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Young Alcoholics' Perceptions of the Family System

By

John Nicholas Williamson

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

Fall, 1986

ISBN 0-315-32352-3

THE UNIVERSITY OF ALBERTA

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TITLE OF THESIS: Young Alcoholics' Perceptions of the Family System

DEGREE: Master of Education

YEAR THIS DEGREE GRANTED: Fall, 1986

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "Young Alcoholics' Perceptions of the Family System" submitted by John Nicholas Williamson in partial fulfilment of the requirements for the degree of Master of Education in Counselling Psychology.

Supervisor

Date Oct. 6 '86

To my Uncle Dudley

Abstract

Young Alcoholics' Perceptions of the Family System

The perceptions of thirty young adults admitted as alcoholics to in-treatment or residential centres, concerning family functioning were compared to the perceptions of thirty young adults who did not have problems with alcohol. Family functioning is viewed in terms of cohesion and adaptability perceived in the family system. Olson's Family Adaptability and Cohesion Scale (FACES II, 1982) was used to measure the degree of cohesion and adaptability perceived. Subjects were matched for age, socio-economic status and gender.

The results indicated that young adult alcoholics perceived their family system relationships as rigid and themselves as disengaged within the family system. The "level of satisfaction" with the family system also measured significantly lower for the young adult alcoholic than for his non-alcoholic counterpart. Also, alcoholism was significantly associated with extreme levels of cohesion and adaptability in the family system.

Results also indicated that socio-economic status may be related to the young adult alcoholic's "disengaged" position in his family system. However, this finding was not reflected in the other measures of family functioning in the study.

Consistent with Olson's findings on FACES II, (1982), the results indicated no significant gender-related effects

on the perceptions of family functioning in this study.

"T" tests were used to evaluate statistically the major hypotheses in the study. Pa[redacted]elation coefficients, Chi-square and a two-way analysis of variance [redacted]d to examine the effects of age, socio-economic status, gender and the family function variables, and to answer related research questions.

The implications of the findings for the treatment and and rehabilitation of the young alcoholic were discussed.

Acknowledgements

Grateful acknowledgement is made to the many young people and friends who made this project possible; to Dr. H. Zingle and Dr. E.E. Fox for their active support and encouragement.

I also wish to thank the AADAC management, and staff at Henwood and Claresholm for allowing access to these clinics; and special thanks to Frank Jansen at the Henwood clinic.

I am especially grateful to dear friends who helped and encouraged. Finally, my thanks to Janine, my daughter, for her special contribution.

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1. INTRODUCTION

1.1 Introduction

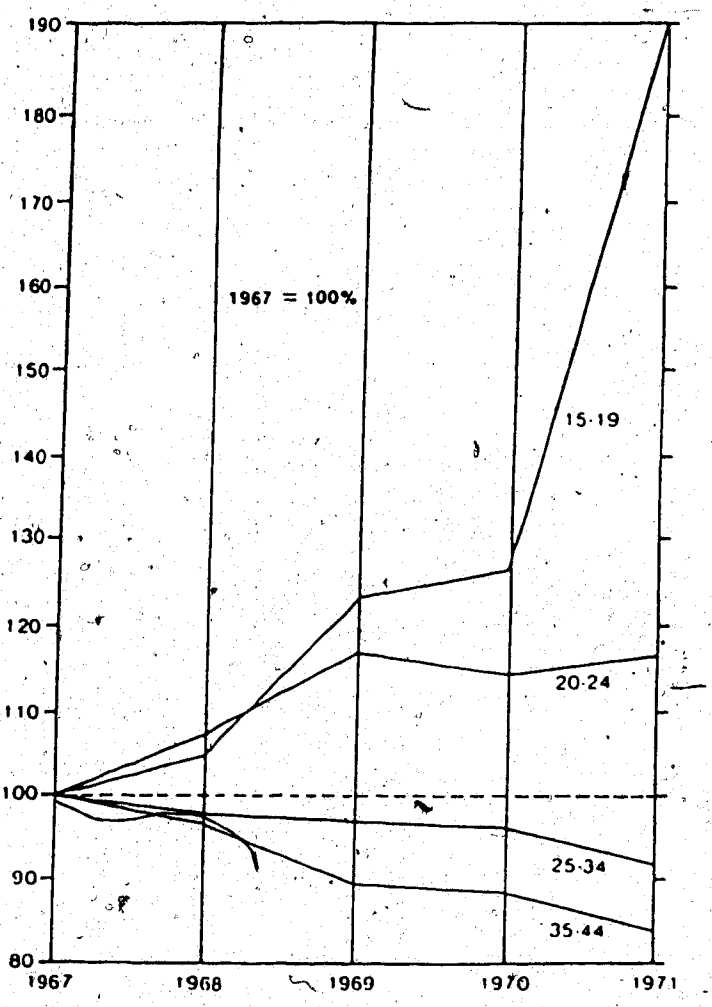
The author of the present study employed a family systems approach to review the family context of the young adult alcoholic, both from a treatment perspective and by way of an empirical investigation of family functioning as perceived by the young adult alcoholic (hereafter referred to as the young alcoholic or Y.A.).

The young adult in North America is drinking more alcohol and at an earlier age than ever before (Smart 1980b). This increased drinking has given rise to more problems of alcohol abuse and has forced the recognition that alcohol abuse by young adults is a present and increasing social problem in contemporary society (A.R.F., 1981; Smart, 1980b; Blane, 1977).

One particular response to increased drinking by the young adult has been legislative action to raise the legal drinking age (Wechsler, 1980; Blane, 1979; Havard, 1975). Figure I depicts the proportional representation of various age groups in alcohol-related motor vehicle accidents in Ontario over the period 1967-1971; it also shows a steep rise in the already disproportionate representation of the 15-19 year old group following legislation to lower the legal drinking age from 21 to 18 in 1970 (Schmidt & Kornaczewski, 1973).

INSERT FIG. 1 HERE

FIGURE I *Change in the Proportional Representation of Various Age Groups of Drinking Drivers in Accidents Ontario 1967–1971*
1967 = 100%



Source: Ministry of Transportation and Communication, Ontario

Smart (1977) suggests that the Ontario situation is by no means unique, and reflects a trend in increased alcohol consumption in North America in conjunction with an increase in alcohol-related accidents and other problems stemming from alcohol abuse. In fact the use of alcohol in one form or another is so widespread in North America some researchers view drinking as integral to the socialization of the young adult (Maddox & McCall, 1964) or as part of a developmental process (Zucker, 1979).

