valuable art. Husband stated he drinks too much, but can "control it at will."

This woman had a "nervous breakdown" after her first marriage, and went into psychoanalysis after second marriage broke up. Both husbands (1st and 2nd) were verbally and sometimes physically abusive. Second husband, a physician, was aware of her drinking problem, but never encouraged her to get treatment. Her heavy drinking pattern emerged in the second marriage (which lasted 11 years). Feelings of inadequacy in his presence (she stated) and uncomfortableness with his social circle were precipitating factors to the alcoholism. She drank for release of tension and in social situations, for courage to last out an evening. This husband adopted her two children, and they had a third -- a son -- together. He often beat her children with a strap; this and other violent, physically abusive behavioral patterns led to the divorce. This husband suffered a "nervous breakdown" after the divorce -- still believes she will reinstate their relationship; visits the son three times a week or more.

Father: Age 40, Episcopal religious upbringing, English-German descent, college graduate, extensively travelled, inherited family wealth. An intelligent, sophisticated and articulate man; when not drinking is loving and concerned husband and father. Wants to stay in this marriage, but often threatens to leave if drinking patterns continue. Once during the wife's drinking period he filed for divorce. In response and on the promise that he would withdraw the action, she entered a month-long program at a hospital for treatment of alcoholics. Husband drinks frequently, with friends and/or employees in bars. Often returns home late -- after midnight.

Children: Daughter (hers) age 21, married, on good terms with mother. Son (hers) age 19; in college, very close to mother -- calls her two or three times a week. Protective and concerned about her drinking problem. Son (hers) age 14; has several learning problems; enrolled in private school for educationally handicapped. A sensitive, loving child. Mother is exceptionally fond of this child -- feels sense of responsibility and guilt about his handicap.

Daughter (his) age 18; displays possessive behavior towards her father. Arrogant and brusque in presence of stepmother. This girl has manipulative power. Vicariously instigates conflict between her father and stepmother. Heavier drinking periods often follow visits from this daughter.

Son (his) age 16; know little about him; visits often, but lives with his mother.

Daughter (his) age 7; was emotionally disturbed and under psychiatric care when they were married. Her mother was psychoticc and physically abused her. Mother in G family feels she has helped this child, and draws great satisfaction in the child's improving condition since she has taken charge of her. Much tension and manipulative behavior between husband and wife around the care and needs of this child.

Drinking and Treatment History

The mother in family G has had a serious of drinking problems for eleven years. In the past five years, she has maintained short periods of abstinence -- once for a two-month period. Drinks daily, would not reveal how much she consumes. Is often incapacitated when husband arrives home in evenings. Had embarrassed both husbands with her drinking in social situation. Sensitive about this issue, she often withdraws from their active social live for a short period of time after an embarrassing incident. When she and husband drink together, they engage in verbal insults and sometimes physical or abusive behavior. Both of her parents have recently become concerned about her drinking behavior -- a fact that is distressing to her.

This woman has been seeing a psychiatrist weekly, sometimes twice weekly visits, for eleven years. She has been hospitalized for hysteria, and extreme hyperventilation. She has taken valium for "as long as she can remember." During the month-long stay at alcohol treatment hospital, she tried Alcoholics Anonymous (and disliked it), individual and joint therapy. Her

husband went to two joint therapy sessions, then discontinued them. She declined to enter the follow-up sessions. She complained that the food, accommodations, treatment procedures and quality of therapy were "mediocre." After this treatment procedure, both she and her husband stopped drinking; when I terminated our research relationship, they both were still abstaining; as a diversion, they devoted their energies to redecorating their home and planning trips.

Comments

The seeds of the mother's drinking problem were planted in the first marriage. She coped with a highly structured and restrictive environment as imposed by her surgeon-husband by drinking. She was intimidated by him intellectually, socially and to some degree physically. She was particularly distressed by his physically abusing disciplinary action with her children and uncomfortable with their social circle. Husband was frequently absent from home; often slept at hospital. The fact he, as a physician, never moved to help his wife with her drinking problem is a strong indicator that the drinking behavior complemented, at least to some degree, his personal problems and needs. The same pattern emerged in the present marriage. Husband spent long hours away from home, at work or in a bar; in this case, perhaps as a withdrawal-coping mechanism. Principal manipulators of power include the mother herself, the father, and his adult daughter. Daughter flirts with father, alienates stepmother, father and mother argue, mother drinks in retaliation. Father sometimes drinks to get drunk, often, he states, in retaliaton to her drinking. Again arguments and fighting ensue, they show great remorse next day; wife refrains from drinking for several days. Then pattern repeats itself in some form and in response to various family-based stimuli. A complex and difficult-to-analyze family system.

FAMILY H

Husband and wife in family H have been married 5 years. It is the second marriage for both, and each has one child by their first marriage. They own their home and live in a comfortable middle class neighborhood. Husband is county fire marshall and wife supplements income by the care of two foster, retarded children.

Mother: Age 35, Episcopal religious upbringing, English-Welsh descent, some college. Attractive, well-groomed, intelligent, affectionate and caring mother, good cook and housewife; enjoys her role as wife and mother. Only wife's daughter lives with family; before the onset of the study, and due to the increasing seriousness of the mother's drinking problem, the two foster sons were returned to an institutional environment. The mother was emotionally attached to these children, and expressed sadness and remorse over their leaving. The mother-daughter dyad is loving and relaxed when they are alone, but in presence of father, the mother becomes tense and highly critical of both husband's and daughter's opinions, behavioral movements and manner of expressing themselves. She operates with a high level of control over the family unit. Insists on controlling

input even to mundane decision-making as for example when and how her husband should walk the dog.

Contends that she loves her husband, and desperately wants to solve problems related to their relationship and her drinking. However, here again, there is a sexual dysfunction -- she does not enjoy it, but was open to joint therapy on the problem. Husband declined such therapy for the present -- primarily because he was embarrassed. Primary problem in family -- other than drinking -- is finances. She took on the care of foster children to meet payments on expensive truck-camper, speed boat and new family car. She worked her drinking patterns around the care of the children, until on the advice of a therapist she discontinued this stressful practice. Her husband was reluctant to let the children go for reasons of financial need.

Father: Age 40, Baptist religious upbringing, Irish-American Indian descent, some college. Handsome, muscular, intelligent, kind and pleasant personality. Expressed ongoing concern about national and world affairs. Considers wife far above himself both socially and intellectually. Describes her as "the classiest lady I've ever known." Wife uses this to her advantage, manipulates him by interacting in this mode when it is convenient for her needs. He enjoys verbalizing his opinions on economic and political issues; wife manifests embarrassment over his comments -- in presence of researcher, tried to divert subject matter away from his interests. Husband likes his job as fire marshall, enjoys his home, his recreational activities of fishing and boating. He tries to discipline step-daughter; wife always interferes with his fathering role.

Children: Daughter age 12. Struggling with school work, has several peer-group friendships; is frightened of her mother's drinking problem. She often searches for liquor supply, and when it is discovered, pours the alcohol out; threatened suicide three times since age 8; once tried to drink clorox; another time mother discovered a "hanging" apparatus in daughter's clothes closet. Daughter is under a high element of control from mother who is determined to "raise her right" in the face of an admitted drinking problem.

Drinking and Treatment History

Onset of problem at age 29, has had drinking problem for 6 years. Drinks vodka at home, scotch socially. When in her drinking period, drinks up to a fifth of vodka a day. Her pattern is to have two drinks in the morning before breakfast, two more in late morning, then abstain until children return home from school and are reasonably settled she drinks again in late afternoon and is unconscious by 8 p.m.

Precipating factor to drinking problem was a hysterectomy and feelings of inadequacies in her first marriage. Now she drinks to maintain a tolerable level of stress. When she drinks, she becomes aggressive, argumentative with husband. During her non-drinking periods (two weeks on, two weeks off) she enjoys social activities with her husband, and often accompanies him for boating and fishing trips.

This woman first talked to her internist-physician about her nervous problem. Although she was by then drinking a fifth of alcohol a day, and she strongly hinted that she had a drinking problem, he never questioned her about her drinking habits. During her fifth year of problem drinking she admitted herself to an alcohol treatment hospital. She phoned her father for financial assistance (the cost was $6,000) and he paid the bill. Her mother is an alcoholic. Husband drinks socially, but does not have a drinking problem. He does not view her problem as "alcoholism"; he has asked her to "consider" drinking less -- he is not aware of how much she daily consumes, only that she is frequently asleep or aggressive towards him when he returns home from work. Husband did not participate in couples therapy at the hopsital or any form of treatment. At the close of the study period, the mother had maintained abstinence for a one-month period, with the support of group therapy (at the treatment hospital) and bi-weekly A.A. meetings.

Comments

The drinking is to some degree related to the stress level in this household. This woman appears to be a high-strung perfectionist. When caring for the the two severely retarded boys, she pushed herself beyond her energy and tension-tolerance level. She stated she did this to prove herself a "worthwhile" person. The family had adjusted their debt level to her added income, so she was obliged to keep the boys in the face of tension and alcoholism. Also, with the lack of sexual compatibility, it is probable that she drinks to avoid sexual relations with her husband. Another factor is her apparent need to be the controlling person in the household; when the tension around the control element reaches the dangerous point (in terms of her threatening her marriage) she drinks. In this sense, the drinking supports family stability by relieving tension around her efforts to be the dominant, controlling family member. The daughter resists mother's drinking overtly by destroying her alcohol supply but never verbalizes her feelings about the drinking situation. She covertly resists it -- if one can call suicide threats "covert." This daughter appears to be in great need of therapeutic help; unless whole family intervention occurs in the near future, the situation will certainly worsen.

CHAPTER 7: A FAMILY-LEVEL CULTURAL MODEL OF ALCOHOLISM

In the preceding chapters, I have presented a rather grim and sometimes deleterious portrait of alcoholic family life. This is not to say that **all** families with an identified problem drinker are equally troubled, or that non-alcoholic families do not have similar problems. However, the complex and troubled nature of this sample of middle class Protestant families emerged as a significant and repetitive fact of life. Among all of the eight families, I found commonalities in behavioral responses to maternal drinking behavior. I have introduced a three-level theoretical framework for the purpose of analyzing these commonalities. This framework, which I have conceived as "A Family-Level Cultural Model of Alcoholism," examines alcoholism in terms of the sociocultural context in which it occurs and as part of an ongoing interactional pattern within the family system.

Essentially, the purpose of this model is to call attention to the fact that families who are afflicted with chronic alcoholism must confront three major problems. The first problem is to protect the family from being ostracized from society; the second is to keep the family organization functioning at a level which insures its members an adequate chance for survival; and the third is to incorporate the drinking behavior as a homeostatic mechanism which supports family stability. I am proposing that all alcoholic families must work out solutions to these three problems in the face of the breakdown of maternal role behavior. This study offers a naturalistic, (in the home) view of the interactional processes by which families meet this challenge. In my observations, I found that families work out different kinds of solutions to these problems, but the underlying tasks remain the same. It can be said that the only invariant factor of this proposed model is that there are at least

three major levels of analysis for alcoholism and family life, and that repetitive and reoccuring evidence supporting these levels was a constant among all eight families of this study.

It is important to emphasize that this proposed model is **not** aimed at establishing alcoholic family "types" identifiable in terms of identical behavioral patterns as determined by designated ethnic, religious or socioeconomic backgrounds. As was clearly demonstrated in the case studies, although all came from similar cultural backgrounds, each family displayed structural and behavioral idiosyncracies. However, as commonalities of an analytical nature do exist, I suggest that the proposed model is useful for understanding alcoholism and family dynamics not **only** in the context of middle class Protestant culture, but in various other kinds of sociocultural environments as well. I further suggest that these same sets of problems may exist for families experiencing other kinds of chronic or stigmatizing illnesses. This perspective hopefully will provide clinicians and researchers with an analytical framework for the examination of alcoholism or other kinds of illnesses within the context of family life.

LEVEL I: Cultural Patterning and Alcoholic Family Behavior

In recent years research and intervention with alcoholic families has focused primarily on the interaction between family and the problem drinker. This study proposes that it is equally important to consider the interaction between the family and the broader cultural environment. Whereas alcoholism in American society is generally perceived as a "stigmatizing" health problem, and whereas the illness related behavior, again by prescription of the culture at large, is generally recognized as unacceptable or deviant behavior, it would seem imperative that any attempt to help alcoholic families must first of all consider the impact of cultural pressures on behavioral responses to alcoholism. The first level of this model addresses these problems by explaining ways in which alcoholic families adapt to their external ecological dilemma. The focus of investigation is on family structure and behavior as related to exterior factors such as cultural norms, beliefs and values and in terms of family interaction with other supporting social organizations such as church, school, workplace and health-seeking resources.

The line of evidence which I have presented in support of this first level came from a historical review of American beliefs about alcoholism (Chapter 2) and from my own observations of interactional behavior in the homes of alcoholic families In seeking to understand why and how alcoholic families must struggle against the stigmatizing effects of alcohoism, I addressed the following questions: 1) What is the nature of this chronic illness in terms of both scientific definitions and cultural beliefs? 2) Why are alcoholism and excessive drinking patterns considered a stigmatizing condition among families from middle class Protestant backgrounds? 3) Why did this group of otherwise normal and caring families allow concerns for the safety and health of the mother to be overruled by cultural pressures to conformity? and 4) How did

these families keep up a front for culturally prescribed notions of normality when one family member, the mother, repeatedly behaved in a "culturally deviant" manner? I will address these problems in the logical order in which they were presented.

Definitions and Beliefs about Alcoholism

In the chapter on "Alcoholism and American Culture" I discussed the ambivalent nature of "scientific" definitions for alcoholism. Over the past three decades alcoholism has been perceived from two basic and sometimes opposing definitional frameworks: the medical and sociolcultural. Whereas the former views alcoholism as a "disease" (Jellinek 1946; Gitlow 1973) with pathological, genetic and other individualistic predispositions, the latter explains it in terms of learned behavior and therefore in relation to psychosocial and broader cultural considerations (Bacon 1957; Cahalan 1970; Cahalan and Room 1974; MacAndrew and Edgerton 1969). These entrenched positions are critically important concerns of most alcohol researchers and policymakers, myself included. However, as we look beyond scientific arguments to the inclusion of real-life experiences of the people who are suffering with alcoholism, we get a different picture. When we view the experience of alcoholism in relation to deep-seated cultural and religious beliefs about alcohol and to varying emotional responses to drinking behavior, it can be said that a drinking problem presents for many people not a medical or scientific controversy, but a moral controversy.

