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Familial perspectives with regard to chemical dependency

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Abstract

Recent literature supports the belief that alcoholism has adverse effects on family systems. It is the intention of this paper to illustrate what role alcohol plays in family systems, and how family members react to this disease. This review of literature has a second purpose which is to discuss how family therapists propose to treat chemical dependency.

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Recent literature supports the belief that alcoholism has adverse effects on family systems. It is the intention of this paper to illustrate what role alcohol plays in family systems, and how family members react to this disease. This review of literature has a second purpose which is to discuss how family therapists propose to treat chemical dependency.

Currently there are at least nine million adults in the United States who abuse or who are addicted to alcohol (Kaufman & Kaufman, 1981). Less conventional estimates range up to 15 million people (Steinglass, 1976). Due to the impact on family members a staggering amount of individuals are indirectly effected by alcoholism.

The situation of alcoholism in families is complicated by the contradiction between the popular stereotype of the alcoholic and the realities of alcoholism. Only an infinitesimal percentage of all alcoholics comprise the continually intoxicated, "Skid Row Bum," who is in the chronic stage of alcoholism. Most alcoholics, until well along into the disease, spend the greatest majority of their time sober and handling their roles in an acceptable manner. The discrepancy between the stereotype and the reality blinds the family as well as the alcoholic to the nature of the situation (Jackson, 1959).

A significant, if not major, percentage of the alcoholic population continues to function with reasonably intact and stable family systems (Kaufman & Kaufman, 1981). Kaufman (1985), relates that there is no single typology of the dysfunctional family with an alcoholic member, nor does any alcoholic family maintain the same patterns of interaction. He continues by stating that alcoholic families may be functional and homeostatic; neurotic and enmeshed; disintegrated or absent.

A basic premise of family systems is that the family itself, rather than any one member, is the unit of concern (Bowen, 1974). By definition a change in any one element of a system affects all other elements. Therefore, the development of the disease of alcoholism in any member of the family affects all the other members of the family system (Straussner, Weinstein, & Hernandez, 1979).

Systems theory is also based on the premise that all important people in the family unit play a part in the way family members function in relation to each other (Bowen, 1974). As a psychological unit, the family moves to establish an emotional balance in order to preserve itself. This balance or equilibrium shifts in response to changes which occur within the family (Meeks & Kelly, 1970).

In systems theory the focus is on the operative facts of relationships--on what happened, how it happened, and when, and where it happened, insofar as observations are based on fact. It carefully avoids why it happened. Therefore, cause and effect situations, as well as blame are avoided (Bowen, 1974). Linear causality does not find a place in systemic thinking. It is replaced by circular and multiple causality.

> A man and a woman, each with a unique personality, each with needs and values reflecting their familial and cultural origins meet, are attracted to each other, and form a family unit--a new system unique to this couple. Although family units may have many similarities, each one, whether happy or unhappy, reflects the uniqueness of its system. Roles, alliances, and patterns of interaction and communication gradually become firmly entrenched. (Straussner et al., p. 112)

Accordingly systems theory contends that the whole is greater than the sum of its parts. A couple is not the sum of the personality of each member alone, but the result of the dynamic interaction that occurs between them (Stahman & Hiebert, 1984).

On the average, the progression of alcoholism from the onset of early, subtle characteristics to the late chronic

stage, takes from 10 to 15 years (Straussner et al., 1979). Throughout this time, the family slowly and steadily adapts and learns to live with the dysfunctional member, thereby maintaining the system's balance. However, family members living in this type of dysfunction pay a price. "The end result is the development of certain defenses and even symptoms by all the members of the family. Thus, alcoholism becomes a 'family disease'" (Straussner et al., 1979, p. 113).

Kaufman (1985) reports that family patterns will vary based on ethnic, cultural, and socioeconomic status, as well as the age and life cycle stage of the alcoholic. Family function and dysfunction also varies depending on the sex of the alcoholic as well as with the role the he/she plays in the family system. In most families, alcoholism is a systems-maintaining and systems-maintained device (Kaufman, 1985). Russell, Olson, Sprenkle, and Atilano (1983) contends that the functional repercussions of the alcoholic's behavior may be different for each family system and may operate at several system levels such as: individual, dyadic, family or beyond.

"The use of alcohol is purposeful, adaptive, homeostatic and meaningful" (Kaufman & Pattison, 1981, p. 952). The problem of alcoholism is not just the consequences of drinking in and of itself, but more importantly, the system function

that drinking fulfills in the psychodynamics of the family system (Kaufman & Pattison, 1981).

