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Alcoholism: Family as the identified patient

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Abstract

Alcoholism or chemical dependency is a disease that is chronic, primary, progressive, and fatal. The progression of the disease can be arrested but not cured (Johnson, 1973). There are over ten million .adult drinkers in the United states that are problem drinkers (United States Department of Health, 1980). Therefore alcoholism is a major health problem in the United states today.

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Alcoholism or chemical dependency is a disease that is chronic, primary, progressive, and fatal. The progression of the disease can be arrested but not cured (Johnson, 1973). There are over ten million adult drinkers in the United States that are problem drinkers (United States Department of Health, 1980). Therefore alcoholism is a major health problem in the United States today.

Traditionally alcoholism was treated as an individual problem, but for every alcoholic there are three or four other family members that are affected. For that reason alcoholism is called a family disease (Al-Anon, 1972). Treating alcoholism by working only with the individual addict is..."like treating malaria by swatting the mosquities" (Lawson & Lawson, 1984, p.14). Family therapy for alcoholism and drug abuse attempts to improve the functioning of the whole family (Goldenberg & Goldenberg, 1985).

As the family struggles to control the chemical dependent person's behavior the family's life style changes, the members' role in the family become more rigid, communication breaks down, and essentially the family members become addicted to the chemical

dependent person (Goldenberg & Goldenberg, 1985). Stenzil (cited in O'Connell-Cahill 1986) compares living with an alcoholic to living in a home with slanted floors, where everything is on an angle and out of shape. In time this becomes normal for the family.

The breeding ground for alcoholism is the family, and therefore it is important for the counselor to go to the breeding ground if the intergenerational disease is to be arrested (Lawson & Lawson, 1984). Kaufman and Kaufmann (1979) reviewed histories of hundreds of alcoholics and found that..."nuclear families of addicts replicate the pattern of the family of origin" (p.45). When family therapy becomes a part of the treatment process, new family patterns are learned and the cycle of dysfunction is interrupted (Priest, 1985).

All family members affect and are affected by one another (Haber, 1983). It is important for counselors to examine the interactional patterns of families in the treatment process. The purpose of this paper is to help the counselor recognize the patterns in a dysfunctional alcoholic family, to explain the rationale for the whole family treatment, and to explore some family counseling approaches.

Rationale For Treating The Whole Family

Family therapy operates on the theoretical assumption that family members are a part of the whole and if an individual changes, reciprocal changes are required of others, if the system is to be maintained (Kaufman & Kaufmann, 1979). This means that if the dependent person changes and others do not, the alcoholic family system will be thrown off balance. The transactional patterns that developed during the period of active alcoholism may become familiar and preferred, even though dysfunctional. According to Kaufman & Kaufmann (1979), the family will maintain these patterns as long as possible and may actually resist the removal of alcohol (Chermus, 1985). Behavior that deviates from the usual role may be perceived as threatening and disruptive and the family may force the deviant or alcoholic behavior back (Meeks, Tarter & Sugarman, 1976).

Chermus (1985) reported a positive correlation between improved family functioning and successful recovery from alcoholism. In a self-reporting survey done through St. Mary's treatment center in Minnesota, 91% of the family members that received family treatment reported significant improvement in their

family life, employment, and personal happiness (Wegscheider, 1981). Even if the alcoholic continues to drink, the other family members can be helped to break the dysfunctional cycle and strive for their own recovery (Burgin, 1982).

No matter how effective individual treatment for alcoholism is, it is counter-productive to return the alcoholic to the same destructive family system that created or maintained the problem (Lawson & Lawson, 1984). The children in the family typically believe that sobriety is the answer to the family's problems. They are greatly disappointed when distrust, confusion, tension, and fighting still exists within the family (Priest, 1985).

Drug abuse treatment providers and researchers seldom deal with the whole family (Bratter & Forest, 1985). Some reasons for this are: Chemical dependency counselors have not been trained to work with families, it is expensive to treat all the family members, there is little research available for the precedence of family treatment, and some providers view family therapy as incompatible with the disease concept of alcoholism (Lawson & Lawson, 1984).

Family Dynamics of the Alcoholic Family

The human family is made up of component parts that are linked together in a particular way to accomplish a goal or purpose (Wegscheider, 1981). Sometimes the roles that the family members play and the rules they play by are counter-productive to accomplishing a healthy goal. Such is the case in an alcoholic family.