As almost all of the participants in this study grew up in middle class Protestant culture, they -- perhaps more so than women from most other subcultures in American society -- were socialized to the immoral connotations of excessive alcohol use and alcoholism. The women alcoholics and their families accepted more or less on "faith" that alcoholic behavior is socially

and morally deviant behavior. Within their ethnoreligious tradition, "alcoholism" as a concept is equated more generally with weak-willed character than illness. As such, alcoholic becomes an unacceptable label for one's own mother, and in fact, family members (other than the mother) never referred to the drinking problem in relation to terms such as drunkenness, alcoholic, alcoholism and so forth. In their efforts to avoid these stigmatizing labels, they referred to her periodic "sickness" as a symptom of variously described nervous or physical ailments, or in relation to an ongoing stressful situation within the family.

The implications of these cultural beliefs for treatment were recognized in the preceding case studies as for example, when Molly Andrews was coerced by her family to seek help from church-related rather than medical sources, or when Joyce Barker was too embarrassed about what she perceived as a negative reaction of her physician to make return visits for treatment of advancing physiological symptoms of alcoholism and the fact that Donna Carter was seeking therapy relevant to long-standing beliefs that alcoholism was an immoral condition of her life. These and other kinds of interactions with external cultural environment (as opposed to internal familial interactions), suggest that the women of this study perceived their struggles with alcoholism more as a stigmatizing or moral problem than a chronic illness or a disease. This is an issue of conflicting beliefs about matters of health and illness in a pluralistic society. To ignore the impact of cultural beliefs on illness behavior, family responses to an illness and treatment processes would, in any case, be folly.

The History of the Stigmatizing Condition

All of these families manifested behavior which suggested an entrenched belief that alcoholism is a stigmatizing condition. As a result, they tended to deny or ignore the seriousness of the mother's illness and remain confused

on what to do about the situation. At this point of the study, I found it imperative first of all to understand the history of these entrenched beliefs about alcoholism and of the conditions by which it became a stigmatizing illness.

In this study of permanent stigmatizing conditions, Erving Goffman stated that it is particularly important to both recognize that we are socialized to notions of stigma, and to understand the historical origins of that view.

> Persons who have a particular stigma tend to have similar learning experiences regarding their plight, and similar changes in conception of self -- a similar "moral career" that is both cause and effect of commitment to a similar sequence of personal adjustments. (The natural history of a category of persons with a stigma must be clearly distinguished from the natural history of the stigma itself -- the history of the origins, spread, and decline of the capacity of an attribute to serve as a stigma in a particular society, for example divorce in upper middle class society (1963:32).

In a preceding chapter (Chapter 2), the origins and spread of the capacity for alcoholism to serve as a stigma was explained historically and in relation to the old 19th century "Protestant and Victorian culture" (Clark 1976). It was clear that the history and cultural patterns of the Temperance Era provided a context for changing the attitude about the condition of alcoholism from a normal, albeit unhealthy state of "habituation" to immoral, depraved and sometimes mentally deranged behavior. This mode of thinking of the early twentieth century persisted for many years not only among the larger American populace but also with health professionals and scientists. During that period, American "beliefs" about alcoholism centered not on health but on moral aspects of drinking behavior. Beginning in the 1940's and thereafter, behavioral and medical scientists attempted to combat the stigma and prejudice by redefining alcoholism in more "palatable" terms (Straus 1976). The so-called disease or medical model of alcoholism was an outgrowth of this movement. While it is true that negative attitudes about alcoholism have changed somewhat,

and many alcoholics are now encouraged to seek help, deeply imbedded cultural beliefs about the immoral aspects of alcoholism still persist and many people who suffer with this illness still experience loss of self-esteem and guilt to the degree that they are inhibited from seeking early treatment.

In terms of treatment, perhaps we should consider here how the knowledge of historical determinants of a particular stigmatized condition can serve practical as well as theoretical needs. Just as leprosy of Biblical times is associated with hideous disfigurement (Ablon 1981), inebriety of the Temperance era is associated with derelict and immoral behavior, or even insanity. If the "identified alcoholics" of these case studies would read the second chapter of this dissertation, they might find therapeutic benefit in the knowledge that Carrie Nation and her cohorts had more to do with the stigmatizing burden of their illness than anything they themselves have ever done or thought of doing.

The Struggle for Cultural Conformity

Why did this gorup of otherwise normal and caring families allow concerns for the health of their mother to be overruled by cultural pressures to conformity? In other words, why was it more important for families to keep up the pretense of "normal" family life than to face up to the fact and the seriousness of the mother's chronic alcoholism? To answer this question, I considered the social and cultural ecology of a middle class suburban neighborhood. I found that their behavior was adaptive and necessary to survival of a family unit in that cultural mileu.

Marshall Sahlins has pointed out that the truism that cultures are ways of life, taken in the ecological perspective, begins with the ground premise that cultures are human adaptations (1968:367). This definition stipulates that there is an ongoing interchange between people's behavior and their physical

and social environment, "perhaps continuous dialectic interchange" (Ibid). In complex, pluralistic societies like the United States, people must adapt in general to a range of socio-environmental settings; however, most comport their behavior in relation to one or another particular system of beliefs and values. These various "subcultures" as they are called, whether defined in terms of ethnicity, religion, socioeconomic class or sociopolitical ideology, maintain to some degree, specific notions of conformity. People make commitments to certain significant external conditions of life -- sometimes by choice and sometimes by imposition -- in order to maximize their life chances. A person or persons whose way of life does not reflect the expected level of conformity to a given subculture may be under what cultural ecologists refer to as "critical selection" meaning "diminished chances of survival" (Sahlins 1968). For the purposes of this study, it means diminished chances of continuance as participating, functioning and conforming members of a specific cultural environment. In other words, repeated periods of nonconformity and breakdown in appropriate role behavior, if discovered by significant others of a cultural grouping, become thresholds beyond which a given way of life as environmentally or culturally constituted cannot be maintained (Ibid).

The impending possibility of critical selection was an ongoing fact of life for the participating families of this research. Socialized in middle class conventionality and physically located in the heart of middle class suburban environments, this group (with the "expressed" exception of the father in the Barker family) placed a high value on conformity to the norms of middle class culture. These expected norms included such things as economic security, stylish clothing, attractive and congenial, non-disruptive family living (Nye and Berardo 1973). In short, conventions of middle class culture like those of any other culture, prescribed how the family members in their respective roles of

father, mother or child should perform in both private and public arenas. The ongoing reality of an alcoholic mother -- a critical contributor to group survival -- who repeatedly displayed nonconforming behavior and breakdown in role performance, and the possibility that these discrepancies would be discovered, placed these otherwise firmly imbedded middle class families under critical selection. In order to "survive" and to appear as productive, participating units within that sociocultural environment, the families were forced into certain makeshift behavioral and structural adjustments.

These adjustments to external pressures of conformity were manifested in several differing behavioral patterns. However, all of the families shared the stigma-related consequences of alcoholism to the degree that it took the form of a "family illness." In their efforts to avoid loss of self-esteem both for the mother and for all other family members, the family as a unit organized what Goffman refers to as a "protective capsule" (1963) or what Knupfer (1964) refers to as a "cultural protection" around the stigmatizing problem. This "capsule" afforded separation from the broader cultural environment and protection from outside intervention in their own adaptive way of life. Unfortunately, it also supported the continuance of the mother's drinking problem, further impaired her health and lessened the chances of successful treatment and intervention.

The last, but perhaps most important question for understanding the impact of external cultural pressures on alcoholic family dynamics addresses the problem of how families keep up the "front" for culturally prescribed notions of normality when the person most central to family activity deviates rather radically from her expected role behavior. How do they "keep the world out" of the protective and adaptive capsule of alcoholic family life? I found that the protective capsule was actualized in two simultaneous and

interdependent adaptive measures: first in the formation of a distinctive family "culture" and secondly in the maintenance of physical, social and in some cases emotional boundaries around that culture. First I will explain the concept and form of the family culture and then discuss the boundaries.

The Concept of Alcoholic Family Culture

The overall impact of external pressures on alcoholic family life force families to effect ongoing adjustments to the concomitant factors surrounding chronic alcoholism. Ablon has suggested these adjustments take on the form of a "peculiar" family culture:

> Because alcoholism affects the total family, in such households all family members may be living within a world of chaos, shame and guilt often denied and hidden to the extent possible from even close friends and relatives. A peculiar family culture is thus constructed (1979:199).

"Peculiar" family culture, if defined in terms of covert and non-normative behavior, was a constant among all of my family participants. As I have demonstrated with three families, internal situations of crises, fear, guilt, adjusted values, belief conflicts, and role reversals, were at first initiated and later intensified by external pressures of conformity. This pressure, combined with the ongoing struggle to cope with the disruptive nature of maternal alcoholism, took on the form of an ongoing charade of normalcy. Over time, that charade became a way of life. Behavioral adjustments -- though "culturally deviant" -- became the norm behind the closed boundaries of the family home. To the degree that these adjustments were learned, shared and transmitted among all of the family members, it became in effect, the family culture. The concept of a "pathological" family culture is explained by Henry (Pathways to Madness: 1965) in terms of its importance for therapeutic intervention.

> Every family is different, and this individuality maintains itself even in the presence of the determined efforts of a therapist to change it. Such resistance to change develops as a direct consequence of the social interaction of the members of the family with one another, and of their mutual adaptation and conflict. Interaction, adaptation and conflict, meanwhile, occur in relation to a set of values adapted by the family from the values of the culture. If, in one family, the values of struggle, male dominance, female subordination, permissiveness, and so on, have become frames of reference in terms of which all interaction takes place, these can arise only because they are present in the culture as a whole. If we put together the pattern of interaction and the value system, we have the family culture (1965:457).

In agreement with Henry's explanation of family culture, these families did indeed display differing "frames of reference in terms of which all interaction takes place." Further their "interaction, adaptation and conflict," in short, their way of life, as dysfunctional as it sometimes appeared to be, occurred in relation to a set of values consistent with the values of the culture at large. The Andrews family framed their family life around hyperactivity. Their pursuit of high achievement and creative activities -- components of the middle class value system -- was a dominant and ongoing behavioral theme. But the flurry of activities and high pursuit of external commitments served another and important purpose. It facilitated frequent withdrawals from the home and avoidance of the mother's drinking problem. It allowed for their charade of normalcy to continue with or without the mother's participation.

The values of male dominance and female submissiveness facilitated the Barker's adaptive family culture. Ralph's disinterest in household maintenance and his wife's submissive acceptance of basic inconveniences evolved into a lethargic frame of reference. As opposed to fighting the battle of conformity, they effected structural arrangements which incorporated the drinking behavior as the natural way of things. Both the Barkers and the Carters seemed to

camouflage the maternal alcoholism with other family problems such as obesity, truancy, drug use and delinquency. As antithetical expressions of the middle class value system, these conditions served a useful, adaptive purpose.

The husband and wife of family E have framed their family culture in the context of a love triangle. The maintenance of the long-standing arrangement of husband, wife and wife's lover is facilitated by their loyalty to marriage vows; their ethnoreligious value system dictates that "marriage is forever." They often sought counsel from their minister for the relationship problem along with the alcoholism. Here too, another family problem served as a convenient camouflage for a long-standing and serious condition of alcoholism.

All of the families managed to maintain unit survival by means of varying charades of normalcy. However, the odds of the continued survival, or put another way, the chances of normal development for individual members was questionable. Enculturated into the protective capsule of an alcoholic family culture, the children were ill-equipped socially, emotionally and in some cases physically, to compete in the broader circles of their environment. The exception to this was the Andrews' children and the older children in families F and G, all of whom in their formative years were socialized to a non-alcoholic household. Their mothers began drinking after their primary socialization period (after age 12). These children were able to transcend the internal and external boundaries of their family life (albeit with difficulty and as yet unknown repercussions), and compete along what appeared to be normal lines of development. In contrast, the Barker and Carter children, who have always lived in a heavy drinking environment, manifested marginal ability to adapt to their outside social and academic environments. They were, in fact, rejected by their social peers. In family F, the 12 year old daughter was

placed in a private school as a protective measure against "undesirable public school environment;" still her chosen neighborhood playmates remained in the much younger five and six year old range. Her older brothers have severed all ties with the family -- and the alcoholic environment -- in their fight for survival. The half-hearted suicide attempts of the young daughter in family H suggest an awareness of her cultural difference and inability to cope with outside social pressures to conformity.

Boundary Maintenance

Very early in the field work, in fact when I was still in the "getting acquainted" stage of the research, I picked up cues which suggested each family as a unit had set up and maintained boundaries around their natural habitat of the family home. Concerted efforts at "closing out" the outside world were manifested symbolically, and by distinctive physical and social expressions of separateness. I have explicitly analyzed boundaries as they existed in the Barker family and implied their existence in the other case studies. Among all of the families, curtains facing the street side of the homes were drawn closed day and night, an anomalous feature among the open, convivial appearances of other suburban homes. Well-kept lawns, trimmed shrubbery and other expressions of suburban affluence were in most cases absent -- the yards were neglected and some were obvious eyesores. Children's play areas were restricted to the family property line and in three cases to the house and fenced backyard. Social mobility of teenagers in six of the families was guarded and controlled with a seemingly paranoid and unnatural intensity. Entertainment or receiving of visitors in the home was a rare occurrence among all except the Andrews family. Even there, when church groups met at their home, the mother was "confined" to her room. Mothers rarely left the house when they were drinking. And even during their non-

drinking periods, they limited their trips outside the home to family, business, church affairs or shopping. In one of her rare appearances in her own front yard the mother in family F was shaken by a neighbor's comment "I heard you had died six months ago." The neighbor and others, she said, had not seen her in many months, and excused the rundown condition of the house and yard as an expression of her husband's grief.