It is increasingly clear that raising the "legal" drinking age will not eliminate alcohol abuse by the young adult, (Shaw et al., 1978; Gillies, 1975; Whitehead, 1977). Blane and Chafetz (1979) even posit that "any direct attempts to modify drinking at this population level is doomed to failure"(p.3). However "hard liquor" is no longer advertised on television, and the beer commercials have come under the scrutiny of public interest groups. Focus has shifted from restrictive legislation to prevention and treatment. The Addictions Research Foundation (A.R.F.) in Toronto, and the Alberta Alcohol and Drug Abuse Commission (AADAC) run ad campaigns that reflect this shift to prevention strategies being used to combat alcohol abuse.

This study finds context in the treatment of alcoholism in the young adult. The theoretical stance is that the drinking behavior of the young alcoholic is mediated via family dysfunction, and that the dysfunction may itself be both cause and effect of alcoholism in the young adult.

Nichols (1984) has observed that "symptomatic families remain stuck, using a symptomatic member to avoid change; normal families are able to change and so do not require any such sacrifice"(p.403). The presumption in this study is that the young alcoholic is the "identified patient" in a dysfunctional family system.

In family systems theory the family is conceived as a system of interacting elements and relationships which define the particular organizational structure of the family as a unit. The behavior of every individual is seen as related to and dependent on the behavior of all other family members. In Family Systems Therapy (F.S.T.) the treatment focus shifts from the individual alcoholic to his family context. ("His" will be used as representative of "his or her".) The theoretical shift in F.S.T. is from linear causal to circular causal; the interactional patterns within the family system that maintain, or are maintained by, the alcoholic behavior are to be determined prior to the therapeutic process. The underlying premise for the therapist is that change in the organisational relationships of the family will effect change in the entire system (Minuchin, 1974). In effect, any change in the interactional patterns of the the family system where alcoholism is symptomatic of underlying dysfunction will in turn impact on the alcoholic behavior.

Implicit in this view of the family is a major shift in the treatment of alcoholism in the young adult.

Traditionally, treatment modalities have followed the "disease model" of alcoholism in its linear causal focus on the individual alcoholic and his rehabilitation. It is now recognized that alcoholism in the young adult does not in fact meet Jellinek's (1960) criteria of what constitutes alcoholism; the Y.A. does not fit his *alpha, beta, gamma* classification of alcoholics (Smart, 1980b; Bacon, 1977; Strauss, 1976). It is also recognized that treatment strategies applicable to adult alcoholics may be less effective with young adults (Goby, 1977; Gwinner, 1977); that alcoholism may be symptomatic of a number of quite separate conditions (inclusive of family dysfunction) (Mandell & Ginsburg, 1977).

It is suggested that a family systems approach, because of its focus on the patterns of interactions within the family system that maintain, or are maintained by, the alcoholism, offers a theoretically cohesive approach for the treatment and rehabilitation of the Y.A.

Empirically, the study employed the Circumplex Model of Marital and Family Systems (Olson et al., 1979) to investigate the young alcoholic's perceptions of *cohesion* and *adaptability* in his family system. It was conceptualized that the young alcoholics in the study would in fact perceive their families of origin as dysfunctional given that the model proposes a balanced level of both cohesion and adaptability as optimal to family systems functioning. Olson's Family Adaptability and Cohesion Scale (FACES II,

1982) was used to determine the level of cohesion and adaptability perceived in the family systems of the young alcoholics.

The demonstration of significant dysfunction in the family systems of young alcoholics does not in itself prove the efficacy of F.S.T. in the rehabilitation of young alcoholics. However, it does provide a reference frame for the F.S.T. therapist seeking to rehabilitate the young alcoholic and indicates an empirical basis for F.S.T. research and application in this area.

1.2 Statement of the Problem

The defined problem of this study is the investigation of family systems dysfunction in relation to alcoholism in the young adult and to point to treatment implications to be derived from the findings. The study focused on the following objectives:

1. to determine significant differences in the Y.A.'s perception of family functioning as compared to his non-alcoholic counterpart;
2. to identify particular family system configurations that serve to maintain and are maintained by the alcoholism of the young adult;
3. to assess significance in the relationship between alcoholism and dysfunction as a feature of the family's organization;
4. to determine post-treatment effects, if any, on the

Y.A.'s perception of family functioning.

5. to suggest or indicate treatment and rehabilitative options for the therapist working with the Y.A.

The objectives indicated have been formulated from the author's own observation of young alcoholics during clinic practice and from the literature of family systems therapy and alcoholism. The rationale for identifying these objectives follow.

1.3 Rationale

This study is concerned with determining and assessing the young alcoholic's perceptions of self-in-relation to the family system. The alcoholism of the Y.A. is viewed as symptomatic of family dysfunction, i.e. a specific response/interaction directly related to his perception of particular interactional patterns within the family system. A contention of this study is that these perceptions of the young alcoholic reflect his phenomenal reality and determine the nature of his responses and interactions between himself and family members.

Cognitive psychologists suggest that what is perceived is in very large measure what we anticipate to perceive (Livingstone, 1978; Combs & Snygg, 1959). Moreover, what is seen and heard and sensed generally, is a cumulative process that selectively accrues information (Neisser, 1967) which in turn is organized, synthesized and expressed interactively between people and the events in their lives.

Keen (1978) sees this as an on-going open-ended and interactive process contributing directly to a *mental set* or world view. How we respond or interact is a function of the contextual meaning attributed to the continuum of experience in the phenomenal world (Bruner, 1973; Combs & Snygg, 1959).

In the context of their family systems, the young alcoholics are already locked into interactional patterns of response to roles and relationships they have attributed to themselves and to the other members of their families. They may be seen as focused and discriminating on this or that specific transaction that fits their perceptual reference frames. Transactions that do not fit the perceptual reference frame are glossed over or even ignored, and transactions that do fit serve to corroborate their particular viewpoints. Alcoholism becomes, in effect, a way of relating to the world, a Procrustean framework for fitting themselves interactively and contextually into their world, or more immediately, the family system (Steinglass, 1979).

It is emphasized that this adjustment (into alcoholism) on the part of the young adult is an interactive process within the family system as a whole, as the other members adjust and organize to cope and deal with the alcoholic member (Steinglass, 1982). In this adjustment process mutually causative systems interact to establish complementary behavior patterns. These in turn serve to reinforce and perpetuate the alcoholism.