Marital and family conflict may cause, promote, and maintain alcoholism as a symptom of family system dysfunction. Alcoholism can be used as a coping mechanism to deal with family dysfunction, as this takes the focus off what is really going on. Alcoholism is also seen as a consequence of dysfunctional family styles, rules, and patterns. In this way, "alcoholism is not the cause of family dysfunction but the effect of family dysfunction" (Kaufman, 1985, p. 901).

Steinglass (1976) demonstrates through his interactional theory that a sophisticated and delicate balance exists between drinking and the day-to-day functioning of the family. The abusive use of alcohol seems to produce extremely patterned, predictable, and rigid set of standards that allow a family to function within a known boundary system both internally and externally.

Higher functioning and healthier family systems are more flexible. This is helpful in adapting to the expected and unexpected changes that life brings. The more dysfunctional the family system, the more rigid and static it becomes, and the less flexible it is in readapting to life's challenges (Straussner et al., 1979). Klagsburn and Davis (1977) go on to say that a system is flexible insofar

as it can adapt to change without becoming disorganized; otherwise it is rigid.

Davis, Berenson, Steinglass, and Davis (1974) provide a model for conceptualizing alcoholism with the following characteristics: (a) The abuse of alcohol has adaptive consequences; (b) 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; and (c) 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.

The Role of the Symptom

Alcohol may serve functions within a family. Pearson and Andersen (1985) report three functions: (a) to signal stress and strain within the family, (b) stabilize a chaotic system, and (c) regulate emotional intimacy. Davis et al., (1974) add three more uses that alcohol yields: (a) it assures acceptance into the family, (b) cements role differentiations, and finally (c) allows for responsibility avoiding maneuvers.

Drinking is often an escape for managing daily stress. In the absence of more adaptive coping behaviors, families may rely on a pattern of increased drinking to minimize the effects of stress. The stressor can be internal or external.

Unfortunately, the use of alcohol as a coping mechanism only adds further stress, this in turn encourages additional drinking behavior. Thus a cycle is created which can maintain drinking behavior indefinitely (Pearson & Anderson, 1985).

Drinking may balance a family system by acting as an effective smokescreen or scapegoat for other hidden problems. If the drinking ceases, then other underlying family problems may surface. The drinking may maintain family cohesion and stability by bringing the family together either to oppose the drinking or to protect the drinker. Drinking also stabilizes the family system by providing a predictable and rigid set of interactions (Pearson & Anderson, 1985).

Chemical dependency also masks the threatening feelings associated with intimacy. Intoxication provides emotional distance, which eases the discomfort associated with feelings of over-closeness, dependency, and fusion with one's spouse (Pearson & Anderson, 1985). Conversely, Russell et al., (1983), find that drinking to intoxication may function to allow the expression of warmth or caretaking behavior that is otherwise not permitted.

Excessive drinking may secure acceptance into the family system. If a member of the family is seen as "sick," then he/she may be excused from accountability of their actions (Davis et al., 1974).

Control in regard to role differentiation may also be impacted by a member being an alcoholic. The alcoholic partner would acknowledge the other as the controller and renounce his/her own role through symptoms (Davis et al., 1974). Kaufman (1985) also notes that coalitions tend to occur between the non-alcoholic spouse and children or in-laws which distances the alcoholic further.

The adaptive role of alcoholism can also be seen through avoiding responsibility. First, the symptoms of alcoholism has influence on other members of the family. Secondly, the individual indicates to other members of the family that he/she has no control over his/her actions. What these two mixed messages really allow for is power over the entire family (Davis et al., 1979; Straussner et al., 1979).

Downs (1982) discusses the role of the "hyperfunctioning" spouse. When the alcoholic abdicates his/her role, the non-alcoholic spouse must then take on the now abandoned parental role. The result is that of an apparent stable system with the non-alcoholic spouse now hyperfunctioning, while the alcoholic is assigned to the status of a child in the family.

Meeks and Kelly (1979) report there are four basic principles of family equilibrium: (a) For any family, all members are assigned (and assume) roles and are related to

each other in characteristic ways; (b) each family has a set of rules (some overt and explicit, others covert and not in conscious awareness) that govern the roles members are to assume and the ways they are to relate to each other; these roles and patterns of relationship constitute the family equilibrium; c) any attempt to shift the family equilibrium either from within or from without may evoke resistance from the family system which seeks to maintain the status quo; and (d) no matter how sick it may appear to the outside observer, the established equilibrium represents the family's attempt to minimize the threats of disruption and pain.