A side effect of the boundary maintenance was the development of listless, uncreative, rebellious and sometimes dull personalities among the younger children. Their social and academic inadequacies in turn created emotional boundaries of difference and separateness. Here again, the degree of emotional disturbances and social or academic inadequacies differentiated between those children who were socialized to maternal drinking at an early age, and those who encountered it after age twelve.

Among the family participants, boundary maintenance emerged as a purposeful manifestation of cultural distinctiveness. Boundaries keep the outside world out and maintain the protective, alcoholic way of life. However, the boundaries do not restrict family members from carrying on their interactions and interdependence with other social institutions. This situation of internal-external boundary maintenance is in agreement with Frederik Barth's theory of boundary maintenance among ethnic groups. He argues that in poly-ethnic social systems, cultural distinctiveness and cultural diversity persists in spite of inter-ethnic contact and interdependence across cultural boundaries:

> First, it is clear that boundaries persist despite flow of personnel across them. In other words, categorical ethnic distinctions do not depend on an absence of mobility, contact and information, but do entail social processes of exclusion and incorporation whereby discrete categories are maintained **despite** changing participation and membership in the course of individual life histories. Secondly, one finds that stable, persisting, and often vitally important social relations are maintained across such boundaries, and are frequently based precisely on the dichotomized ethnic statuses.... Interaction in such a social system does not lead to its liquidation through change and acculturation; cultural differences can persist despite inter-ethnic contact and interdependence (1969:9-10).

In terms of cultural exclusivity, if we replace the term ethnic with family, Barth's theory explains how a family culture can maintain its distinctiveness by means of internal boundaries and yet allow for continued external interdependence and interactive processes. His premise -- that "stable, persisting, and often vitally important relations are maintained across such boundaries, and are frequently based precisely on the dichotomized ethnic statuses," also occurred among these families. In every case, without exception, husbands established "important social relations" across the boundaries which were justified by their position as spouse of an alcoholic. Molly's drinking patterns gave Carl Andrews a convenient reason to be absent from the home nights and weekends -- and an opportunity to further his career; Ralph Barker maintained separate friendships for fishing and hunting trips and allocated his vacation time to this purpose, rather than to family outings; Steve Carter maintained close ties to his parents and in fact committed himself to relocate his family near them without serious consideration for Donna's feelings on the matter. Her guilt in relation to her drinking and her delinquent daughters afforded him decision-making priorities. In family H the husband maintained payments on an expensive speed boat and mobile home -- both utilized for his leisure activities -- by means of his wife's salary for the care of two severely

retarded foster children -- a convenient job for a woman whose drinking problem held her at home "anyway." In family F the husband had refused sexual rights to his wife for ten years, yet in the evenings he sometimes accompanied her to a neighborhood bar for the first "few drinks," then left her there alone to drink. This interactive process afforded him free evenings to spend as he wished. Other examples exist among all of the families, illustrating how and why the family culture, once established, maintains its internal distinctiveness for purposes of survival, and develops external interdependencies for both vital and contrived needs and for external social relations of individual family members.

In sum, this first level of the model examines ways in which alcoholic families adapt to the stigmatized condition of alcoholism and to external demands for conformity. The focus of investigation is on family structure and behavior as related to cultural norms, beliefs and values and of family interaction with other supporting social institutions.

In response to cultural pressures against alcoholism, families build and maintain protective boundaries separating these private and public social worlds. These boundaries were explained as survival techniques -- or temporary delays from the foreboding possibility of being "selected out" of the ecological reality of their traditional and immediate cultural environment. Faced with the subliminal choice of disbanding as a family unit or organizing and sustaining a family culture which incorporates a culturally deviant member, families of these case studies chose the latter. They chose to protect their mother against exposure and subsequent negative consequences of alcoholism. In other words, if the mother's alcoholism and her breakdown in role behavior is discovered, she will be socially labeled as an immoral woman and unfit mother. The family, by association and as a protective measure, takes on the stigmatizing

consequences of alcoholism but they take it on behind internal boundaries. Rather than externally expose the problem and risk loss of status or prerogatives for the family unit, they hide it, deny it and, in the process, reinforce both the drinking problem and the intensity of the stigma. As we have seen, the whole family suffers the consequences of these culturally-regulated adaptations to alcoholism. Indeed, and by cultural prescription, alcoholism is a "family" illness.

LEVEL II: The Alcoholic Family System and Basic Survival

Boundaries against external pressures to conformity represent only the first adaptive step in the struggle for family unit survival. Once the boundary maintenance is stabilized, the family is still faced with the struggle to adapt their changing family lifestyle to the more static demands of a life-sustaining family system. At this level of analysis I address the issue of family structure and function in terms of basic necessities of human sustenance. The questions to be answered at this level are as follows: how do families adjust to the on-again, off-again drinking patterns of the mother and to the see-saw, unpredictable nature of her maternal role duties? In terms of prescribed (or proscribed) notions of family roles, who decides what should be done, by whom and how during those frequent periods when the principal facilitator of physical sustenance and nurturance is functionally incapacitated? What kinds of conflicts arise when role expectations for basic family sustenance are not met? And finally, does this conflict become a maintaining factor to the drinking problem?

The concept of "middle class family system" implies a culturally prescribed family organization with normatively defined roles, statuses and rules of behavior. This is not to suggest that white middle class family life as influenced by a distinct cultural aggregate of American society has no similarities to say a working class family. American families per se have many similarities stemming from a common overall culture. However, in the fields of anthropology and sociology, it is generally agreed that in a heterogeneous society like the United States, families of specific subcultures are sufficiently influenced by differing values and norms to warrant description of differing kinds of family structures. (Ablon 1980; Henry 1965; Gans 1962; Stack 1975; Howell 1973; Lasch 1979; Nye and Berardo 1973). Likewise, it is reasonable to assume that notions of familial roles, status and division of labor,

as conceptual components of family structure may, be normatively defined by subcultural prescription (Nye 1976). This line of reasoning follows Linton's earlier conceptualizations of role and status as cultural concepts:

> Role will be used to designate the sum total of the cultural patterns associated with a particular status. It thus includes the attitudes, values and behavior ascribed by the society to any and all persons occupying this status (Linton 1945:77).

Ascribed notions of roles, status and role behavior stood out as critical factors in analyzing the middle class -- and alcoholic -- family systems of the participants in this project. Family structure, roles and division of labor were for the most part clear-cut and rigidly observed. In all cases, the father was the principal provider and the mother maintained the traditional role of housewife although some mothers held part-time jobs. The mother performed -- or was expected to perform -- the major portion of domestic, housekeeping and other domestic duties such as cooking, shopping and in most cases, the gardening. She was the principal caretaker of the children, and when not drinking, the most nurturing member of the household. She also held responsibility for monitoring the children's actvities in school, church and community. The planning and preparation for special family rituals, holidays, outings, vacations and in-home entertainment -- if implemented at all -- were the responsibility of the mother. In some families the mother assumed the role of principal disciplinarian, while in others the father enforced the family rules. Oftentimes fathers "punished" children with heavy handed or abusive measures as for example in families Barker, Carter, and F. In only two families, Andrews and E, the fathers pursued and enjoyed recreational activities with their children. In all others, fathers reluctantly pursued child-centered activities or avoided them altogether.

Children's roles varied; some performed minor household gardening duties, but in other families it was uncertain just what the children were expected to contribute to family sustenance. All of the children were "expected" to achieve in their school work, and community or other external activities; however, in most families, parents did not provide established guidelines or other supportive measures for meeting their parents' expectations. This aspect of parental role breakdown was evidenced by T.V. blaring during study hours, minimal parent participation in school activities, no in-home provisions for entertainment of friends and development of social skills, restrictve boundaries to normal sociability and so forth.

Nevertheless, despite the fact of maternal alcoholism, the mother remained as the **major** contributor to the practical maintenance of the family home and to the day-to-day physical, social and psychological sustenance of the other family members. When the mothers were in their drinking periods, and unable to perform maternal role duties, decisions had to be made on life-sustaining matters such as buying the food, preparing at least quasi-nutritional meals for young, growing children, cleaning the house laundering the clothes and coordinating school and social activities. In two cases -- the Carter family and Family H and -- maternal drinking minimally affected the most basic functions of family sustenance; the mother's drinking pattern allowed enough hours in her day for housekeeping duties. The role breakdown in these families occurred in the area of parental nurturance and developmental guidance. But in all of the other families, where the mother experienced intermittent and in some cases incapacitatng periods of alcoholism, total maternal role breakdown did occur. Maternal role breakdown, like the alcoholism, did not occur in a vacuum. It set off a series of adjustments within the family. These adjustments

in turn became precipitating factors supporting both the alcoholism and the alcoholic family system.

The central theme of family systems theory is that in order to understand individual behavior it is important to understand the group in which the person lives and the behavior of all individuals maintaining the group or system (Paolino and McCrady 1977:111). Since a family system, like any social system is made up of interdependent parts, i.e. family members, it is logical to assume that a change in the functioning of one member is automatically followed by a compensatory change in the functioning of other family members (Bowen 1974:115) Following the conceptual frameworks of family systems theory, Ablon summarizes its assumptions about role functioning:

> If the family is considered as a social system with interdependent parts consisting of interacting personalities with each having his own expected role functions, it follows that the behavior of each part sensitively affects the functioning of the others. A malfunction of one part may lead to a disequilibrium of the total system. If one party because of particular problems becomes unable to assume the customary expected behavior and activities associated with his role in the family, all other family members feel the change in balance. Because certain tasks are required for the continuing maintenance of the household, those tasks regularly borne by the malfunctioning member must be allocated to other members. For example, if the husband, because of a pattern of excessive drinking, can no longer maintain his responsibilities in the economic and authority spheres, the wife characteristically will assume these. Significant affect will accompany such transferrals of power and responsibility. The wife may react with considerable hostility, the husband with shame and guilt that precipitates more drinking (1976:209).

The division of labor was clearly defined in the families of this study. When the mother was unable to function as principal provider of family sustenance, sometimes for periods as long as two weeks, the family members did indeed feel the change in balance. However, as for the question of who

stepped into her role and looked to the needs of basic family sustenance, surprisingly, no one did much of anything. Other than periodic and feeble attempts to step into the maternal role, husbands and older children did very little. Carl Andrews cooked from time to time, but his menu was limited to bacon and pancakes, foods of questionable nutritious value, and after a time, of diminishing palatability. The teenage Andrews children coped by buying fast foods or fending for themselves when Molly was drinking. The Barker children sometimes opened canned vegetables and ate them from the container. Ralph Barker refused to cook, and when pushed into it, reacted with rage.

In both the Barker and Carter families, and also in families E, F, G, and H, fathers were reluctant to step temporarily into the maternal role. As with Carl Andrews, they performed poorly, or not at all. In family Barker and Carter, fathers reacted to periods of maternal role breakdown with anger and frustration. This pent-up and displaced anger was often released by physical and verbal attacks on the children.

Donna Carter managed her drinking around the evening meal, but for as long as they could remember, her daughters prepared their own breakfasts. As for other housekeeping duties, if a family member needed clean laundry they might wash their own, but under no circumstances would they launder towels or bed linens, or for that matter their mother's clothes. Laundry accumulated until the mother recovered from her drinking periods -- sometimes for two weeks or longer. If an otherwise clean house became disorderly or unclean, it stayed that way until the mother was sufficciently able to attend to it. This situation was due in part to the reluctance of other family members to take on extra work, but it was also related to the mother's reluctance to release role duties. Once when a daughter tried to step into the cooking role, Molly Andrews threatened suicide. After that incident, the family found it

more convenient to fend for themselves, and eventually adjusted to a family system with periodic malfunctioning of the maternal role. The Barker family, as we know, offered no resistance to the disruption of maternal role function; they adjusted by building and maintaining a family system which "gave up" normative values of clean, attractive home and clothing.

In sum, the families opted to **not** interfere with the mothers' rights to certain role responsibilities and statuses. The positive pay-off of this set-up was the mothers' supreme efforts to please and in fact overcompensate during their non-drinking periods. Children and husbands seemed to enjoy and in fact take advantage of the compensatory, guilt-ridden periods of "super-momism" which occurred for all of the families during non-drinking periods. Some mothers compensated by prepaing special meals, buying gifts, and granting special privileges. Joyce Barker especially manifested an outpouring of affection on her children, both verbally and physically displayed, during her recovering and abstaining periods. These compensatory "rewards" made the drinking behavior more tolerable for family members and in fact helped restore the equilibrium of the family system, if only temporarily.

Conversely, and from a systems perspective, there are built-in pitfalls to a family organization which fends for itself when the mother vacates her role. Over time, behavior which is the "norm" when the mother is drinking or recovering, becomes the "norm" when she is functioning normally, and herein lies another precipating factor to the drinking cycle. Carl Andrews and his children all scheduled themselves out of the house most evenings and on weekends. This had not been the way things were before the onset of Molly's drinking problem. This family worked, prayed and played together, so to speak. But now they vacated the house for two apparent reasons: first of all to avoid the unpleasant view of an alcoholic mother, and secondly to better

facilitate their high achieving lifestyles. When the family members failed to appear for Molly's carefully prepared meals, she experienced a sense of loss in both role responsibility and status. Many evenings when she was left alone, she began drinking again.

The ways in which families adjusted to role malfunctioning, caused as much if not more conflict than the fact of alcoholism itself. So it was not so much the role conflict which precipitating the drinking cycle; the family structure did not change all that much. The precipating factor to drinking was in the coping mechanisms and interactional behavior by which such adaptations were facilitated.