From the viewpoint of the family systems therapist, alcoholism in the young adult is viewed in terms of its systemic function. For example, the alcoholism of the young adult can be seen as underlining the failure of the family system to properly effect separation for the adolescent (Haley, 1980). In this instance, the family may be quite literally *stuck* in a behavioral posture, with the alcoholism of the young adult serving to maintain the nurturance needs of the parental sub-system which in turn operates to maintain the young alcoholic's perception of self as dependant, weak and ineffectual (Reilly, 1979).

Or given a pattern of conflictual relationships in the parental sub-system, is the young adult perceiving self in terms of *savior*, getting drunk in order to unite the parents and/or other members of the family in mutual concern for his welfare (Haley, 1980), thus bridging as it were the emotional space between the parents while directing emotional focus towards self?

Reilly (1979) has also noted that amongst siblings of some disturbed family systems there is a "self-electing" process for one sibling to be the *black sheep* of the family, with the family alternating between recrimination on the one hand, and overt tolerance and material support (for the alcoholic) on the other. The system's needs are met in the provision of a negative role model within the sibling sub-system, and the *black sheep* is free to enjoy pridefully the more successful roles of the siblings while following

his own inclinations into alcoholism (or drug abuse). Landau and Stanton (1983) have also made the observation that when the identified patient improves or leaves the family, another sibling would assume the symptomatic behavior.

Problem drinking or alcoholism in the young adult may also be viewed as an aggressive response/reaction to dependency (Blane, 1968) in what is perceived as an overly rigid family structure. The drinking becomes symptomatic of the young adult's push for autonomy (Jessor & Jessor, 1977) against an overly demanding and restrictive parental sub-system. In strategic terms it is a power struggle (Madanes 1981) in which the powerful parent is rendered helpless against the drunkenness of the young adult.

The drinking may be episodic and serve periodically to force a *crisis* situation onto the family. The parents reacting to the young adults' drinking see themselves as too rigid and retreat, or attempt a redefinition of *boundaries*. As the parents withdraw the young adult is assertive to the point where parental strictures and demands are re-imposed, and an interaction becomes established. In this instance the drinking serves a homeostatic function for the dysfunctional family system in regulating dependency/autonomy issues.

At another extreme is the *chaotic* family organization, characterized by feelings of isolation and negativism among its members, by a lack of clear guidelines, or even confusion over reward and punishment issues (Olson, 1979). In such a family system, the alcoholism can serve to negate

the young adult's isolation and uncertainty.

Steinglass (1979) has noted that in some dysfunctional family systems alcoholism serves as an avenue of communication or even introduces an element of fun for the family. Warmth and caring become demonstrable. For the young adult the drinking allows identification with the family. Intoxication operates to short-circuit the inhibitions and anxieties that mark the way individual family members inter-relate or access the various other sub-systems in the family structure. In this instance the Y.A. is quite literally only comfortable within his family when intoxicated. The drinking operates homeostatically to maintain some degree of comfort for the Y.A. and allows the family to demonstrate tolerance, even caring, if only because the Y.A. is "nicer" when drunk.

The family configurations indicated are by no means exhaustive of dysfunctional family systems that are related to alcoholism in the young adult. However, it is the position of the author that these family system configurations all point to specific perceptual positions adopted by the young alcoholic in dysfunctional interaction with his family. The alcoholism can be viewed as the experiential component of his perceptions of family functioning.

It becomes increasingly clear that given the young alcoholic's skewed perception of self-in-relation to family his alcoholism can no longer be interpreted in purely linear

(if event A then event B) terms but requires a circular causal approach to determine the interactional patterns that maintain, or are maintained by the alcoholic behavior. The point to be made here is that there is sufficient theoretical support in the family systems literature to test the hypothesized relationship between the perceived family systems context of the young alcoholic on the one hand, and his alcoholism on the other.

Nor can the alcoholic behavior in any one instance be regarded as atypical of dysfunctional family systems. This raises the question of definition for alcoholism and for the young alcoholic. How this relates to a treatment perspective for the young alcoholic will be referenced in the chapter following.

1.4 Limitations of the Study

There are three minor limitations to this study. No attempt was made to contact family members and findings may not reflect the family dynamics of the subject's family of origin. (Note. Family members were not included in the study, mainly because of AADAC's management concerns with confidentiality.)

Secondly, in some instances admitted to the author, treatment was a condition for continuing to live in the family home, so that bias caused by coercion may be present.

Also, the young adults agreeing to participate in this study may not be representative of the young alcoholics who

were excluded from this study. Of 145 young adults entering the treatment centers during the period covered by this study less than one-third met the selection criteria or else did not elect to participate. Caution is urged in extrapolating findings to young alcoholics in other institutions or to young alcoholics in general.

1.5 Summary and overview of remaining chapters

Alcoholism with its attendant social problems is an increasing phenomenon in the young adult population. This phenomenon has been addressed in terms of legislative action to restrict drinking by the young adult. This study is focussed on alcoholism in the the young adult as symptomatic of a dysfunctional family system, and so finds context in the literature of F.S.T. approaches in the treatment of alcoholism.

A family systems approach has been used to develop empirical data to delineate the hypothesized relationship between the young alcoholic's perceptions of family functioning and his alcoholism. In Chapter 2 to follow, Family Systems Therapy research and application in alcoholism will be cited to point to specific family system configurations in which alcoholism is symptomatic in the young adult. It is contended that these configurations suggest specific therapeutic direction for the therapist. The family systems model used in the study is described and the hypotheses set out.

Chapter 3 is an outline of the methods and procedures employed in the study. Chapter 4 presents the findings and conclusions of the study. Finally, Chapter 5 discusses the findings of the study. Related areas for research are also indicated.

2. REVIEW OF LITERATURE

2.1 Introduction

This chapter attempts to link Family Systems Therapy research and application in alcoholism to the rehabilitation of the young alcoholic. It is suggested that the lack of a clear definition and the linear perpective implicit in most of the current treatment modalities may have obscured the need for specific treatment programs for the young alcoholic. The literature of F.S.T. research and application to alcoholism is cited in terms of its relevance to the treatment and rehabilitation of the the young alcoholic and as an alternative to current treatment practice.

2.2 Defining Alcoholism in the Young Adult

In this study the author has opted for "admission into a treatment centre" (Smart & Finley, 1975) as pre-eminent criterion for a definition of the alcoholic, in this case, the Y.A. This definition is not completely satisfactory since it is the thrust of this study that the Y.A. is to be defined as distinct and separate from his older alcoholic peer in the treatment centre. Notwithstanding, the study represents an attempt to mark ground for a different perspective for the treatment and rehabilitation of the Y.A.