Family Rules

In chemically dependent families, recurring patterns or rules seem to emerge (Wegscheider, 1981). The families tend to share similar dynamics, rules, and behaviors that shape their systems. The rules family members develop tell them how to act and feel about themselves, how to feel about the other family members, and how to feel about the world about them (Satir, 1972). Rules in an alcoholic family become rigid, make no allowance for differences in people or circumstances, and discourage change (Wegscheider, 1981).

In a dysfunctional family the less healthy member, the alcoholic, often places rigid, perfectionistic rules on self and others. The rules in an alcoholic family are made for someone else's benefit and are unrealistic and impossible to keep.

The rules encourage family members to be dishonest and manipulative with themselves and others (Woititz, 1983). A cardinal rule in an alcoholic family is, "You don't tell the family secret," which is that someone in the family is an alcoholic (Wegscheider, 1981). Another rule is that every member must become an "enabler", which allows the disease of alcoholism to continue because the alcoholic does not have the opportunity to experience the direct consequences of the alcoholic behavior (Burgen, 1982).

A family in which communication is limited by such rigid, inhuman rules is operating in a closed system. The parts of the system or family members are walled off from one another so they cannot interact (Wegschneider, 1981). Their boundaries to the outside world become rigid and inflexible, thus isolating the members from the surrounding community (Goldenberg & Goldenberg, 1985). The members operate with the rules, "don't talk and don't feel" (Cork, 1969). In contrast, the individuals functioning within the family seem to have no personal boundaries. This means individuals tend to personalize everything that happens around them and see it as directly related to them (Schaef, 1986).

In family therapy the therapist can begin by helping the family members understand their own rules and dynamics (Meeks et al., 1976). The ultimate goal is to enable the family members to adapt more flexible rules, develop meaningful and clear communication patterns, establish boundaries for themselves and with the outside world that are functional and to differentiate themselves as individuals (Kellerman, n.d.). The family members can break the cycle of their locked-in rigid patterns and look at options and make choices (Porterfield, 1984).

Family Roles

In healthy homes, the children have the ability to adopt a variety of roles. Children in alcoholic homes seldom learn the combination of flexible roles which mold spontaneous healthy personalities. The family members become locked into roles to survive (Black, 1981). Claudia Black (1981) labeled these roles as the responsible one, who brings order and consistency to life; the adjuster, who usually is the child who seems to be detached; the placater, the one who tries to fix all the problems; and the acting out child.

Sharon Wegschieder (1981) labeled family member roles as: the chemically dependent person, chief

enabler, family hero, scapegoat, lost child, and mascot. The chemically dependent person is preoccupied with the use of the chemical. Their wall of defenses of anger, charm, aggression, righteousness, or grandiosity compulsively covers up the true feelings and they live in a trap of self-delusion.

The chief enabler is often the spouse or parent of the chemically dependent person. Their role in the family is to provide responsibility. They may hide their true feelings of anger, fear, pain, or guilt behind the wall of defenses of powerlessness, manipulation, self-pity, self-blaming, or super-responsibility (Koppel, Stemmler & Perone, 1980).

The family hero's role is to provide self-worth to the family. This is accomplished through working hard, acting special, being successful and super-responsible, and giving the appearance that they have it all together (Weigscheider, 1981).

The scapegoat is the acting out member. Their delinquent, problematic behavior often provides distraction from the issue of the family alcoholism (Black, 1981). They are the ones likely to receive help from the professionals because of their drug

abuse, unplanned pregancy, or school problems. Consequently, they get the family into treatment (Black, 1981).

The role of the lost child is to offer relief to the dysfunctional family. Lost children do not cause trouble for themselves or others. They lock away their feelings of loneliness, hurt, inadequacy, and anger behind a wall of quietness, distance, and super-independence (Wegscheider, 1981).

The mascot's role is to provide fun and humor. They tend to be the clowns and will do anything to attract attention. They hide their true feelings of loneliness, confusion, and insecurity behind their mask of cuteness (Wegscheider, 1981).

Because the behavior patterns or roles are compulsive and rigid the family members tend to take them into every relationship. Rigid roles seem necessary to maintain the homeostasis within the alcoholic dysfunctional system (Haber, 1983).

The common denominator of the fixed roles is that they are compulsive, self-deluding, and repressive of true feelings and destructive for each member. Continuing to play these roles causes family members and relationships to become painfully "stuck", crippled, and increasingly dysfunctional Lerner, 1985).