In terms of external expectations, and as perceived from my own observations, mothers were pressured to maintain a behavioral comportment which served as an appropriate role model not only to their children, but to the community at large. Fulfillment of this latter role was attempted in various ways and against insurmountable odds of reoccurring drinking periods. For example, Molly Andrews made a concentrated effort to abstain in order to give her daughter Barbara a very special party in recognition of her many achievements. Molly was often ill and physically weakened after her drinking periods; but she, and her family, viewed her condition as deviant and improper for a middle class, suburban matron. The graduation party provided Molly with an opportunity to prove to family, friends and relatives that she was still a solicitious and "proper" mother. On the day of the party, and perhaps in apprehension and fear of having guests in her home, she started drinking. Still, and in an intoxicated condition, she made a brief appearance in hopes of gaining deserved recognition for her efforts. Attempts by other mothers to fulfill the external demands on role behavior were evidenced in Joyce Barker's determination to have her son's Indian Guide group meet in her home. This

plan failed when her husband refused to help her make the house "presentable." Joyce stated that she wanted her son "to feel he could bring friends into his home and be proud of his home." When plans for the meeting were aborted, Joyce began drinking. The mother in Family H stated that in hindsight her continuing efforts to care for two severely retarded foster children were an outward attempt to prove to herself and to others that she was a worthwhile person and mother. Her drinking problem worsened during the year the boys lived in her home. In all of the families, the ongoing efforts at role modeling and external approval of the mothers' behavior was evidenced in the attempts to perform as "super mom" during non-drinking periods. Also, and in all cases, the failed attempts for approval and increasing loss of role propriety and status were precipating factors to the drinking problem.

I have presented here only a few of many examples of behavioral links to the drinking cycle. There are many others in every family, and some are discussed in the three case studies. Family responses to maternal alcoholism can be examined at this level of analysis in terms of conflict over role breakdown in the more vital, life sustaining necessities of group survival. In terms of therapeutic intervention, the issue of conflict and precipitating factors to the drinking cycle can be found by comparing behavioral patterns of the drinking and non-drinking periods, and in some cases, the transitional periods between the two.

A Flight for Survival: A Coping Mechanism of Children

On the second level of analysis, and with a focus on techniques of basic survival, we have seen that maternal drinking minimally affected the most basic functions of the family's physical needs. From a family systems perspective we learn how the see-saw nature of the mother's role performance and the family's response to role malfunctioning supported the continuance of

the drinking problem. But another aspect of role malfunctioning occurred and affected another equally vital function of family life. In all of the families there was an absence of adequate parental nurturance and developmental guidance. As evidenced by the inside perspective on the children's troubled lives, they were deprived of a basic human need -- such as nurturance -- in relation to their emotional, social and academic development. This proposes a question which is important to family therapists and other health professionals: How do children survive or cope in a family system where there is inadequate, if any, provision for social, emotional and academic nurturance, and on top of that void, where crises, tension and stressful situations are part of their daily and normal routine? The answer to that question can be found in the more functional analysis (inside view) of the foregoing three families, and can also clearly be seen in all eight families.

When all other ways of coping with their ongoing distressful and oppressive environments were denied or unknown, and when efforts to change the situation consistently ended in failure, the children used avoidance or withdrawal as adaptive measures to alcoholic family life. This coping mechanism, which I am calling "flight for survival," was behaviorally manifested in one form or another, and explicitly described for the three families presented in this text.

The Andrews children, who enjoyed a primary socialization period in a healthy home environment **prior** to the onset of maternal drinking problems, withdrew whenever possible from their radically changed family system. Their flight for survival was manifested in their energetic pursuit of their culturally sanctioned and high achieving school, church and community activities. The seeds of their successful developmental strides had been earlier planted and nourished to the degree that could continue along normal paths without and

in spite of their disruptive and slightly mad home environment. Their escape by withdrawal is functional for the present, but in terms of their future lives it may be no more than a temporary withdrawal from a damaging and emotional crises.

In sharp contrast to the Andrews family situation, the Barker children, still too young to escape from their involuted system, remain as yet trapped in their heavily-bounded family unit. As a result, their developmental processes, like those of the Carter children, are lacking if not irreparably retarded. It remains to be seen how the already rebellious and withdrawn ten year old son, or the verbally abused and socially ostracized thirteen year old daughter, might escape from this system. Mary Ruth, the daughter in question, already suffering from lack of adequate nurturance in both her home and school environment, was secretly dreaming, if not planning, her "flight" to live with kindly rememered relatives in another state.

Susan and Sandy Carter ran away from home for purposes of survival. Like the other children in this study, they were following the instinctive search for emotional nourishment. Though the sources of this nourishment were perceived in their parents' eyes as undesirable persons and social environments, from the perspective of Susan and Sandy, motorcylce gangs and bowling alley dropouts may be suitable companions when the alternative is a social and emotional void. It is one thing to be socially and emotionally restricted by dictate of parental boundaries, but it is quite another to be confined to an environment wherein heavy drinking, parental fighting, irritability, hangovers and ambivalent rules are the norm. As young and developing human beings, they had little chance of thriving, and no guidance on how to cope with a natural habitat where affection was one moment given freely and naturally,

and at another snatched away in a haze of parental mood swings, violence, periods of altered consciousness or total unconsciousness.

"Flight for Survival," whether that means actually running away from home, escape from reality through drug use, touring the country with a motorcycle gang or repeated confinement in juvenile hall, is in this case a purposeful coping mechanism. It is convenient withdrawal from an unhealthy and dysfunctional family system. This way out, as unacceptable and dangerous as it may appear to those who view such behavior from outside the family system, was from an inside view, and for purposes of survival, a practical alternative.

LEVEL III: Chronic Alcoholism and Family Problem Solving

In the process of this field research, and as I began to spend long periods of time with each family, I was struck by the enormous amount of energy and "hasseling" exerted in their ongoing struggles to maintain an intact and surprisingly stable unit in the face of a serious maternal drinking problem. The emerging questions to be answered were: **what** holds these families together in a daily routine of crises, humiliation and guilt? **How** did they do it, that is to say, what were the behavioral mechanisms by which they managed to adapt to the drinking behavior and to a quasi-functional parent? and most importantly, **why** did they work so hard at maintaining what might appear to any observer as a dysfunctional, oftentimes unhappy or pathological existence?

These were complex questions to which there were not immediate, definitive answers. Thus far, I have attempted to examine them in terms of external pressures for conformity and internal pressures to keep the family functioning at a level which provides the basic necessities of human survival. But, if I were to end the analysis at this point, it might be said that the model represents a rigidly-observed structural functional approach to family life, in keeping with the early structuralist thinking that the source of all that is obligatory in human behavior comes from outside the individual (Durkheim, 1895).

But this was not the case here. Among all eight of the families -- in some, more so than others -- there was evidence that chronic alcoholism served a hidden function which was related to a more psychological or intrapsychic level of family interaction. There were allowances and tradeoffs of certain behavioral patterns; that is, individual family members accepted, tolerated or in some cases encouraged drinking behavior as compensation or license for pursuing personal, self-centered needs. Where on the first two levels I explained

how families adjusted their normal routines of family life to accomodate the drinking behavior, on this third level of the model, the drinking behavior, conversely, takes on the important function of facilitating solutions to the needs, wants or problems of other family members.

At this level of analysis, we can see **why** the families work so hard at maintaining what appears to be a "dysfunctional" system. The answer is that over time, the drinking behavior and family adjustment to alcoholism have become regulatory to the degree that it is a critical factor to family equilibrium. All of the family study participants had been struggling with alcoholism for extended periods of time and the **dsysfunctional** nature of the family system has by now become **functional,** in the sense that it holds the family together. The third level of analysis agrees with Steinglass' conceptualization of the alcoholic system, wherein he postulated that among structurally and economically intact families, alcohol might come to play such a critical role in matters of individual gratification that it becomes a "central organizing principle around which patterns of interactional behavior are shaped" (1980: 213). He further proposed that families cycled between two predictable interactional states, one associated with sobriety and one with intoxication.

> There were not merely differential patterns that the family used in dealing with its identified alcoholic member. There were truly different interactional states at the family level. The repetitive and stereotyped aspect of behavior within the family during periods of actual intoxication, we proposed, might actually be associated with certain aspects of problem-solving by the family, and it might also serve to reduce uncertainty. In this sense, intoxicated interactional behavior might become as habitual as the alcohol consumption (Ibid).

Recognizing that alcoholism is a chronic illness with reoccurring **behavioral** symptoms, Steinglass has suggested that that family interaction, as developed around these bouts, supports not only the maintenance of the illness iteself,

but also the long-term stability of the family system. It becomes a locked-in cyclical arrangement.

In applying Steinglass's theory to my research sample, I found that the patterns of interactional behavior supporting the alcoholic family system fell under three major thematic categories: balance of power, affection, and sexual dysfunction. These categories have already been discussed in the case studies. I will summarize them here and in terms of the changes in family interaction during the drinking periods, the non-drinking periods and the transitional periods between the drinking episodes.

Balance of Power

Within all of the family systems, the drinking behavior served an adaptive function in relation to one or another aspect of power balance. Interactional behavior around the struggle for dominance and control was manifested in relation to differing needs and family situations. In some situations, the power imbalance was expressed in terms of role distribution. In these cases it was a struggle for primacy in decision making or for status recognition or for obtaining special privileges of a material, social or emotional nature. In some families, couples used the drinking behavior as a means of balancing communication patterns; if one party dominated the other in dyadic conversation, this pattern was reversed during the drinking periods. In all of the families, there was a prescribed or deeper psychological notion of dominant-submissive relationships between husband and wife. With the exception of Families F and Barker, the wives seemed to carry the dominant personality. In any case, the submissive or more dependent spouse enjoyed a respite from this implicit power imbalance during drinking periods.

In some cases, families were not aware of the reciprocal nature of repeating, patterned struggles for power, and the drinking behavior. In others,

these exchanges were so obvious that a casual observer might assume that the players in these games of power consciously calculated their interactional moves. For example, both Joyce and Ralph Barker often implied that alcohol functioned as a tension release valve for their relationship. Pent up anger and frustration, over such things as the broken appliances, sleeping arrangements, the children's problems and Ralph's reluctance to change his cavalier and uncaring attitude about such matters, was greatly relieved by Joyce's drinking periods. Ralph seemed to view these periods as a welcome respite from Joyce's daily complaints and "nagging". Also, on the first few days after a drinking bout, and perhaps out of guilt, Joyce was even more submissive and placating than she was during her longer sober periods. This facilitated Ralph's pursuit of his own private, "thing oriented" world, and enabled him to avoid unwanted responsibilities of fix-it man, and companion to his children. The relief they experienced after Joyce's drinking periods was rather openly and joyously manifested. There was a sense of relaxation, calmness and affection which lasted until an aggravating situation or incident again came into Joyce's view. We can see here how the drinking became a trade-off for parental role imblanace. In the Barker family the drinking also functioned as a lubricant for communication inequities between Joyce and Ralph. Joyce is frightened of her husband; when he is angry or offensively debating their many problems, he clearly dominates the interaction. This pattern reverses itself when Joyce drinks. He "allows" her time out to angrily, tearfully or rationally communicate her pent-up feelings, disappointments and fears. They spend whole days on the front porch or in their favorite rockers by the television set accomplishing this temporary restoration of power. After a period of time, and when Joyce senses she has pushed him just far enough, she initiates the transitional period back to sobriety. The cycle repeats itself,

individual needs are met, and the family equilibrium is stabilized. In the process, the alcoholism is supported, if not encouraged.

In the Andrews family, the power imbalance occurred in all three categories. During abstaining periods, Molly exerts a high level of control in family-decision making, is verbally aggressive and is the dominating member of the marriage dyad. Her solicitious involvement in her children's activities, and her decision-making power afford her a special status in the family. When verbal disagreements occur, and after only a few feeble protests, Carl gives in to her demands. The children are aware of the submissive nature of their father, and resent the fact that their mother can so easily dominate him. However, all of these power deficiencies were corrected during Molly's drinking and recovering periods, and whatever status Molly normally enjoyed was greatly diminished by the volatile nature of her drinking behavior. When Molly was drinking and especially during the recurring crises, Carl facilitated the balance of power in his favor. As an example, he recruited the fifteen year old son to "physically restrain" his mother in the back seat of the family automobile when she resisted being taken to the hospital or to her mother's home. These kinds of experiences were unpleasant and demeaning for both Molly and her son. Carl made certain that the children visited their mother in the unpleasant environment of a maximum security psychiatric ward where he himself had committed her. He often diminished the life-threatening aspects of Molly's attempted suicides, and subsequently of the otherwise high status of her "mother" role -- when he did such things as order his daughters to go on about their normal routines of job and dancing lessons, rather than accompany their critically ill mother to the hospital. These are realistic, not exaggerated, examples of how alcoholic behavior diminishes a person's power as well as her sense of self-esteem, and in this case, with the purposive direction of a spouse.

As long as Molly continues her drinking patterns, Carl does not have to fight the battle of control and status. Decision making rights, control of communication and dominance are his whenever she drinks -- and for a short period of time during her recovery periods. For whatever the reasons, Molly's power and ability to control the family system is in herself; Carl's power -- in the context of family life -- is in Molly's drinking behavior. The cyclical patterns of things maintains a homeostatic balance for this family system.

The issue of drinking as vehicle for power balance was not limited to the parents. Children also learned how to use the definitive behavioral changes to their own best advantage. Ambivalence in family rule systems, inconsistent discipline, withdrawal of maternal control were but a few of the family characteristics which afforded children the opportunity to take -- or request -- special privileges and material wants. In some cases, children gained special status during the drinking periods by fulfilling a role that otherwise would not be available to them. Ron Andrews gained family status and power in his role of spiritual mentor to his mother, and as decision maker on her resources for treatment. Barbara enjoyed the role of surrogate wife and family comedian during Molly's absence. In Family F the 12 year old daughter also became surrogate companion to her father when the mother was drinking, and he often took her to restaurants in lieu of cooking, an outing which she looked forward to. In some cases, the children were placed in "victim" roles which were indirectly related to the drinking. In families Barker and Carter, the daughters became identified as family "problems" on an almost equal footing with the identified family alcoholic. While these roles might be negatively perceived in terms of children's overall well-being, in the case of the Carter daughters, it afforded them a kind of recognition and attention from their parents that they otherwise would not have enjoyed.