On the question of definitional issues surrounding young adult use and abuse of alcohol, the speakers at the Conference on *Defining Alcohol Use - Implications Toward a*

Definition of Adolescent Alcoholism, (1976), held by the National Council on Alcoholism, U.S.A., could not agree on a definition. The view was expressed that "..the conferees would not agree that a drinker is a drinker is a drinker..."(p. 3). What is being reflected in this statement is the very complex nature of alcoholism giving rise to "ambiguity and confusion in its definition" (Polich & Stambul, 1978 p. 9: Mayer & Filstead, 1980; Blane, 1977).

Blane (1979) has argued persuasively that there are "two alcoholisms"; the one referring to "traditional clinical, diagnostic and treatment nomenclature, the other to the transitory social and behavioral consequences of the episodic consumption of relatively large amounts of alcohol at a single sitting"(p.35). Blane suggests that the traditional drinker is more likely to be found in the 35-55 year old group, while the "new alcoholism" is more likely to be found in the 18-24 year old adult.

Defining what the term alcoholic means, and more particularly the young alcoholic, is not a simple issue and it may well be that "a single definition covering all alcoholic patterns is impossible" (Schmidt, 1973; Strauss, 1977).

This ambiguity and confusion surrounding issues of definition related to alcoholism and alcoholics may have derived from a lack of any sort of focus in terms of professional or academic interest (Mandell & Ginzburg, 1977) or social policy that addresses consequences rather than the

nature and causes of alcoholism (Blane & Chafetz, 1979), or what is reflected may be the complex and multi-dimensional nature of the disorder (Polich & Stambuhl, 1978).

Perhaps the most critical issue stemming from the lack of definitional clarity for the young alcoholic relates to his treatment and rehabilitation. Definitionally, the young alcoholic is simply an alcoholic, and in treatment terms, his alcoholism remains a unitary concept. The implicit assumption here is that an understanding of cause allows prevention, treatment and cure. In the interim, the absence of any sort of focus or framework for a specific therapeutic approach tailored to the family systems context of the Y.A. is increasingly problematical.

2.3 A Treatment Perspective

The young alcoholic once admitted to a treatment centre is an alcoholic like any other alcoholic, notwithstanding as Blane (1977) notes, that admissions of young people to in-treatment clinics result more from acute, as distinct from the chronic effects of alcoholism. The family context of the young alcoholic is obscured or even lost in the context of treatment for the alcoholism "viewed as a unitary condition".

The problem for the Y.A. is that treatment and rehabilitation programs in these clinics are still in the mold of the "disease model" of alcoholism propounded by Jellinek (1960). The implicit assumption of the disease

model is that the cause of drinking rests entirely with the individual, and so the major focus of rehabilitation is on the individual and on his return to sobriety (Wilson, 1982). The treatment perspective in rehabilitation thus remains linear, whether programmed as individual or group therapy, pharmacotherapy, or teaching control techniques to the alcoholic or using operant conditioning approaches to limit the drinking behavior. The family context of the young alcoholic is ignored; also ignored is the particular developmental stage of the young alcoholic.

Studies of in-treatment populations seem to indicate that, generally, younger alcoholics are less likely to improve in treatment than older alcoholics (Gillies et al., 1974); that treatment strategies applicable to older alcoholics may be less effective with younger adults (Goby, 1977; Gwinner, 1977). However, it should be noted that very few rehabilitation programs are designed specifically for young alcoholics. Smart points to the lack of "both research and evaluated program development in the area of youthful drinking" (p. 163, 1980). It seems hardly surprising that treatment programs geared to the older alcoholic impact less effectively on the Y.A.

This ~~absence of a~~ specific treatment focus may present a problem in terms of the number of young alcoholics who continue to abuse alcohol after "treatment". The numbers can only increase as more young alcoholics seek treatment. Smart & Finley (1975) measured a five-fold increase in the number

of young adults 21 years and under being admitted to treatment centres over the 1967-1975 period in Ontario. As indicated in Table 1 the figures for Alberta (AADAC) for the period 1979-1984 reflect a consistent increase both in terms of absolute numbers and as a percentage of the total number of alcoholics in in-treatment programs; from 669 (8.2%) young adults in 1969 to 1241 (11.2%) in 1984. It should be noted that these numbers measure 15-24 year old alcoholics.

INSERT TABLE 1 HERE

Whether this growth reflects an increase in the numbers of young adults with alcoholic problems or a more successful advertising campaign by AADAC concerning its treatment program, is uncertain. What is clear is that the problem of alcoholism in young adults remains, and in effect, underlines the issue of a specific treatment focus for young alcoholics.

2.4 Family Systems Therapy in Alcoholism

It is the thrust of this study that one area of focus for the rehabilitation of the Y.A. is Family Systems Therapy. Family Systems Therapy has been described as "the most notable of current advances in the area of psychotherapy of Alcoholism" (The Second Report to the U.S. Congress on Alcohol and Health - 1974).

Notwithstanding this endorsement, the literature of Family System Therapy does not reflect a plethora of research and/or application of the various approaches to

Table 1

Characteristics of Young Adults Between the Ages of 15 and 24 Admitted to Henwood Between January 1, 1979 and December 31, 1984 by Calendar Year.

	1979	1980	1981	1982 *	1983	1984**
Total Admissions	669	673	690	794	921	1241
Young Adult Admissions	55	57	77	117	140	145
% of Total	8.2%	8.5%	11.2%	14.7%	15.2%	11.7%
Gender						
Male	39	46	53	96	113	106
Female	16	11	22	21	27	29
Age						
15 - 19	41.8%	29.8%	33.8%	35.0%	34.3%	23.4%
20 - 24	58.2%	70.2%	66.2%	65.0%	65.7%	76.6%
Primary Drug Of Abuse						
Alcohol related	85.5%	87.7%	84.1%	84.4%	90.8%	92.0%
Other	14.5%	12.3%	15.9%	15.6%	9.2%	8.0%

* Program change i.e. 3 week program introduced (additional to 4 week program).