Family therapy is directed at helping the family to modify its patterns of functioning (Bowen, 1978).

Growing up in an alcoholic family disrupts and interferes with a child's normal development. The children lack a consistent, stable environment and adequate role models (Hawley & Brown, 1981,; Priest, 1985). Margaret Cork's 1969 study of 115 children, identified as growing up in alcoholic homes, concluded that most children in the study had difficulty in establishing relationships where they could learn to trust (Cork, 1969). A trusting relationship is important in establishing a sense of identity and self-worth (Lerner, 1985).

Black (1981) stated that the most important ingredient in a nurturing relationship is honesty. A child cannot learn to trust unless significant people around him are open and honest about their own feelings. As the disease of alcoholism progresses, the family members lose the ability to be honest.

All children raised in alcoholic homes need to be addressed in family therapy (Black, 1981). The child's sense of self is distorted and that distorted image may be carried into adulthood (Woititz, 1983). Priest (1985) and Kaufman & Kaufmann (1979) pointed to the high incidence of stress related illnesses, sexual

dysfunctions and emotional disturbances among children of alcoholics as other reasons for treating all family members.

Family Adjustment Stages

A United States Department of Health (1983) publication has identified and described seven stages and behavior adjustments of the family to alcoholism. These stages are most often refered to when explaining alcoholism as a family disease.

1. Denial of the problem. This is a period when there is excessive drinking but the alcoholic explains it away and the rest of the family avoids the topic (U.S. Department of Health, 1983). The alcoholic and those intimately involved develop psychological defenses that protect them from the guilt, fear, emotional pain, anger, and anxiety (Leikin, 1986). The use of denial makes it difficult especially for the children to know what is real (Burgin, 1982). To break through the denial stage is the first step to getting proper treatment for the alcoholic and the family (Kaufman & Kaufmann, 1979).

2. Attempts to eliminate the problem. During this stage, the non-alcoholic spouse tries to hide the problem from the family, employer and friends. There

is a desperate effort to handle the problem themselves (U.S. Department of Health, 1983).

3. Disorganization. This is the period of chaos for the family members. The spouse is frustrated and unhappy with the many ways they have tried to avoid or control the drinking (U.S. Department of Health 1983). The whole of family life seems to be caught up in trying to control the uncontrollable (Burgin, 1982). The training of professional social workers and counselors to recognize symptoms and stages of an alcoholic family would enable them to intervene at this stage (Hawley & Brown, 1981). They need to avoid identifying alcoholic behaviors as symptoms of another problem (Wegscheider, 1981).

4. Attempts to reorganize despite problems. Often during this stage the spouses separate and the family begins to break apart. The reorganization may involve seeking some professional help for the family, getting a job, or finding a self help group (U.S. Department of Health, 1983). If a professional becomes involved it is important that the family be presented with information and evidence of alcoholic behavior. The rule of secrecy is so important in the alcoholic family often even the counselor avoids talking about it (Wegscheider, 1981).

5. Efforts to escape the problems. During this stage the separation might become more permanent and final or the alcoholic may desert the family and move on. This may be a geographical move for all or part of the family. Children are often divided between the parents or removed from the home (U.S. Department of Health, 1983). Cork, (1969) in her studies of children in alcoholic families, concludes that there is a great need for recognition and treatment of families at an early stage to avoid severely damaging the children and destroying the family unit.

6. Reorganization of part of the family. After parental separation the family begins to establish a new life without the alcoholic, but they may still be affected by calls, threats, violence, or enlistment of sympathy by the alcoholic (U.S. Department of Health, 1983). As part of the reorganization, family members need to reestablish relationships with the outside world because frequently they have isolated themselves during the active stages of alcoholism out of a sense of shame (Leiken, 1986).

7. Recovery and reorganization of the whole family. If the alcoholic achieves sobriety, the whole family may reorganize, which includes dealing with problems that were masked by the alcoholism, changing

family roles, and redefining family rules (U.S. Department of Health, 1983). The couple is able to repair the marriage and the family is able to share a broader range of feelings and regain their own sense of self worth (Burgin, 1982).

The Recovery Process

Goals of Family Therapy

The therapeutic approach begins by helping the identified patient and the family accept that alcoholism is a disease and not a moral problem or weakness (U.S. Department of Health, 1983). One goal of treatment is for the primary patient, the alcoholic, to remain chemically free (Lawson & Lawson, 1984). To aid in the recovery process for the alcoholic the family needs to be enlisted as an ally to treatment (Haber, 1983).