Affection

The expression of human caring and affection proved to be one important element in family cohesiveness among all eight of the families. To put it very simply, most of the participants of this study -- children and parents, husband and wife -- loved one another. Considering their prevailing cultural and moral belief system about alcoholism, and the recurring alcohol-related incidents of trauma, crises and humiliation, affection may not appear as a plausible conceptual theme for cohesiveness among alcoholic families. On the face of it, it would seem that the discordant nature of maternal alcoholism as manifested in "unladylike" mannerisms, breakdown of role performance, withdrawal from the family circle and so forth, is a predisposition to dislike and permanent withdrawal of affection. Strangely enough, the opposite was true. Families openly expressed affection for their mother, and she for them. Affection was noted, and recorded, in terms of the number of times mother and children, and to a lesser degree, mother and father, touched one another, explicitly and sometimes implicitly intertwined with normal, everyday activities of family life. Generally speaking, behavioral mannerisms in each others presence -- during non-drinking periods -- could be categorized as affectional rather than anything else, such as resentful, sulky, alienating or retaliatory.

But, the abundance of affection and nurturance tipped the scale **only** during the non-drinking periods, and appeared to some degree as compensatory for the periods when affection and nurturance was totally withdrawn. The question to be addressed here is what is the reciprocal nature of the alcoholic behavior and the high degree of family affection? And how do reciprocal understandings between maternal alcoholism and affection become a stabilizing force for family cohesiveness? Again these questions can be answered in terms of the cyclical nature of the drinking periods.

The mothers of this study were at most times burdened with feelings of guilt and remorse. As intelligent and responsible women socialized to the middle class wife and housewife role, they were aware of the seriousness or "wrongness" of maternal role neglect. However, and because of the denial factor, this guilt was never verbalized. There was no formal arena, so to speak, for confession and retribution. That need was disallowed for the reason that if the mother admitted to her alcoholism and her remorse over her periodic or ongoing neglect of children and spouse, she would in effect be admitting to immoral behavior and to the right to be a part of the family circle. In other words admission of repeated failure at role performance without just cause implies deviant behavior which in turn implies loss of status in her primary role of wife and mother. This dilemma was resolved first of all by avoiding discussion of the issue of role breakdown, and second by conditioning the family to an overabundance of nurturance and affection during the mother's non-drinking periods. During her sober period, she tried to become the total, "super-mom" (albeit with many failed attempts). During these periods, and as I observed, the mother expresses her affection whenever possible, in terms of endearing words and touching. She works hard at accomplishing "special," out-of-the-ordinary projects for the children. These might be special meal preparation, sewing, shopping trips or, on rare occasions, attendance at their school activities. For some of the mothers, such as Molly Andrews, and the mothers in D, F, G, and H, these activities were performed with feverish energy and considerable time allotment. For those who were slow in recuperating from drinking periods, the activities required extraordinary physical effort. Joyce Barker and Donna Carter were often not physically conditioned to accomplish special projects, but during their sober periods, they were always and without fail especially affectionate to their children.

The demonstration of affection and attempts at compensatory nurturance can be viewed as adaptive behavior for the mother. The children respond to affection with affection. This is therapeutic to the mother in that it releases her fear of rejection. This was never more obvious than with Joyce Barker's pattern of holding her youngest, a full grown seven year old, on her lap, and, maintaining body contact with the other children. The feverish attempts to please children through special projects served as a release of concomitant guilt feelings, and as a form of moral retribution for periodic neglect or abusive behavior. Molly Andrews repeatedly used this method to restore family balance after her aggressive and disruptive drinking behavior. Following the violent argument with Barbara -- which occurred while she was drinking - Molly abstained for three weeks, during which time she dedicated many hours to sewing Barbara's graduation dress, and preparing for her graduation party. She became a model mother with a dedicated purpose of getting Barbara to move back into the home, and restoring family unity. She refrained from drinking until the balance of nurturance, affection and family unity was accomplished.

The affectionate behavior becomes adaptive for the children in the sense that they look forward to the periods when their mothers performs so diligently in their interests. They adjust their thermometer of maternal affection and nurturance to the non-drinking periods, and monopolize on the compensatory rewards for maternal alcoholism. By the same token, when the mother was out of her nurturance-affectionate mood, children accepted the unpleasant but practical reality that "this is the way it is." Children did not turn to their fathers for emotional needs; as has been demonstrated in the case studies, fathers were reluctant to step into this role, and in fact were more irritable, and emotionally aloof -- in terms of children's needs -- during drinking periods than at any other time.

Sexual Dysfunction

Sexual incompatability was a constant among seven of the eight marriages, and in the one exception, the Andrews couple, it was fast becoming a problem. In six of those marriages, the women found sex unenjoyable and some believed themselves to be frigid. In the seventh case, family F, the husband had for the past ten years refused to have sex with his wife.

Donna Carter found that her desire for sex was limited to four or five days before menstruation. She observed that she drank less during those days for the reason that she retired early with her husband to have sex. This differed from her usual pattern of late-night drinking. It could be assumed that on other nights she drank to avoid sex and in fact, Donna herself often alluded to that possibility. A similar situation occurred in the Barker marriage. When the fence was finally put in place and Joyce no longer had to stay up half the night for guard duty, she was unable to sleep comfortably with Ralph. She returned to her old pattern of sleeping in the armchair and sometimes to drink. Given that Ralph's sexual overtures caused her to experience physical revulsion, it is reasonable to assume that marital sex and the drinking problem are to some degree related. In family H, the husband returned home from his fire department duties after eight p.m. He enjoyed and pressured for frequent marital sex. The wife consented to his needs only after she had numbed her senses with alcohol. On many days she was nearly unconscious and in bed by early evening or when he returned home. As mentioned earlier, the father in family F often accompanied his wife to a neighborhood bar, and then left her there alone to drink until the bar closed. He viewed this as a caring and supportive gesture. She viewed it as his way of avoiding sex, which she often requested when she was drinking.

What the women lacked in sexual desire, they made up for in affection. During their sober periods, the wives were genuinely caring and attentive to their husbands. Perhaps the husbands accepted this as compensatory reward for the lack of sexual activity. I can postulate no further relationship between sexual dysfunction and the drinking cycle. I discuss the subject here as a fact of these alcoholic marriages, and suggest that the drinking behavior functioned at least partially to camouflage sexual incompatability. In that respect, I suggest that the regulatory patterns around this issue supported the chronic alcoholism and the maintenance of the alcoholic family system. Ablon (1980) postulates a differing, but equally connected relationship between alcoholic behavior in Irish Catholic men and their ongoing sexual problems with their wives.

IMPLICATIONS FOR TREATMENT

In attempting to apply both cultural and family systems concepts to the alcoholic family experience, I have constructed a model which incorporates three central but overlapping frameworks which hopefully will be useful for research and intervention. The complexity of the web-like pattern of alcoholic family life cannot be denied, it cannot be ignored. Taken separately, the levels of this model explain only pieces of the alcoholic family puzzle. Taken together the model offers an attempt at a more holistic and integrated portrayal of the problem than we have at this time. The various motivations, interactions and adjustments of troubled families, in the final analyses, add up to -- rather than explain -- the "pathology" of the family (Ablon: 1979).

On Treatment and Belief Systems

The medical establishment and the alcoholic patients they treat are often operating with conflicting explanatory models for alcoholism. Alcoholics Anonymous is included here as a treatment modality which utilizes a particular belief system about alcoholism. Whether a treatment establishment is using the disease theory, personality theory, genetic tendency theories, or whatever other theory of etiology, without proper knowledge of the patient's "theory" on alcoholism, the result is always the same. As was shown in the case studies, an identified problem drinker can be taken out of his or her family or other social community, educated on whatever etiological theories a treatment resource adheres to, and, in terms of achieving temporary abstinence, perhaps be cured. However, when that person is sent back into a cultural community that has not had the benefit or experience of such education, and/or a community that is operating within a differing belief system about alcohol use and drinking behavior, he or she does not get the emotional support needed

to sustain abstinence. The family, friends and relatives may listen to the "medical" stance on alcoholism, even "mouth" the words about such "new" findings of genetic tendencies and disease and then in the end, still opt for an ethnic and/or religious over a "scientific" explanation of alcoholism. Deep-seated cultural beliefs about alcoholism -- in this case Protestant middle class beliefs -- cannot change in midstream just because of the "accident" of an alcoholic family member. For example, the families of this study resisted treatment through Alcoholics Anonymous primarily because of its name and the extended stigma which they might absorb by association. When the therapist and physician team retorted to the Andrews' family religiously-oriented approach to Molly's drinking and suicide patterns with "The Bible hasn't done it for you folks!" the family, in deference to the medical profession, did not argue their case. They simply withdrew from all professional alcohol treatment services. This kind of ethnocentric and relevantly naive approach of the treatment professionals threw up the final and permanent ideological wall between family and secular treatment services.

Successful treatment and rehabilitation of alcoholics and their families may, in most cases, require that health professionals first of all recognize the existence of belief conflicts; secondly, define the differences between client and professional healer; and thirdly, take sensible, thoughtful steps toward a mutual understanding of such differences. I am suggesting that the healer must be enlightened along with their patients. A major key is to work within the client's belief system, of if possible, gently incorporate it into whatever treatment approach is utilized. This requires more time and effort on the part of the professional healer, but in view of the acknowledged poor success rate of professional alcoholic treatment modes, it might well be worth the effort.

On Treatment and the Alcoholic Family System

As most experienced alcohol treatment personnel know, unless the identified problem drinker is unusually resistent to the influence of whole family dynamics, she or he will not be able to abstain in an "alcoholic" family environment. Successful treatment and rehabilitation of alcoholism in terms of both abstinence and family unity and happiness, probably will not be possible without a cooperative effort of the whole family. The family must change from an alcoholic system to another kind of system. The alcoholic family system, structured and maintained as a protective capsule for both the drinker and the family, and serving as a system which incorporates alcohol as a homeostatic mechanism for unit stability, must undergo dramatic changes if it is to incorporate a non-drinking mother -- and in this case one whose role behavior is appropriate to that of a "normal middle-class suburban housewife."

Set patterns of adaptive role behavior and family rules and habits, so deely ingrained and protected by family boundaries, will not change unless or until the family understands them and wants them to change. For example, clinician-researchers in the field of family systems therapy point out the importance of understanding how the drinking behavior is serving an adaptive function:

> In each individual or family that presents with an alcohol problem, it is important to ascertain how the drinking behavior is serving an adaptive function. The maladaptive aspects are readily apparent and can usually be recited quite easily by doctor, patient, and family members. Usually, in spite of the agreement by all of how terrible drinking is, the drinking pattern continues with a concomitant increase of feelings of frustration on everybody's part. Care must be taken to avoid this trap and to concentrate during the history-taking and clinical observation on what is adaptive about the drinking. We believe that in this way more useful information can be gathered and a better therapeutic alliance can be established.

> Once the adaptive consequences of drinking have been ascertained, therapy may be structured around helping the patient to manifest the adaptive behavior while sober instead of only during drinking and to learn effective alternative behaviors (Davis, Berenson, Steinglass, and Davis 1974:209-210).

But in order to initially determine how the drinking behavior serves an adaptive purpose, it would seem that the therapist, him or herself, must first understand family interaction during both drinking and non-drinking periods. This may be a difficult if not impossible task. Davis et al. (1974) suggested that insight into behavioral changes might be gained through experimentally induced intoxication in a clinical setting, and the author's recognize that encouraging someone to drink is a controversial issue. Steinglass and his colleagues (1971a,b) carried out this clinical research procedure with familial pairs of chronic alcoholics. The researchers observed patterns of interactional behavior before, during and after a 14-day period of experimentally-induced intoxication. The "alcoholic family system" model (Steinglass et al. 1971b) was, for the most part, based on clinical experiments and practice.

While I would agree that clinical observations of behavioral changes while intoxicated bring out some information that might have only been referred from observations of the patient while sober (Davis et al. 1974) I would also suggest, as do the above authors, that this mode of observation does not provide information about behavioral changes within the context of normal, everyday interaction. Also, the "hidden" functions or meaning of the alcoholic experience in the home cannot come into view in a clinical setting. The description of observations and interviewing within household settings and the model presented here -- for in-depth analysis of behavioral interactions in the homes of alcoholic families -- will hopefully provide therapists and other health professionals with one mode for illiciting more information to accomplish this task.

APPENDIX

ALCOHOLISM AND THE FAMILY: A REVIEW OF THE LITERATURE[1]

Prior to 1940, research on alcoholism and the family had been inhibited by the lingering shadows of the Temperance Era and the old middle class Protestant value system wherein excessive or addictive drinking was a moral rather than a health issue. The families of alcoholics were pitied as innocent victims of the "evils of drink" and responsibility of helping or reforming the sinful member was left to the police or clergy (Gusfield 1962). By the mid 1940's, a small group of scientists under the leadership of E.M. Jellinek (1946) attempted to change established public attitudes about excessive drinking by "creating" a medical model of alcoholism. This new theoretical paradigm defined alcoholism as a progressive disease (Ibid), with genetic predispositions. Within this new attitudinal context, clinical or research papers began to appear about the spouses and children of alcoholics. But now rather than "victims" the families were viewed as a possible cause of the father's drinking problem, or as a complicating factor to the illness." Maternal drinking problems were not yet a subject of alcohol research.

Wives of Alcoholic Men

Until very recently, research on alcoholism and the family seemed to be directed primarily towards the wives of alcoholics and under two major

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1. In compiling the review of the literature on the alcoholic family, I was greatly assisted by the existing, comprehensive reviews by Joan Ablon (1976), Peter Steinglass (1976), and Thomas Paolino and Barbara McCrady (1977).

opposing propositions generally categorized as the "disturbed personality theories" and "stress theories" (so labeled by Edwards, Harvey and Whitehead 1973).