** 4 week program discontinued.

Source: A.A.D.A.C.

alcoholism (Ablon, 1974; Steinglass, 1979). Still less does it reflect any research directed to youthful alcoholism (Smart, 1980a; Mandell & Ginzburg, 1977; Blane & Hewitt, 1977). This lack is somewhat surprising since the F.S.T. shift to circular causal investigation seems eminently suited to the investigation of alcoholism as a multifaceted and complex condition. Ablon's comment that a "serious failing (of researchers and clinicians in F.S.T.) has been the lack of studies tying in the specific alcohol-related crisis syndrome to the existing body of theory dealing with family and community behavior.." (1974, p. 236) is particularly representative of research in the area of youthful alcoholism.

It should be noted that Family Systems Therapy embodies several approaches as distinct from being an application of a unitary theory. These approaches tend to reflect the particular theoretical stance of the originator and/or the particular "therapeutic style". Bateson, Haley, Jackson, Minuchin, Palazolli and Watzlawick are some of the more familiar names in Family Systems Therapy. It has been a field of vigorous growth and to delineate the various approaches would be to deal in differences and similarities beyond the scope of this study.

However, all these approaches derive conceptually from von Bertalanffy's General Systems Theory (1968). What distinguishes General Systems Theory is its conceptual framework which stresses organismic relationships as basic

to an understanding of function rather than the linear-causal explanations more familiar in the physical sciences. Steinglass (1982) suggests that a linear-causal perspective on alcoholism would seek to identify personality traits or search for genetic factors that predispose alcoholism.

In contrast to the linear-causal approach, restricted in the main to the individual alcoholic, Family Systems Therapy would focus on the individual only in so far as the *symptom* (behavior) was indicative of the way the family functioned as a whole. There is a shift in focus from the individual to the family as a unit. From the perspective of circular causality any delineation of cause and effect, before and after, is purely arbitrary (Nichols, 1984). Behavior is a circular pattern of response and interaction. In F.S.T. the family is viewed as an ongoing system of relationships that maintains itself around some point of equilibrium which has been or is being established relative to the family's dynamic functioning. Family members are seen as sub-systems of the main system, with specific roles and inter-relationships governed by the particular set of rules and communication styles that govern family life. The family is recognized as as "part of the solution as well as the problem" (Kaufman & Kaufmann p.468, 1977).

The family systems therapist thus addresses the alcoholic behavior in systemic terms, i.e. determining how the family is contributing to the maintenance of the

alcoholic behavior and/or identifying the particular system needs being met by the alcoholic behavior.

According to Steinglass (1979), it was Ewing and Fox (1968) who explicitly brought family systems theory and alcoholism therapy together. Theoretical concepts derived from Bateson and Jackson's (1956) research work with schizophrenic families like the concepts of the *implicit interpersonal bargain* (sex between husband and wife) and *complementary role functioning*, (passive-dependent husband to a protective and nurturing wife), were adapted to concurrent group therapy for the treatment of alcoholism. The interactional patterns of the alcoholic couples were seen to serve as a *homeostatic mechanism* maintaining the alcoholic behavior. Perhaps more significant was the recognition that therapy should proceed reciprocally for the husband and for the wife in order to effect and co-ordinate change in the interactional patterns they share, towards developing new patterns of intimacy and sobriety. latter treatment issue is important for the young a[illegible] rehabilitation. A family system entrenched in the particular dysfunctional interactions that produced the alcoholism symptom seems more likely in the absence of therapy to reproduce the alcoholism when the Y.A. rejoins the family.

A key study by Steinglass, et. al. (1971a) observed interactional relationships in the family system during experimentally induced intoxication. One of the more notable features observed was the way drinking was used to

communicate warmth, affection and caring between family members. Steinglass determined that the interactional patterns both in terms of behavior and communication were in sharp contrast during sobriety or intoxication. For young alcoholics being drunk may be one way of focusing care and attention to themselves, or to express care and affection for other family members-- behavior that would be rejected or not attempted when sober. Steinglass stresses the need to understand the sober/intoxicated range of interactions of the entire family as critical to any assessment of the family's dynamics.

Steinglass et al. (1971b), using a systems approach that incorporated the principles of homeostasis, circularity of causal events, and feedback mechanisms, developed an *interactional model* for viewing the alcoholic family. What he suggests is that alcohol could profoundly affect a family's organization. "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 between non-drinking members of the family as well" (Steinglass 1979, p. 279).

The drinking behavior operated in two ways. When limited to the individual it served symptomatically to relieve conflictual stress within the family system; or the drinking was an integral part of the family's interactional process in such areas as role differentiation or the

distribution of power. In either case, the drinking served a homeostatic function. A typical example is alcoholic behavior on the part of the young adult as a response to an unresolved conflict situation in the parental sub-system; here the alcoholism is triggered by any discord or overt expression of conflict in the parental dyad. By focusing on the young adult the parents avoid dealing with the conflict as they give support and comfort to the young adult. Such families Steinglass identifies as *alcoholic systems*.

More experimental studies of intoxication in families (Davis et al., 1974; Wolin et al., 1975) further elaborated on the *interactional model*. Alcoholism, as a homeostatic mechanism in the family system, could be seen in certain instances as a stabilizing rather than a disruptive factor in the interactional functioning of the family. Davis (1974) postulated an adaptive role for alcoholic behavior in system maintenance related to three categories of interactional functioning, i.e. at an individual level, an intra-family level, and a family/environmental level.

What was observed in each case was a family level response that incorporated intoxicated interactional behavior as a way of dealing with problem-situations both inside and outside the family. What the studies suggest is that these adaptive consequences were sufficiently reinforcing to serve as the primary factors in maintaining the alcoholic behavior. In effect, the family remained structurally intact, alternating between sobriety and

intoxication as interactional states, with the intoxication being associated with certain aspects of problem solving by the family and perhaps serving to reduce uncertainty and stress between members of the family, or from extra-family sources.

Therapy would first require that the specific adaptive consequences of the drinking behavior be determined. The alcoholic family with the symptomatic member could then be helped to exhibit adaptive behaviors when sober, or helped to develop alternative patterns of behavior. An alcoholic father, or a young alcoholic, who brought a sense of fun and cohesiveness into the family when inebriated could learn to share love and a sense of fun and laughter when sober. The studies suggest that failure on the part of the therapist to recognize the homeostatic function of the drinking behavior in such a family, or to neglect developing with the family alternatives to drinking that facilitated communication and fun, could result in treatment failure or even destabilize the family as a unit.