Secondly the intergenerational dysfunctional cycle should be broken. Woititz (1983), Black (1981), and Schaef (1986), discussed the likelihood that the untreated child of an alcoholic will become an alcoholic themselves or marry an alcoholic. Bratter and Forest (1985), suggested that the key to breaking the cycle is to work with families of origin and families of procreation to understand and change their destructive relationships.

Family members should be able to look at their own response to the alcoholism. They need to understand the whole relationship and the role they play. They then need to get some separateness and a sense of meaning and self-worth for themselves (Wegscheider, 1981). Wegescheider (1981), Haber (1983), and Porterfield (1984), stressed that the ultimate goal is the promotion of clear communication within the family, the allowance of honest expression of feelings and the validation of self-worth of everyone involved.

Counseling Techniques

Family therapy is complex and requires therapists to use different approaches (Kaufman Kaufmann, 1979). Leiken (1986), suggested that, "successful and lasting recovery for the family requires a multifaceted approach," (p.67). Kaufman and Kaufmann stated that there is little data available to compare the efficiency of different strategies and techniques of family treatment of alcoholism. He suggested using integration of structural, behavioral, psychodynamic, and a systems approach. Bratter and Forest (1985), reported on a study done with 200 families that received family treatment. He concluded that the structural approach seemed to produce the best

results. This type of therapy places the major emphasis on current interaction (Wordin, 1985).

Each counselor needs to modify these techniques to fit his/her own style, the work setting, and the type of clients with whom they are working (Bratter & Forest, 1985). Siddons (1985) emphasized the importance of the whole family staying in counseling for about two years so that they have enough time to resolve conflicts and develop a healthy profile.

Treatment Approaches

Family members are usually involved with counseling concurrently as outpatients, while the alcoholic is in in-patient treatment (Siddons, 1985). The first step is for the counselor to establish rapport or join the family (Bratter & Forest, 1986). Family education is a most useful tool for initial entry into the family because it helps the members gain an understanding of the alcoholic and of themselves. They can then begin to support and nurture each other and recognize and tend to their own needs (Siddons, 1985).

If the family is enmeshed, more active structural and psychodynamic work needs to be done with the family (Worden, 1985). Bratter and Forest (1985), believes that although education and behavioral

approaches may provide initial changes they will have little lasting impact on an enmeshed relationship.

During therapy, the counselor should be careful to mark boundaries. One individual should not feel for or answer for others. Personal boundaries need to be well defined and structured and outside or societal boundaries need to become more flexible. Another tool for working with families is re-enactment and actualization (Bratter & Forest, 1985). The family members should be encouraged to talk directly to each other and to enact transactional patterns. Some techniques are role playing, family sculpturing, and space manupilating. Non-verbal communication should be observed by the therapist and pointed out to the clients. The counselor may then challenge the family members to interact in different ways (Kaufman & Kaufmann, 1979).

It is important to involve the family in a variety of approaches, individual therapy, co-joint family therapy, multiple family groups, and self help groups (Bratter & Forest, 1985). Wegscheider (1981), Siddons (1985), and Leiken (1986), concluded that the best collective recovery process is one that includes Alcoholics Anonymous, AlAnon, and AlAteen. These self help groups do not replace professional counseling but

are a necessary adjunct intervention (Bratter & Forest, 1985).

Siddons (1985), stated that the counselor is a most effective change tool when he/she is well trained, hard working and emotionally healthy. He/she needs to be a good role model in exhibiting congruance, flexibility, acceptance, and confidence (Bratter & Forest, 1985).

Conclusion

Professionals in the field of alcoholism treatment are becoming more aware of the importance of the role of the whole family in the intervention, recovery, and relapse of the disease of alcoholism. The entire family has become diseased or dysfunctional during the addiction process. If they are to live more healthy, fulfilling lives, they must break recurrent, self-defeating patterns of behavior. Treatment of the dysfunctional alcoholic family is a complicated process and takes place on many levels. (Kaufman & Kaufmann, 1979). The counselor must work with the whole family system, the multiple sub-systems within the system, and each individual if there is to be significant and lasting change (Lawson & Lawson, 1984). The inhuman rules need to be changed to more functional, humanistic rules which are made for the

benefit of the whole family. Family treatment can help all members to change, to expand their range of choices, to build self-esteem, and to establish meaningful relationships.

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