The disturbed personality framework, which was primarily based on clinical and psychoanalytical studies, viewed the wife of an alcoholic as a person with long-standing psychopathology, whose choice of an alcoholic or potential alcoholic as husband was directed by unconscious intrapsychic needs of her own. It further suggested that the husband's abberant drinking behavior and subsequent dependency was unconsciously welcomed by the wife because it complimented her masochistic or domineering or emasculating characteristics, thereby enhancing and stabilizing the marriage (Lewis 1954; P 1945; Whalen 1953). Other studies offered clinical evidence that wives exhibited physical and mental decompensation, increased tension levels, and attempts to inhibit improvement when the husband showed signs of achieving controlled drinking or abstinence (Futterman 1953; MacDonald 1956). The "Decomposition Hypothesis" like the "Disturbed Personality Hypothesis" focused on mentalistic, rather than interpersonal or intragroup aspects of family life. (A comprehensive explanation of these two theoretical frameworks can be found in Paolino and McCrady's The Alcoholic Marriage: Alternative Perspectives 1977:62-69.) After reviewing the literature from this era, one is left with the impression that wives of alcoholics are insecure, nervous, hostile, domineering women and that their behavior is more of the cause than effect of their husband's drinking problems. In some of this literature, the alcoholic husband emerges as an innocent victim of his manipulatng spouse. A later series of papers investigating the wife-personality theories indicated that this highly generalized approach to alcoholic families was not warranted (Kogan and Jackson 1965a,b; Edwards, Harvey and Whitehead 1973).

The pioneering papers on "the stress theory" and on whole family involvement in the alcoholic situation, were contributed by the sociologist, Joan Jackson (1954; 1956; 1959, 1962). Based on three years of systematic observation of wives of alcoholics at Al-Anon meetings, and interviews with 157 of its members, Jackson took an alternative and opposing position to the disturbed personality theory. She focused more on how the family as a unit coped with the drinking problem. She described the stressful lifestyle of alcoholic families in terms of seven progressive stages of whole family adjustment to paternal alcoholism. There are: 1) attempts to deny the problem, 2) attempts to eliminate the problem, 3) disorganization, 4) attempts to reorganize in spite of the problem, 5) efforts to escape the problem, 6) reorganization of the family, 7) recovery and reorganization of the home and family (1954). Within this explanatory framework, Jackson challenged the position that the psychopathology of wives of alcoholics existed in the premarriage or prealcoholic stage, and suggested instead that these symptoms were a manifestation of the repetitive stress, strain and cumulative crises of living with an alcoholic.

Although later stress theory research generally supported Jackson's conclusions, there has not been sufficient evidence that all seven stages are experienced by most or nearly all families of alcoholics who have reached abstinence, nor that they occur in the same sequential stages (Bailey 1961; Bailey et al. 1962; Haberman 1964; Lemert 1960; James and Goldman 1971; Sundgren 1978). Lemert (1960) found that families' reactions to alcohol-related events differed according to socioeconomic status, adding an important cultural dimension, which heretofore, had not been considered. Lemert modified Jackson's stages somewhat, suggesting that adjustments tended to group together into early and late phases. Examples of early adjustments were:

awareness of the problem, attempts to control the problem, and social isolation. Later adjustments centered around feelings of giving up or hopelessness, role changes of the wife and divorce. In yet another modification to Jackson's observations, withdrawal or divorce was found to be the chosen coping mechanism in 50% of James and Goldman's (1971) study of 85 wives of alcoholics.

Following Jackson's lead, a series of papers appeared in the 1960's which further challenged the disturbed personality theories and which investigated various aspects of the problem, such as exploration of early-life experiences of wives and current stress situations (Kogan and Jackson 1965b), comparison of neurotic behavior of wives of alcoholics and those of nonalcoholics (Bailey et al. 1962; Corder et al. 1964; Kogan et al. 1963), comparison of certain personality traits in wives whose husbands had drinking problems before marriage, and those who became alcoholics after marriage (Lemert 1960).

In general, the implication of these findings is that no particular personality "type" can be distinguished among wives of alcoholics, however, the personality of a wife "should be treated as an important variable rather than a constant" (Kogan et al. 1963:237). Challengers of the personality theories generally concluded that while on the one hand, it may be true that "some" women tend to select mates which satisfy their unconscious needs, it is equally true that women undergoing the stress of living with an alcoholic (and other types of stress), manifest common neurotic traits. Bailey summarizes the issues:

> While no one denies that the spouse of the alcoholic is seriously disturbed by the time she reaches an identifiable source of help or community intervention, there is a basic question as to whether her disturbance antedates the partner's alcoholism or stems from it. Logically, the two hypotheses need not be mutually exclusive, yet their implications for treatment, for public education and for future direction of research are very different (1961:90).

Family Systems Approach to Alcoholism

Among the first to apply theoretical notions about the family to alcoholic treatment were Ewing and Fox (1968). Drawing on concepts from general systems theory, and on the pioneering works of other family systems theorists (Jackson 1957; Bateson et al. 1956), these authors applied the notion of homeostasis in family systems. Based on their clinical experience they proposed tht alcoholism could no longer be viewed only in terms of intrapsychic dynamics, and that the drive for family hemeostasis may be the perpetuator of drinking patterns. They stated that husbands and wives, over time, establish an "alcoholic marriage" in which certain needs related to dependency or sexual unresponsiveness or other factors are met. They viewed this system as a homeostatic mechanism which is established to resist changes over long periods of time.

> The behavior of each spouse is rigidly controlled by the other. As a result, an effort by one person to alter his typical role behavior threatens the family equilibrium and provokes renewed efforts by the spouse to maintain the status quo (Ewing and Fox 1968:87).

In terms of therapy, Ewing and Fox emphasized the need to work with both halves of the marriage -- and homeostatic dyad. Where working with only the alcoholic spouse, the therapist might initiate change of that individual; this change might in turn initiate increased resistances on the part of the non-drinking partner, thereby minimizing the changes for successful therapeutic outcome.

Adopting the same general concepts of family systems theory, Peter Steinglass and his associates (Steinglass, Weiner and Mendelson 1971a; b) have presented a more comprehensive interactional model of alcoholism. Based on their clinical observations of family interaction during states of experimentally induced intoxicaton, these authors suggested that alcohol use may serve some important dynamic functions in the alcoholic family. In a review of family treatment approaches to alcoholism, Steinglass comments on his own theoretical model:

> The interactional model proposed by Steinglass is based on general systems concepts of family functioning. These concepts posit that families are operational systems obeying laws general to all systems, including the importance of organization, drive toward homeostasis, circularity of causal events, and feedback mechanisms as factors determining the quality of interaction between the component parts of the systems (in this case, members of the family plus alcohol).
>
> Alcohol ingestion and intoxicated behavior is then viewed from the perspective, of the extent to which, and manner in which, it affects the interactional life of the members of the family. Steinglass also suggested that alcohol, by dint of its profound behavioral, cultural, societal, and physical consequences, might assume such a central position in the life of some families as to become an organizing principle for interactional life within these families. He labeled such a family an "alcohol system." In such a system the presence or absence of alcohol becomes the single most important variable determining the interactional behavior not only between the identified drinker and other members of the family but among non-drinking members of the family as well.
>
> This model implied that an intricate and delicate balance exists between drinking and the day-to-day functioning of the family. In fact, it was suggested that in certain instances alcohol might be unconsciously viewed by the family as a stabilizing rather than a disruptive influence on their interactional life. Although superficially disruptive, from a different vantage point, the abusive use of alcohol seemed to produce extremely patterned, predictable, and rigid sets of interactions that

> dramatically reduced uncertainties about the family's internal life and its relationship in the external society (Steinglass 1976:105-106).

Steinglass states that a logical extension of this theoretical model is to view family therapy not so much as a mechanism for improving the condition of the identified alcoholic but rather to view the entire family or the marriage as the patient. The focus of treatment is not so much on the reduction in drinking on the part of the identified alcoholic, but rather on the "functioning flexibility, and growth potential of the family system as a whole" (Ibid:106). Steinglass and his associates introduced the concept of the "alcoholic family system," and a model for explaining alcohol use as a functioning part of the ongoing interactional patterns of family life.

Expanding on the work of Steinglass et al., Davis et al. (1974) proposed a theoretical model which incorporates behavior theory **and** emphasizes the importance of explaining chronic alcoholism in terms of maintenance factors rather than etiological factors. This group based their conclusions on their clinical experiences with marital couples who were experiencing problems with alcoholism. Moving away from the historical premise of therapy that considers that excessive drinking is **maladaptive,** and that the ultimate causes leading to alcoholism are essentially personality or biological traits, they hypothesized that the maintenance of drinking behavior has **adaptive** consequences for either the drinker, other family members or both. These authors stated:

> We propose a model for conceptualizing alcoholism with the following characteristics. (1) the abuse of alcohol has adaptive consequences. (2) These adaptive consequences are sufficiently reinforcing to serve as the primary factors maintaining a habit of drinking, regardless of what underlying causation there may be. (3) The primary factors for each individual differ and may be operating at an intrapsychic level, intra-couple level, or at the level of maintenance of homeostasis in a family or wider social system (Davis et al. 1974:210).

In terms of therapy, the major implications suggested by this model are first, that it is necessary for the therapist to ascertain how the drinking behavior is serving an adaptive function; second, once the adaptive consequences of drinking are detrmined, therapy may be structured around helping a patient to manifest the adaptive behavior while **sober** instead of only while **drinking,** and to learn effective alternative behaviors. Bowen (1974) also viewed alcoholism as explainable through the concepts of family systems theory. Comparing alcoholism to other "common human dysfunctions," Bowen states:

> As a dysfunction, it exists in the context of an imbalance in functioning in the total family system. From a theoretical viewpoint, every important family member plays a part in the dysfunction of the dysfunctional member. The theory provides a way for conceptualizing the part that each member plays. From a systems therapy viewpoint, the therapy is directed at helping the family to modify its patterns of functioning (117).

Bowen suggests that "when it is possible to modify the family relationship system, the alcoholic dysfunction is alleviated, even though the dysfunctional one may not have been part of the therapy" (117). Steinglass (1979) suggests that Bowen's "undiluted justification for family therapy of alcoholism" (168), is probably too strong an approach for most therapists because it does not take into account the behavioral consequences of alcohol consumption. Although other family systems theorists have recognized, as Bowen has, that it is the drinking system rather than the individual which deserves therapeutic attention, most would not agree that the alcoholic dysfunction can be alleviated even though the alcoholic may not have been part of the therapy.

Steinglass' most recent contribution to the field of alcoholic family studies is a life history model of the alcoholic family (1980) wherein he incorporates the concepts of the alcoholic system, family homeostasis and a new dimension, the "family alcohol phase." Using four case histories, he traces

chronic alcoholism and the distortions it produces, in the normative family life cycle. This "macroscopic" (longitudinal) dimension is an important complement to the more microscopic (day-to-day) dimension on the **cyclical** use of alcohol. He states:

> Our primary interest in the life history model is the macroscopic dimension -- those long periods of months or years that can be characterized as "dry" or "wet" by the family. Although such distinctions are obviously tied to the drinking behavior of one (or perhaps two) family members, it is our perception that the entire family not only can clearly demarcate these time periods one from another, but tends to associate these different periods with profoundly different life experiences and patterns of behavior. In this sense, these different time periods can be thought of as "family-level alcohol life phases." .... a dry phase; a wet phase; and a transitional phase (transitions from wet to dry and dry to wet time frames) (214).

Steinglass' developmental approach has several important clinical implications. As an extension of the concept of family systems, it suggests the importance,

> of making a clinical distinction between those families that have introduced alcohol use as a central organizing principle for interactional behavior and those families that seem to treat the drinking of their alcoholic member as an isolated or circumscribed symptom (224).

But more importantly, the life history mode in its use of the family alcohol phase concept, suggests that,

> the developmental history of the alcoholic family rather than consisting of a series of progressive stages, is instead organized in a cyclical fashion. The family returns repeatedly to stages already experienced rather than moving ahead in stepwise fashion to deal with a progressive series of tasks and stages" (224).

The fluctuating between long periods of "stable-wet and stable-dry family life phases produces a "plateauing" effect that profoundly alters the customary slope of family development (Ibid).

Ablon (1980) adds another important and heretofore ignored dimension to the family systems approach to alcoholism in her recent paper on drinking practices and behaviors among an Irish-Catholic population. Her four-year study on non-labeled, Irish-Catholic families wherein the father was the problem drinker illustrates the significance of cultural patterning for both the inception and continuance of excessive drinking patterns. She states:

> This study of a specific group of families at high risk for frequent and severe alcohol problems illustrates the importance of looking at the behavior of family members as they relate to each other in a complex of social and cultural expectations rather than focusing only on individuals as interacting bundles of pathological needs. In contrast to labeling the wife (or any other family member) as culprit or martyr, in this population of families, a perpetuating, encompassing, culturally defined family system may be perceived as both culprit and martyr. A holistic perspective allowing the delineation of cultural prescriptions and expectations regarding behavior and attitudes directly and indirectly related to drinking patterns may contribute another dimension to the systems model proposed by clinicians (142-143).

The series of papers by the family systems theorists can be recognized as a revolutionary effort to view chronic alcoholism in its functional and interactional relationship to family and other social groupings. This perspective has helped researchers, clinicians and family therapists to achieve step-to-step progress towards understanding the complex problems surrounding chronic alcoholism and family life.

Female Alcoholism in American Society

Over the past two decades, the number of women who use alcohol has increased in the United States from 45 to 66 percent, while the number of male drinkers rose from 70 to 77 percent (Gallup 1958, 1978). Not only are women drinking more frequently, they are starting to drink at an earlier age and are drinking publicly with much more acceptance than ever before (Sandmaier 1980). The institutional statistics of the past decade show that

incidence of alcoholism among women has also been on the increase: in 1966 the estimated number of female alcoholics was one million (Kinsey 1966) and by 1974, the national figure had risen to three million (Chafetz 1974). In that same year, Alcoholics Anonymous reported that one out every three new members over a three-year period was a woman, and that women now account for 28 percent of their membership (National Clearing House 1975). Considering that these figures exclude the many women who are drinking secretly and/or those who choose not to seek professional help for their drinking problems, these figures are almost certainly conservative estimates.