Steinglass (1980) later developed a developmental life history model of the alcoholic family -- in effect a marriage of two constructs, i.e. the developmental aspect of the family life history model and the unique life history of the alcoholic family. Steinglass proposes that the family goes through a series of developmental stages. These stages are premarriage, early marriage, mid-life plateau, mid-life crisis and late solutions. The pattern of alcohol use is

seen as responsive to the developmental changes in family life and the nature and frequency of stress derived from the family's interface with larger systems in the environment. "These transitional periods also frequently highlight competing developmental needs, either of separate individuals within the family or the competing needs of an individual and the family itself" (my emphasis)(p.213).

The Steinglass model presents an important perspective for the therapist since it alerts him to potential stress points in the family's life history and also enables the therapist to set priorities for the issues being presented by the family. More importantly perhaps, the Steinglass model sets the alcoholic behavior of the young adult against the context of the family system. Treatment focus accordingly shifts from the young adult to the family system of which he is a part.

Steinglass (1979) also emphasizes the need to take into account the profound behavioral consequences of alcohol consumption especially as it becomes increasingly clear that an individual focus for alcoholism therapy may simply bypass the larger issues of family dysfunction that maintain or are maintained by the alcoholic behavior.

Murray Bowen (1974), who also views alcoholism in the context of family systems, is even more insistent on a family context for treatment and rehabilitation. Alcoholism he sees as a family dysfunction that can only "exist in the context of an imbalance in functioning in the total family

system", with every family member contributing to the dysfunctional behavior of the alcoholic member. According to Bowen, treatment that alters the behavior patterns of these other family members will by definition eliminate the necessary substratum for the existence of the alcoholism, even though the alcoholic is not included in the therapy.

Alcoholism often impacts beyond the family into the larger community (an impaired drinking offence by the young alcoholic resulting in death or injury is one example). This in turn brings the larger systems in the community (police, welfare agencies) into more direct contact with the family, with sometimes less than positive outcomes. Ablon cites Ward and Faillace (1970) as pointing to yet a wider perspective for family systems application. The alcoholic is viewed not only in the context of the family, but in the contexts of the workplace and the larger community. Ward and Faillace, focusing on complementary and circular patterns of interactional systems within the alcoholic family suggest that agencies (like police, employer, welfare) can sometimes function in the roles of persecutor, rescuer and absolver and so serve the punishment/forgiveness needs of the alcoholic family system. The young alcoholic as *scapegoat* (Berman, 1973) is a familiar enough figure in rehabilitation practice. Effectively these agencies in interaction with the Y.A. and/or the family serve to maintain the homeostatic functioning of the alcoholic behavior.

2.5 A Structural-Strategic Approach

One notable application of Family Systems Therapy that developed out of clinical practice is a *structural-strategic approach* in the treatment of drug abuse and addiction (Stanton & Todd, 1982). In essence, it is a specific adaptation of two approaches; Minuchin's structural approach (1981, 1978, 1974) and Haley's strategic approach (1980, 1976, 1973) geared to the particular problems of drug addiction. The therapy is significant in its differential focusing on the young adult drug abuser in terms of "physiological dependence, the group context, family life cycle and transition stage". The family systems context is viewed against the developmental stage of the young adult and the therapy directed to specific issues such as individuation and/or separation, or reintegration into the family system.

Notwithstanding its particular focus in drug addiction, the author suggests that this particular meld of the structural and strategic therapies is no less applicable to alcoholism treatment. Both drug addiction and alcoholism can be seen as *symptomatic* of family dysfunction. In both instances the drug addict/alcoholic is central to the family's organization with the addiction/alcoholism functioning homeostatically in system maintenance. Notable also is the involved and complex inter-relationships that characterize the family system's functioning; there may be one set of behaviors for a drunk/addicted state and another

set of behaviors even quite the opposite, when drug-free or sober, (Stanton & Todd 1982, Steinglass 1979).

A prime focus for the therapy is "actively involving the addict's family of origin in the therapy even if the addict (alcoholic) is not living with them" (my emphasis). Stanton and Todd maintain that therapy will falter and possibly fail without this involvement of the family. Bowen (1974) also insists that the involvement of family is "absolutely necessary" for the rehabilitation of the alcoholic. Most significant for this approach, and pertinent to this study, is the distinction made between the adolescent and the older addict. Stanton and Todd recognize "clear differences" between the two. Therapy is explicitly targeted to the particular developmental stage of the adolescent drug abuser. *Reintegration* into the family system is suggested as a more developmentally appropriate goal of therapy for the younger adolescent as contrasted with the idea of *separation* for the older addict stuck in a transitional phase of the family life cycle.

It should be pointed out there are no clearly defined boundaries marking one developmental stage from another: child - adolescent - youth - adult represents a continuum of the developmental process, and the specific course of therapy can only be determined in the context of the presenting family system.

This is not to suggest that every Y.A. is a candidate for a family systems approach. The Y.A. outside the context

of the family system for some considerable time may require a somewhat different emphasis in the therapeutic approach. He may in fact be more readily treated in any of a number of modalities, such as group therapy, individual counseling, pharmacotherapy, and so on. It is important to recognize that no client can be described or truly understood only in terms of a theoretical construct. What is being suggested is that F.S.T. because of its theoretical underpinnings,allows a more explicit investigation of the alcoholism of the young adult.

2.6 Family Systems Therapy and The Circumplex Model

Family Systems Therapy was the paradigm of choice principally because of the "family context" it affords the therapist; and also because its theoretical shift to circular causality allows a more explicit investigation of the young adult's alcoholism.

Olson's Circumplex Model is an empirical approach that attempts "a more comprehensive and realistic picture of the complexity" of the family system while allowing diagnostic assessment. What the model does attempt, following Olson, is an integration of family systems concepts and empirical studies studies in the marital and family process literature.

The model explicitly examines the dynamics of the family system. It was designed "to provide a framework that could be used by clinicians working with families to make a

more systematic diagnosis and to establish more specific treatment goals" (Olson et al., 1979, p. 20). In this study the dynamics of family functioning is explored empirically, albeit in terms of a perceptual context for the young alcoholic. The young alcoholic's perception was the lens through which the issues stemming from self-in-relationship within the family system were interpreted.

The two primary dimensions of family functioning identified in the model are cohesion and adaptability. Sixteen major family types are described in the model and these relate to the levels of *adaptability* and *cohesion* in the particular family system. Both morphogenesis (change) and morphostasis (stability) are hypothesized as necessary for a viable family system. Optimal cohesion, or optimal adaptability, represents a balance between extremes, i.e. maintaining a balance between morphogenesis (change) and morphostasis (stability). On the *cohesion* dimension too much closeness leads to *enmeshed* systems, too little closeness leads to *disengaged* systems. On the *adaptability* dimension too much change leads to *chaotic* systems, too little change leads to *rigid* systems, Fig. 2 identifies the sixteen family types in the Circumplex Model.