Dynamics

There are dynamics that shape the chemically dependent family. These include communication, rules, behavior, and roles. Another dynamic deals with the family's inability to distance itself from the chemical problem. Specifically, the entire family in its responses toward itself and toward the outside world revolves around the chemically addicted person, whose life in turn revolves around chemicals (Steinglass, 1985).

Communication

One force that weaves itself throughout the family fabric is the family's total inability to communicate in healthy ways. Communication patterns are the most observable aspects

of family interaction. Communication occurs both on verbal and nonverbal levels. Usually the messages that are sent are conflicting. The way in which the alcoholic communicates while intoxicated is quite different from when he/she is sober, and in turn the same is true for other family members (Davis et al., 1974).

Quantitative studies of communication patterns have also demonstrated several abnormalities in the families of alcoholics. Spouses are usually competitive in style, and use more one-up messages and cooperate less than other couples (Kaufman, 1985).

Rules

Invariably there are also a set of rules that a chemically dependent family lives by. Frequently, a substantial amount of time passes before any of these rules are challenged or questioned. Rules are not stated directly; they usually stem from the needs of the system. The rules are usually rigid and harmful. These rules govern the actions of the family. They are unknowingly accepted and adhered to. These rules help the chemically dependent person stay sick (Straussner et al., 1979).

One rule says that family members won't talk directly or realistically among themselves or with others about what's really going on in the family. Usually the family members

are too sick or fearful to do so. Another rule implies that everyone should believe and act as if something or someone other than the chemically dependent person is responsible for the dependence (Klagsburn & Davis, 1977). These rules help keep equilibrium within the family.

Other rules that are common to alcoholic families are: do not make waves, do not look at each other, do not express certain feelings, and do not disagree. These rules typically are made by the parents (Phillips et al., 1987).

Behavior

The behavior that takes place in chemically dependent families is also quite dysfunctional. Families display a wide range of enabling behaviors which help to cover up what's really going on. As the disease progresses another behavior begins to appear. The family collectively and singly engages in more and more isolating behavior. The family as a unit becomes a social isolate, as well as each individual member keeps a distance by staying away from home or in one's own room (Downs, 1982).

Roles

With the alcoholic's decreased ability to meet responsibility other family members have to take over in order to maintain the family's homeostasis. Although the family members may appear to "pull together," in reality

each individual within this system feels more and more isolated from the outside world and from each other (Straussner et al., 1979).

In response to feelings of isolation, the spouse of an alcoholic may turn to the oldest child, perhaps the family hero, for the emotional and at times even sexual support he/she does not receive from his/her spouse. In this way, dysfunctional, cross-generational alignments develop (Straussner et al., 1979).

When the alcoholic is actively involved with chemicals, he/she eventually abdicates his/her family role. This drastically affects the family structure; and usually by the time the alcoholic has gone through treatment, the family has reorganized around the new framework that no longer includes the alcoholic in a functioning role (Pearson & Anderson, 1985).

The alcoholic loses his/her spousal role in many areas of the family system, one being the level of sexual functioning. The alcoholic gives up his/her role as a parent. Other roles, such as household chores and maintenance, are also abandoned and given to others. As non-alcoholic members take over full management of the family, the alcoholic is relegated to child status, which perpetuates drinking. Coalitions occur between the non-alcoholic spouse and children

or in-laws, which tend to further distance the alcoholic (Kaufman, 1985).

Ultimately, the consequences of the accumulation of symptoms can no longer be denied, which shifts the alcoholic family system from homeostasis to imbalance. There are usually a series of escalating crises in family structure and function, which may bring the family system to an extreme catastrophic state (Kaufman, 1985).

Tensions accumulate and are released when the alcoholic drinks. Sometimes, the family becomes angry and tries to restore their earlier balance. The drinker then becomes apologetic and promises to behave. The family will do what it can to restore stability, or what has been normal to them in their lives, even if it means that the drinking is resumed. This cycle is repeated over and over again (Phillips et al., 1987).

Anxiety mounts to considerable intensity before the family is able to comprehend that the alcoholic's behavior is involuntary and cannot be handled by any of the usual methods of social control. Until this time the family's history is one of chameleon-like shifts in organization and member roles, in the alignment of relationships within the small family group and within the families of the parents. At any given stage the family's functioning is related to

the stage the alcoholic is in, whether the alcoholic is drunk or sober, and to other problems the family faces which usually accompany alcoholism (Jackson, 1959).