Until very recently, the alcohol literature in general that is written by both clinicians and sociologists has reflected the notion that alcohol addiction is a problem attributed primarily to adult men. While it is generally true that heavy drinking is more incorporated into the American male's behavioral patterns, as the above statistics indicate, many American women are also regular and heavy drinkers. In our society, heavy drinking and most certainly drunkenness among women has been considered by most to be deviant or immoral behavior (Block 1965; Gomberg 1974; Kinsey 1966; Schuckit 1972). My own research experiences over the past six years have shown that this attitudinal pressure still persists to the degree that it inhibits women and their families from seeking professional help (Ames 1978; 1981b). In one national survey, it was found that in the United States, there is a 6 to 1 ratio of men to women who seek help for alcohol related problems (Cahalan and Cisin 1968). In view of the rapidly rising consumption rates and incidence of alcoholism among women, the low ratio of women seeking professional help would indicate that the cultural bias against female alcoholism has far-reaching implications for the health needs of many American women. Cultural attitudes against female alcoholism have encouraged a kind of "cultural protection" (Knupfer

1946) around women who have drinking problems. Unfortunately, this protection extends to all levels of American society to the degree that it has inhibited much needed studies on alcohol-related problems of women. (For a comprehensive review of women and alcohol see Schuckit 1972 and Lindbeck 1972).

Husbands of Alcoholic Women

Lindbeck (1972) and Wilson (1980) identified the role of the spouse in the inception, progression and treatment of problem drinking among women as an area especially neglected in the literature on women, and as representative of "yet another example of the general tendency for researchers to regard the male drinker as a more important subject for study than his female counterpart" (Wilson 1980:102).

Reporting from her psychiatric practice, Fox (1956) found that men are more likely to leave alcoholic wives and are less accepting of their excessive drinking patterns than women are of alcoholic husbands, a fact which no doubt is related to the wife's weaker economic position (she may be dependent upon her husband for subsistence) and general social stigma associated with female drunkenness (Ablon 1976). Over the years alcoholic marriages, whether the wife, the husband or both are alcoholic, have been consistently found to have more marital conflicts, separation, and divorce than control groups (Cahalan 1970). One study indicated that between a third and two-thirds of all women diagnosed as alcoholic are divorced or separated (Schuckit 1971). Among researchers and clinicians, there is a general consensus that alcoholism contributes to family stress and instability, and that wives, husbands and children of alcoholics have "relatively high rates of physical, emotional and psychosomatic illnesses" (Straus: 1971:259). Straus suggests that because of preoccupation with alcohol, personality factors associated with alcoholism or

the sedative impact of ethanol, women alcoholics are often unsatisfying sexual partners, a factor which causes additional stress on the marriage (Ibid).

Still another issue of importance with regard to the quality of marital relationships, are the reports that many women who are problem drinkers are married to men who have similar problems (Wilson 1980). Various theories of explanation are offered for the fact that a higher ratio of women to men who are alcoholics are married to alcoholics or heavy drinkers. Lisansky, in her study of two samples of alcoholic men and women from differing socioeconomic backgrounds offered that "persons with a predisposition to alcoholism are more likely to marry individuals with similar predispositions" (1957:604), a like chooses like theory. One variation on that theme, correlates the spouse selection problem to the high percentage of alcoholism in families of orientation, that is, having lived with an alcoholic mother or father, women feel equipped to cope with or to "nurture" an afflicted husband (Jacob and Lavoie 1971; Gomberg 1978). Another suggests that women may become addicted to alcohol as a result of social drinking with a heavy drinking spouse over extended periods of time (Orford et al. 1975; Gomberg 1976), or spouses become alcoholics simultaneously as a result of convivial drinking.

It should be noted that the theme of "disturbed personalities" of wives of alcoholics (as previously reviewed) seemed to be carried forth to the studies of women alcoholics. This was evidenced in the literature which related the higher ratio of alcoholic women who marry heavy drinkers to preexisting psychopathology on the part of the wife (Kinsey 1966; Sclare 1970; Rathod and Thomson 1971). One study of hospitalized alcoholic women viewed these women's alcoholic husbands as a marital problem, but **not** as a contributor to the overall stress and situational context of the excessive drinking (Rosenblaum 1958). This ongoing bias against women who are in alcoholic marriages --

whether the woman is the drinker or the spouse of the drinker -- is viewed by Lindbeck as the "she done him wrong" versus "she drove him to drink" syndrome (1972:575).

The present dissertation, a naturalistic study building on Ablon's study with Irish-Catholic families, contributes another dimension to the systems approach: it is an exploration of the significance of cultural beliefs about alcohol use and alcoholism, and of the impact of cultural patterning for alcoholic family life. This dissertation likewise contributes to a number of areas where there is a dearth of material in the field of alcohol studies. These areas are: alcoholism and women, maternal alcoholism, alcoholism and total family life and a detailing of the effects of parental alcoholism on children.

BIBLIOGRAPHY

Ablon, Joan

1981 Stigmatized Health Conditions. Social Science and Medicine, Vol. 15B:5-9.

1980 The Significance of Cultural Patterning for the Alcoholic Family. Family Process, 19:127-144.

1979 Research Frontiers for Anthropologists. In, Family Studies, A Case in Point: Alcoholism and the Family. Human Organization, 38:196-200.

1976 Family Structure and Behavior in Alcoholism: A Review of the Literature. In, B. Kissin and H. Begleiter, eds., The Biology of Alcoholism Vol. 4, New York: Plenum Publishing Corporation.

1974 Al-Anon Family Groups: Impetus for Learning and Change through the Presentation of Alternatives. American Journal of Psychotherapy, 28:30-45.

Ablon, Joan, Genevieve Ames and William Cunningham

1982 To All Appearances: An Ideal American Family. In, E. Kaufman, ed., The Power to Change: Case Studies in Alcoholism. New York: The Gardner Press.

Albrecht, Gary L.

1973 The Alcoholism Process: A Social Learning Viewpoint. In, Peter Bourne and Ruth Fox, eds., Alcoholism: Progress, Research and Treatment. New York: Academia Press, Inc.

American Medical Association

1968 Manual on Alcoholism. Chicago, Illinois: AMA.

1961 Standard Nomenclature of Diseases and Operations, Fifth Edition. E.T. Thompson and A.C. Hayden, eds. New York: Blakiston.

American Medical Association
Council on Mental Health and Committee on Alcoholism and Drug Dependence

1972 Medical School Education on Abuse of Alcohol and Other Psychoactive Drugs. Journal of American Medical Association, 219:1746-49.

Ames, Genevieve

1981 Family Dynamics and Alcoholism: Implications for Treatment. Paper presented at the annual meetings of the American Anthropological Association, Los Angeles, California, December 1981.

1978 The Problem-Drinker Housewife: Changes in Role and Role Behavior. Paper presented at the annual meetings of the American Anthropological Association, Los Angeles, California, November 1978.

Ames, Genevieve
1977 A Description of Women Alcoholics' Behavior as Affected by American Sociocultural Attitudes. M.A. Thesis, Anthropology, San Francisco State University.

Ames, Genevieve and Joan Ablon
1981 Naturalistic Studies of Alcoholic Family Life: Practical Issues of Entree, Rapport, Reciprocity and Ethics. Paper presented at the Forty-First Annual Meeting, Society for Applied Anthropology, University of Edinburgh, Scotland.

Armor, David J., Michael Polich, Harriet Stambul
1978 Alcoholism and Treatment. New York: John Wiley & Sons.

Bacon, Selden
1957 Social Settings Conducive to Alcoholism: A Sociological Approach to a Medical Problem. Journal of the American Medical Association, 164:177-81.

Bailey, M.B.
1967 Psychophysiological Impairment in Wives of Alcoholics as Related to their Husbands' Drinking and Sobriety. R. Fox, ed., Alcoholism: Behavioral Research, Therapeutic Approaches. New York: Springer.

1961 Alcoholism and Marriage: A Review of Research and Professional Literature. Quarterly Journal of Studies on Alcohol, 22:81-97.

Bailey, M.B., P.W. Haberman, H. Alksne
1962 Outcomes of Alcoholic Marriages: Endurance, Termination or Recovery. Quarterly Journal of Studies on Alcohol, 23(4):610-623.

Bales, Robert F.
1946 Cultural Differences in Rates of Alcoholism. Quarterly Journal of Studies on Alcohol, 6:482-498.

Barry, Herbert, III
1974 Psychological Factors in Alcoholism. In, B. Kissin and H. Begleiter, eds., The Biology of Alcoholism, Vol. 3. New York: Plenum Press.

Barth, Fredrik
1969 Introduction. In, F. Barth, ed., Ethnic Groups and Boundaries: The Social Organization of Culture Difference. Boston: Little, Brown and Company.

Bateson, Gregory, Don D. Jackson, Joy Haley, John H. Weakland
1956 Toward a Theory of Schizophrenia. Behavioral Science, 1:251.

Bennett, Linda A., S. Wolin, D. Noonan
1976 Family Identity and Intergenerational Recurrence of Alcoholism. Paper presented at the Sixth World Congress of Social Psychiatry. Opatija, Yugoslavia, October 1976.

Block, Marvin
1964 Alcoholism, Its Facets and Phases New York: John Day Co.

Bott, Elizabeth
1957 Family and Social Network. New York: The Free Press.

Bowen, Murray
1974 Alcoholism as Viewed through Family Systems Theory and Family Psychotherapy. Annals New York Academy of Sciences.

Cahalan, Don
1970 Problem Drinkers. San Francisco: Jossey-Bass, Inc.

Cahalan, D. and I.H. Cisin
1968 American Drinking Practices: Summary of Findings from a National Probability Sample. II. Measurement of Massed vs Spaced Drinking. Quarterly Journal of Studies on Alcohol, 29:642-656.

Cahalan, Don, I.H. Cisin, and H.M. Crossley
1969 American Drinking Practices: A National Study of Drinking Behavior and Attitudes. New Brunswick, New Jersey: Rutgers Center of Alcohol Studies (Monograph No. 6).

Cahalan, D. and R. Room
1974 Problem Drinking among American Men. New Brunswick, New Jersey: Rutgers Center of Alcohol Studies (Monograph No. 7).

Chafetz, Morris E.
1974 National Institute on Alcohol Abuse Report. Twin City Feature Weekly, October 10, 1974. Minneapolis, Minnesota: Sun Newspapers, Inc.

Chafetz, Morris E. and Harold W. Demone, Jr.
1962 Alcoholism and Society. New York: Oxford University Press.

Clark, Norman H.
1976 Deliver Us From Evil: An Interpretation of American Prohibition. New York: W.W. Norton & Co., Inc.

Clark Walter
1975 Conceptions of Alcoholism: Consequences for Research. Addictive Diseases: An International Journal, 1(4):395-430.

1966 Operational Definitions of Drinking Problems and Associated Prevalence Rates. Quarterly Journal of Studies on Alcohol, 27:648-688.

Corder, B.F., A. Hendricks, and R.R. Corder
1964 An MMPI Study of a Group of Wives of Alcoholics. Quarterly Journal of Studies on Alcohol, 25(3):551-554.

Cumming, Elaine and John Cumming
1957 Closed Ranks: An Experiment in Mental Health Education. Cambridge, Mass.: Harvard University Press.

Davis, Donald, David Berenson, Peter Steingless and Susan Davis.
1974 The Adaptive Consequences of Drinking. Psychiatry, 37:209-215.

Durkheim, Emile
1895 The Rules of Sociological Method. Chicago: University of Chicago
(1938) Press.

Edwards, P., C. Harvey and P.C. Whitehead
1973 Wives of Alcoholics: A Critical Review and Analysis. Quarterly Journal of Studies on Alcohol, 34:112.

Ewing, J.A., and R.E. Fox
1968 Family Therapy of Alcoholism. In, J.H. Masserman (ed.), Current Psychiatric Therapies, Vol. 8. New York: Grune & Stratton.

Everett, Michael W., Jack O. Waddell, Dwight B. Heath, Editors
1976 Cross-Cultural Approaches to the Study of Alcohol: An Interdisciplinary Perspective. The Hague and Paris: Mouton Publishers.

Fox, R.
1962 Children in the Alcoholic Family. In, W.C. Bier (ed.), Problems in Addiction: Alcohol and Drug Addiction. New York: Fordham University Press.

1956 The Alcoholic Spouse. In, V. W. Eisenstain (ed.), Neurotic Interaction in Marriage. New York: New Books.

Friedson, E.
1979 Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead.

Futterman, S.
1953 Personality Trends in Wives of Alcoholics. Journal of Psychiatric Social Work, 23(1):37-41.

Gallup, George
1958 The Gallup Poll: Nationwide Drinking Audits. Princeton, N.J.: American Institute of Public Opinion.

Gans, Herbert
1961 The Urban Villagers. New York: The Free Press.

Gitlow, Stanley E.
1973 Alcoholism: A Disease. In, Peter Bourne and Ruth Fox (eds.), Alcoholism: Progress, Research and Treatment. New York: Academia Press.

Glaser, Frederick B.
1976 Alcoholism in Pennsylvania -- A Bicentennial Perspective (reprint). Pennsylvania Medicine, July.

Goffman, Erving
1963 Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, N.J.: Prentice-Hall, Inc.

Gomberg, Edith S.
1978 Risk Factors Related to Alcohol Problems Among Women: Proneness and Vulnerability in Alcohol and Women. Research Monograph I. Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism.

1976 Alcoholism in Women. In, B. Kissin and H. Begleiter (eds.), The Biology of Alcoholism. Vol. 4, Social Aspects of Alcoholism. New York: Plenum Press.

1974 Women and Alcoholism. In, V. Frank and V. Burtle (eds.), Women in Therapy: New Psychotherapies for a Changing Society. New York: Brunnell-Mazel.

Goodwin, Donald
1976 Is Alcoholism Hereditary? London: Oxford University Press.

Greenblatt, M. and M.A. Schuckit
1976 Alcohol Problems in Women and Children. New York: Grune and Stratton.

Gusfield, Joseph R.
1967 Moral Passage: The Symbolic Process in Public Designations of Deviance. Social Problems, 15(2):175-188.