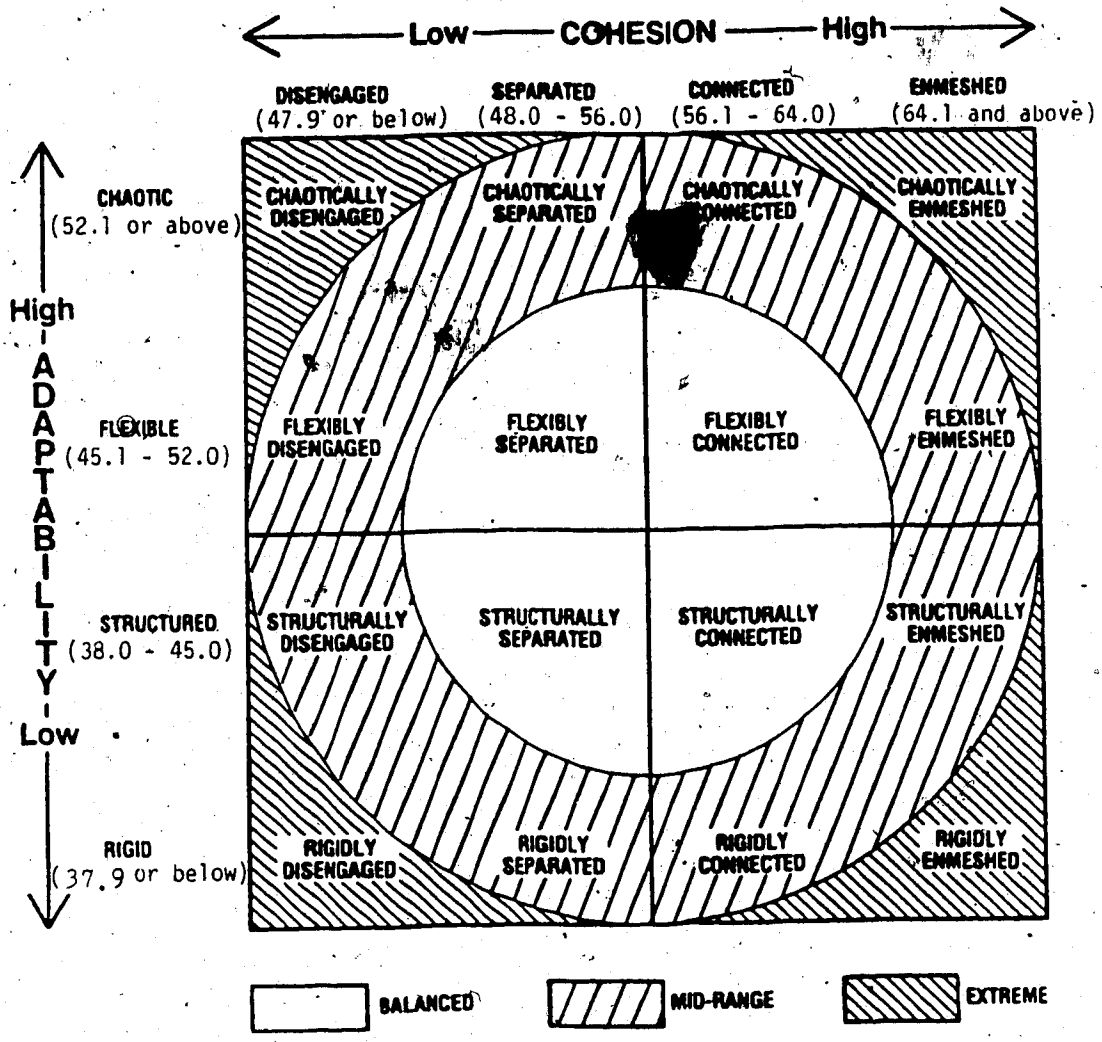
INSERT FIG. 2 HERE

In this representation the four family types at the centre are seen as *balanced*, the eight adjoining groups are designated *mid-range* families and the remaining four groups of families mark the *extreme* ranges of the cohesion and

FIGURE 2

CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS

(with Adolescent Norms indicated).



(n=416)

Cohesion	Mean = 56.3	S.D. = 9.2
Adaptability	Mean = 45.4	S.D. = 7.9

Source: Olson 1979

adaptability dimensions. Table 11, following, presents the family types identified by the alcoholic and control groups in the study.

Family cohesion assesses the degree to which family members are separated or connected to the family and is defined as the emotional bonding that family members have toward one another. Specific concepts used to diagnose and measure the cohesion dimension are emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests and recreation. (Refer Appendix C). At the extreme of high family cohesion, enmeshment, there is an over-identification with the family, characterized by extreme bonding and limited individual autonomy. The low extreme, disengagement, is characterized by low bonding and high autonomy from the family.

Family adaptability has to do with the extent to which the family system is flexible and able to change. Family adaptability is defined as the ability of the family system to change its power structure, role relationships, and relationship rules in reference to situational and developmental stress. Specific concepts used to diagnose and measure the adaptability dimension are: family power (assertiveness, control, discipline), negotiation style, role relationships and relationship rules. (Refer Appendix C.) FACES II which is used in this study, was developed to empirically test the Circumplex Model. A brief description follows in Chap. 3.

2.7 Summary

What is apparent from the literature is the relative dearth of both research and family systems theory application in the field of alcoholism treatment. This applies more so for the Y.A.

Steinglass, Davis and Berenson have made significant contribution to the therapy of alcoholism, especially: 1) the concept of drinking as an adaptive behavior in maintaining homeostasis in the family system, and 2) the concept of the *alcoholic family* life cycle viewed in a developmental perspective.

There is as yet no alcoholism treatment focus in family systems research or application that explicitly deals with the Y.A. In fact there are issues of definition to be resolved here. Steinglass' developmental perspective for the alcoholic family merely provides a therapeutic focus for dealing with the alcoholic behavior of the young adult.

A structural-strategic approach as developed by Stanton and Todd explicitly linked to the family life cycle, with its differential focus on the key issues of *individuation* and *separation* for the young adult may in fact be indicative of therapeutic direction in the treatment of alcoholism in the young adult.