Removing alcoholism results in a disruption of equilibrium, and stress throughout the structure. The family will either move toward recovery, or they will fight to keep the balance by encouraging the alcoholic further (Downs, 1982).

The hoped for outcome in this situation is that any or all the family members will seek help outside the system (such as family therapy) and thus experience a permanent change within the system. With a breakdown of denial, a family system may shift away from supporting the alcoholic and move toward recovery (Stanton, 1979).

At this time, the marriage may become worse when the drinking stops because other areas of conflict such as poor communication, differences about child rearing, sex relations, homemaking, and family goals may be unmasked (Straussner et al., 1979). It is almost as if it has to get worse before it can get better.

Because of the emphasis of alcoholism as a family disease, an increasing number of therapists are treating the abuse of alcohol as if it were an adaptive behavior (Davis et al., 1974). Kaufman and Pattison (1981) feel that because members of an entire three-generational system affect the alcoholic,

this in and of itself make it necessary to include all generations in treatment.

The idea of relating chemical dependency treatment to family therapy first appeared in the late 1960s and early 1970s. Ewing and Fox borrowed concepts from Bateson and Jackson's work with families. They felt that family therapy would work in chemically dependent families for two reasons. First they felt that it would increase the likelihood that individuals would admit they were chemically dependent, and would motivate the alcoholic toward internal change (Steinglass, 1976).

> A logical extension of this theoretical model is to view family therapy not so much from the point of view of involving family members as a mechanism for improving treatment with the identified alcoholic but rather to view the entire family or the marriage itself as the patient. Therapeutic intervention becomes interactionally oriented rather than intrapsychically oriented, and goal for treatment center around an improvement in the functioning, flexibility, and growth potential of the family system as a whole rather than the more limited focus on reduction in drinking on the part of the identified alcoholic. (Steinglass, 1976, p. 106-107)

Janzen (1977) supports alcoholism treatment including the family. In family treatment for this disease he feels (a) One or more family members must be involved in addition to the alcoholic, (b) alcoholism should be viewed as both cause and consequence of the family's relationship difficulties, and (c) treatment can be successful for both the alcoholic and the family.

Janzen (1977) also reports that therapists avoid the problems of confidentiality when the whole family is in treatment. He says the joint interviews allow the therapist to grasp family goals and to get a more objective and realistic view of the situation. Finally, he notes that the involvement of the whole family in treatment increases the understanding by the alcoholic and other family members about other problems within the family besides the alcohol. Family therapy then may reduce blame and anger, and increase coping mechanisms while the family tries to reach a common goal.

Kaufman (1985) feels there are two ingredients for successful family therapy when dealing with substance abuse. He feels the therapist must have a working knowledge of substance abuse and its repercussions on the family, and secondly, the family therapist must be knowledgeable and experienced with the concept of systems theory. Kaufman also describes certain therapist variables that are associated

with successful treatment, which include: empathy; interpersonal functioning; and a directive, powerful style.

Meeks and Kelly (1970) feel that there are nine factors that treatment for chemically dependent families must address. These are: (a) Attention must be given as to why the entire family is in treatment; (b) the superficial harmony families want to maintain must be dealt with honestly; (c) the role alcoholism plays in the family should not be negated, but put into perspective along with other dysfunctional behaviors; (d) games that the family plays at home should be openly talked about and confronted; (e) individual behaviors that reinforce the dysfunction of the family should be brought out in the open, and explored; (f) the inevitable shifts in equilibrium brought on by change should be recognized and addressed; (g) periodically the effects caused by disequilibrium should be talked about; (h) compromise and support should be asked for and dealt with on a realistic level; and (i) the family should be helped to learn problem-solving strategies so they can continue to function in a healthier manner once treatment is terminated.

Regardless of the style of treatment that is used, all therapists tend to agree that the whole family needs to be in therapy, and that continued association with Alcoholics Anonymous, Narcotics Anonymous, Al-anon, or Ala-teen is a

necessary element in maintaining a functional and chemical-free lifestyle (Janzen, 1976; Kaufman, 1985; Meeks & Kelly 1970; Steinglass, 1976).

In conclusion, this author has tried to illustrate current support and agreement for the suggestion that chemical dependency can be purposeful and that it helps to maintain harmony within family systems. Present research also asserts that chemical dependency is a family illness, and therefore should be addressed as such in therapy. Family therapists not only need to address the alcoholism, but also the behavior, communication, roles, and rules the chemically dependent families adhere to. Family treatment for chemical dependency has proven to be beneficial especially when sought in conjunction with support groups.

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