1963 Symbolic Crusade: Status Politics and the American Temperance Movement. University of Illinois.

1962 Status Conflicts and the Changing Ideologies of the American Temperance Movement. In, David Pittman and Charles Snyder (eds.), Society, Culture and Drinking Patterns. New York: John Wiley & Sons.

Haberman, P.W.
1964 Psychological Test Score Changes for Wives of Alcoholics during Periods of Drinking and Sobriety. Journal of Clinical Psychology, 20:230-232.

Haggard, H.W.
1945 The Physician and the Alcoholic. Quarterly Journal of Studies on Alcohol, 6:213-21.

Hansen, Connie
1981 Living in With Normal Families. Family Process, 20:53-75.

Heath, Dwight B.
In Press Recent Developments in the Anthropological Study of Alohol Use: 1970-1980. In, Mary Douglas (ed.), The Anthropology of Drink. Cambridge University Press.

1978 The Sociocultural Model of Alcohol Use: Problems and Prospects. Journal of Operation Psychiatry, 9(1):56-66.

1976 Anthropological Perspectives on Alcohol: An Historical Review. In, M.W. Everett, J.O. Waddell, and D.B. Heath (eds.), Cross-Cultural Approaches to the Study of Alcohol. The Hague and Paris: Mouton Publishers.

Henry, Jules
1965 Pathways to Madness. New York: Vintage Books.

1965 Culture Against Man. New York: Vintage Books.

Hill, Reuben and Donald Hansen
1960 The Identification of Conceptual Frameworks Utilized in Family Study. Marriage and Family Living, 22:299.

Hood, William
1972 A Metabolic Clue to Indian Endurance and Intolerance for Alcohol. Psychology Today, 6(2):16.

Horton, Donald
1943 The Functions of Alcohol in Primitive Societies: A Cross-Cultural Study. Quarterly Journal of Studies on Alcohol, 4:199-320.

Howell, Joseph T.
1973 Hard Living on Clay Street: Portraits of Blue Collar Families. New York: Anchor Press: Doubleday.

Jackson, Don
1957 The Question of Family Homeostasis. Psychiatric Quarterly Supplement, 31:79.

Jackson, Joan K.
1962 Alcoholism and the Family. In, David J. Pittman and Charles R. Snyder (eds.), Society, Culture and Drinking Patterns. New York: John Wiley & Sons.

1959 Family Structure and Alcohol. Mental Hygiene, 43:403-406.

1954 The Adjustment of the Family to the Crisis of Alcoholism. Quarterly Journal of Studies on Alcohol, 15(4)562-586.

Jacob, A.C. and C.A. Lavoie
1971 A Study of Some Characteristics of a Group of Women Alcoholics. Paper presented at the Conference of the North American Association of Alcoholism Programs, Hartford, June 1971.

James, E. and M. Goldman
1971 Behavior Trends of Wives of Alcoholics. Quarterly Journal of Studies of Alcohol, 32(2) 373-381.

Jellinek, E.M.
1962 Phases of Alcohol Addiction. In, David J. Pittman and Charles R. Snyder (eds.), Society, Culture and Drinking Patterns. New York: John Wiley & Sons, Inc.

1960 The Disease Concept of Alcoholism. New Haven, Conn.: College and University Press.

1952 Phases of Alcohol Addiction. Quarterly Journal of Studies on Alcohol, 13(4):673-684.

1946 Phases in the Drinking History of Alcoholics. Quarterly Journal of Studies on Alcohol, Vol. 7 (March):1-88.

Kantor, David and William Lehr
1975 Inside the Family: Toward a Theory of Family Process. New York: Harper & Row.

Kaufman, E. and P. Kaufmann, Eds.
1979 Family Therapy of Drug and Alcohol Abuse. New York: Gardner Press, Inc.

Keller, Mark
1977 A Lexicon of Disablements Related to Alcohol Consumption. In, G. Edwards, M.M. Gross, M. Keller, J. Moser and R. Room (eds.), Alcohol-Related Disabilities. WHO Offset Publication No. 32. Geneva: World Health Organization.

1976 Problems with Alcohol: An Historical Perspective. In, Wm. J. Filsted, Jean J. Rossi, and Mark Keller (eds.), Alcohol and Alcohol Problems: New Thinking and New Directions. Cambridge, Mass.: Ballinger Publishing Co.

Kinsey, Barry
1966 The Female Alcoholic: A Social-Psychological Study. Springfield, Ill.: Chas. C. Thomas, Publisher.

Kissin, Benjamin
1974 The Pharmacodynamics and Natural History of Alcoholism. In, Benjamin Kissin and Henri Begleiter (eds.), The Biology of Alcoholism, Vol. 3: Clinical Pathology. New York: Plenum Press.

Knupfer, Genevieve
1964 Female Drinking Patterns. In, North American Association of Alcoholism Programs, Selected Papers Presented at the 15th Annual Meeting. Washington, D.C.: NAAAP.

Kogan, K.L., W.E. Fordyce and J.R. Jackson
1963 Personality Disturbance in Wives of Alcoholics. Quarterly Journal of Studies on Alcohol, 24(2):227-238.

Kogan, K.L., and J.K. Jackson
1965a Alcoholism: The Fable of the Noxious Wife. Mental Hygiene, 49(3):428-437.

1965b Stress, Personality and Emotional Disturbance in Wives of Alcoholics. Quarterly Journal of Studies on Alcohol, 26(3):486-495.

Lasch, Christopher
1977 Haven in a Heartless World: The Family Besieged. New York: Basic Books, Inc.

Lemert, E.M.
1960 The Occurence and Sequence of Events in Adjustments of Families to Alcoholism. Quarterly Journal of Studies on Alcohol, 21(4):679-697.

1951 Social Pathology: A Systematic Approach to the Theory of Sociopathic Behavior. New York: McGraw-Hill.

Lewis, M.L.
1954 The Initial Contact with Wives of Alcoholics. Social Casework, 35:8.

Lewis, Oscar
1965 La Vida, New York: Random House.

1959 Five Families. New York: Basic Books.

Levine, Harry
1978 The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America. Journal of Studies on Alcohol, 39(1):143-174.

Liebow, Elliot
1967 Tally's Corner: A Study of Negro Street Corner Men. Boston: Little, Brown and Company.

Lindbeck, Vera L.
1972 The Women Alcoholic: A Review of the Literature. International Journal of Addictions, 7:567-580.

Linton, Ralph
1945 The Cultural Background of Personality. New York: Appleton-Century-Crofts.

Lisansky, Edith
1957 Alcoholism in Women: Social and Physiological Concomitants. Quarterly Journal of Studies on Alcohol, 18:588-623.

Lolli, Giorgio, E. Golder and P. Luzzatto-Fegis
1958 Alcohol in Italian Culture. Glencoe, Illinois: Free Press.

MacAndrew, Craig and Robert B. Edgerton
1969 Drunken Comportment. Chicago: Aldine Publishing Co.

MacDonald, D.E.
1956 Mental Disorders in Wives of Alcoholics. Quarterly Journal of Studies on Alcohol, 17(2):282-287.

Madsen, William
1974 The American Alcoholic: The Nature-Nurture Controversy in Alcoholic Research and Therapy. Springfield, Ill.: Charles C. Thomas.

Marshall, Mac, Ed.
1979 Beliefs, Behaviors, and Alcoholic Beverages: A Cross-Cultural Survey. Ann Arbor: The University of Michigan Press.

Minuchin, Salvador, B. Rosman and L. Baker
1978 Psychosomatic Families: Anorexia Nervosa in Context. Cambridge, Mass.: Harvard University Press.

Mulford, Harold and Donald Miller
1964 Measuring Public Acceptance of the Alcoholic as a Sick Person. Quarterly Journal of Studies on Alcohol, 25(2):314-323.

National Clearinghouse for Alcohol Information
1975 Fact Sheet - Women and Alcohol: Drinking Practices of American Women. February.

Nye, F. Ivan
1976 Role Structure and Analysis of the Family. Beverly Hills, California: Sage Publications.

Nye, F. Ivan and Felix M. Berardo
1973 The Family: Its Structure and Interaction. New York: The Macmillan Company.

Orcutt, James D.
1976 Ideological Variations in the Structure of Deviant Types: A Multivariate Comparison of Alcoholism and Heroin Addiction. Social Forces, 55(2):419-437.

Orford, J., S. Guthrie, P. Nicholls, E. Oppenheimer, S. Egert and C. Hensman
1975 Self-Reported Coping Behavior of Wives of Alcoholics and Its Association with Drinking Outcome. Journal of Studies on Alcohol, 36:1254-67.

Paolino, Thomas J. and Barbara S. McCrady
1977 The Alcoholic Marriage: Alternative Perspectives. New York: Grune & Stratton.

Pittman, David J. and Charles R. Snyder
19622 Society, Culture and Drinking Patterns. New York: John Wiley & Sons.

Plaut, Thomas F.A.
1967 Alcohol Problems. A Report to the Nation. New York: Oxford University Press.

Price, G.M.
1945 A Study of the Wives of 20 Alcoholics. Quarterly Journal of Studies on Alcohol, 5(4):620-627.

Rathod, N.H., and I.G. Thomson
1971 Women Alcoholics: A Clinical Study. Quarterly Journal of Studies on Alcohol, 32:45-52.

Room, Robin
In Press Sociology and the Disease Concept of Alcoholism. Research Advances in Alcohol and Drug Problems, Vol. 7. New York & London: Plenum Press.

1976 Ambivalance as a Sociological Explanation: The Case of Cultural Explanations of Alcohol Problems. American Sociological Review, 41:1047-1065.

1970 Assumptions and Implications of Disease Concepts of Alcoholism. Presented at the 29th International Congress on Alcoholism and Drug Dependence, Sydney, Australia, February 1970.

Rosenblaum, B.
1958 Married Women Alcoholics at the Washingtonian Hospital. Quarterly Journal of Studies on Alcohol, 19:79-89.

Sahlins, Marshall D.
1968 Culture and Environment: The Study of Cultural Ecology. In, R. Manners and D. Kaplan, (eds.), Theory in Anthropology. New York: Aldine Publishing Co.

Sandmaier, Marian
1980 The Invisible Alcoholics: Women and Alcohol Abuse in America. San Francisco: McGraw-Hill Book Company.

Schuckit, M.
1972 The Alcoholic Women: A Literature Review. Psychiatry in Medicine, 3:37-42.

Sclare, A.B.
1970 The Female Alcoholic. British Journal of Addiction, 63:99-107.

Spradley, James P.
1970 You Owe Yourself a Drunk: An Ethnography of Urban Nomads. Boston: Little, Brown and Company.

Stack, Carol B.
1974 All Our Kin: Strategies for Survival in a Black Community. San Francisco: Harper & Row.

Steiner, C.M.
1971 Games Alcoholics Play. New York: Grove Press.

Steinglass, Peter
1980 A Life History Model of the Alcoholic Family. Family Process, 19(3):211-226.

1979 Family Therapy with Alcoholics: A Review. In, E. Kaufman and P. Kaufmann (eds.), Family Therapy of Drug and Alcohol Abuse. New York: Gardner Press, Inc.

1977 Family Therapy in Alcoholism. In, B. Kissin and H. Begleiter (eds.), The Biology of Alcoholism 5. New York: Plenum.

1976 Experimenting with Family Treatment Approaches to Alcoholism, 1950-1975: A Review. Family Process, 16:97-123.

Steinglass, Peter, Sheldon Weiner and Jack Mendelson
1971a Interaction Issues as Determinants of Alcoholism. American Journal of Psychiatry, 128:55-60.

1971b A Systems Approach to Alcoholism: A Model and its Clinical Implications. Archives of General Psychiatry, 24:401-408.

Skolnick, Jerome H.
1958 Religious Affiliation and Drinking Behavior. Quarterly Journal of Studies on Alcohol, 19:452-470.

Snyder, Charles
1958 Alcohol and the Jews: A Cultural Study of Drinking and Sobriety. New Haven: Yale Center of Alcohol Studies, Monograph No. 1.

Stivers, Richard
1976 The Hair of the Dog. University Park: Penn State University Press.

Straus, Robert
1976 Problem Drinking in the Perspective of Social Change, 1940-1973. In, Wm. J. Filstead, Jean J. Rossi and Mark Keller (eds.), Alcohol and Alcohol Problems: New Thinking and New Directions. Cambridge, Mass.: Ballinger Publishing Co.

1971 Alcohol and Alcoholism. In, Robert Nesbit (ed.), Contemporary Social Problems. New York: Harcourt Brace.

Straus, Robert and Seldon Bacon
1953 Drinking in College. New Haven, Conn.: Yale University Press.

Stull, Don
1975 Hologeistic Studies of Drinking: A Critique. Drinking and Drug Practices Surveyor, 10:4-10. Berkeley: Social Research Group.

Sundgren, Ann S.
1978 Sex Differences in Adjustment to an Alcoholic Spouse. Unpublished Ph.D. Dissertation.

Weakland, John H.
1977 Schizophrenia: Basic Problems in Sociocultural Investigation. In, P. Watzlawick and J. Weakland (eds.), The Interactional View. New York: W.W. Norton and Co.

Whalen, T.
1953 Wives of Alcoholics: Four Types Observed in a Family Service Agency. Quarterly Journal of Studies on Alcohol, 14(4):632-641.

Whitehead, Paul C. and C. Harvey
1974 Explaining Alcoholism: An Empirical Test and Reformulation. Journal of Health and Social Behavior, 15:57-65.

Wilson, Clare
1980 The Family. In, Camberwell Council on Alcoholism, Women and Alcohol. London: Tavistock Publications.

World Health Organization, Expert Committee on Mental Health, Alcoholism Subcommittee
1952 Second Report. World Health Organization Technical Service Report No. 18. In, H. Milt (ed.), Basic Handbook on Alcoholism. Fairhaven, New Jersey: Scientific Aids Publications.

Zwerling, I.
1959 Psychiatric Findings in an Interdisciplinary Study of Forty-Six Alcoholic Patients. Quarterly Journal of Studies of Alcohol, 20:543-554.