There is implicit in Family Systems Therapy the suggestion that the therapeutic approach needs to match the specific developmental level of the Y.A. and the particular context of family functioning related to his alcoholism. The

Circumplex Model of Marital and Family Therapy allows this identification of the family context for the Y.A.

2.8 Hypotheses

In the review of the literature above, F.S.T. research and application in alcoholism has been referenced to the young adult in terms of family dysfunction; optimal family functioning has been posited as a balance between morphogenesis (change) and morphostasis (stability) on cohesion and adaptability in the family system. Extrapolating from these one can frame some guiding questions for delineating the young alcoholic's perceptions of family functioning. These questions formulated as hypotheses are as follows:

HO_I: Young alcoholics as compared to non-alcoholic young adults characteristically perceive themselves as disengaged within the family system.

HO_{II}: Young alcoholics significantly more than non-alcoholic young adults perceive the relationships within their family systems as being less adaptable, or more rigid.

HO_{III}: Family satisfaction for young alcoholics is significantly less than for non-alcoholic young adults.

HO_{IV}: The young alcoholics' perceptions of family functioning, in terms of cohesion and adaptability, will not change significantly post-treatment in a program not oriented to Family Systems Therapy.

3. METHODS AND PROCEDURES

This chapter presents the methods and procedures utilized in the study. The overall approach was:

a. determine a theoretical focus for the study
b. define the population
c. select the participants for the study
d. collect the data
e. analyse the data.

This required collaboration with AADAC staff and management in collecting data and establishing safeguards for confidentiality.

3.1 The Instruments

The instruments used in this study were: i) the Family Adaptability and Cohesion Scale II (Olson et al. 1982) and ii) the Socio-economic Index for Occupations in Canada (Blishen, 1976). Following Olson (1979), FACES II is described briefly in the context of the Circumplex Model of Marital and Family Systems. Detailed descriptions of the model can be found in Olson et al., 1979, and Russell, 1979. (The FACES II questionnaire and tables explicating the inter-related concepts of the cohesion and the adaptability dimensions used in FACES II are attached.See Appendix C.)

3.1.1 Faces II

FACES II is a modification of the original FACES; it was developed as a self-report scale to be used in

conjunction with the Circumplex Model of Marital and Family Systems (Olson et al., 1982, 1980, 1979) discussed in Chapter 2, previously. FACES II was designed to test empirically the concepts of family cohesion and family adaptability. Cohesion and adaptability are identified in the model as the primary dimensions of family functioning. *Cohesion* is defined as "the emotional bonding family members have with one another, and the degree of individual autonomy a person experiences in the family system". *Adaptability* is defined as "the ability of a marital/family system to change its power structure, codes, relationships and relationship rules in response to situational and developmental stress" (Olson et al., 1979).

There are thirty statements on a five-point Likert scale. It should be noted that the questionnaire is designed so that it can be administered twice; once for how family members currently perceive their family (as is) and secondly, for how they would like the family to be (ideal). By comparing both the *perceived* and *ideal* it is possible to assess the level of satisfaction with the family system for the individual family members; for the therapist the comparison also provides information regarding how each individual would like to see the family change. Theoretically, the perceived-ideal discrepancy provides a measure of family satisfaction with the current family system. One hypothesis regarding extreme types in the Circumplex Model is that extreme types of family systems

will function well as long as *all* family members like it that way (Olson et al, 1982).

FACES II was designed so that individual family members can describe how they perceive the family. In clinical practice FACES II is administered to as many members of the family as possible, the assumption being that no two members will see the family in the same light. In this study the FACES II questionnaire was completed by the *identified patient*, the Y.A.

FACES II construct validity as determined via a 30-item factor analysis and reported in the FACES II manual (Olson et al, 1982) reveals that the test does measure what it purports to measure. Three key studies which specifically test the model (Olson et al., 1979) in addition to the several studies reported in the manual, accrue validity for FACES II.

Reliability estimates (internal consistency type) for the FACES II norming samples varied as follows:

	Total Sample	Sample 1	Sample 2
Cohesion	.87	.88	.86
Adaptability	.78	.78	.79
Total Scale	.90	.90	.90

The Pearson correlations on test-retest reliability estimates were 0.83 for cohesion and 0.80 for adaptability.

As can be adjudged, validity and most acceptable reliability have been determined for this instrument and hence it may be used in this study with some confidence.

3.1.2 Socioeconomic Index for Occupations in Canada

Blishen's (1976) Socio-Economic Index for Occupations in Canada was used quite simply to establish comparability in terms of socio-economic status for the families in the study. The scale is an updated version of the 1967 scale (itself a revision of an earlier (1958) scale) and includes education, income and prestige as criteria.

In this index the top rankings were held by nuclear engineers, dentists, optometrists, administrators in teaching and related fields, physicians and surgeons. At the lower end of the index are labourers, trappers and hunters, fishermen and textile workers.

Blishen reports that the initial 1951 index, when compared to the social standings of occupations in other industrialized countries, yielded correlations that may be interpreted as "indices of validity": .94, U.S.A.; .74, Germany; .85, U.K.; .89, New Zealand; .90, Japan.

The 1961 update (Blishen, 1967) yielded a correlation of .96 when compared with the 1951 index. The 1971 scale (Blishen, 1976) is an update of the 1961 scale. The correlation of socio-economic scores was of the order of .97. Accordingly, it is with some confidence that this scale is used to rate S.E.S. in this study.

3.2 Selection of Subjects

The subject population in the study was drawn from 145 young adult alcoholics "admitted" (See Appendix A) to in-treatment (or residential) facilities run by the Alberta Alcoholism and Drug Abuse Commission (AADAC) at Henwood and at Claresholm, Alberta, between November 1984 and December 1985. Selection criteria were limited to age (between 15-24 years) and residence, i.e. living at home or having left home within six months of starting the program.

The initial screening was on the basis of recorded information on admission to the centre. Further screening was on the basis of whether or not they actually lived at home with family. Some few had listed their parents' address even though they lived elsewhere. Subjects were invited to participate in a study on families. There were four refusals. It should be added that a few likely subjects were missed through late notification or severe weather conditions.

The controls were recruited in the community (Edmonton and surrounds) and selected on the basis of age and family status, i.e. lived with family and were 15-24 years of age. Roughly two-thirds of the controls attended university and were recruited in class at the beginning of Fall '85 and Winter '85-'86 sessions.

3.3 Data Collection

The study required the co-operation of AADAC management and staff in setting up safeguards for confidentiality (a prime consideration of AADAC management staff), and for collecting and forwarding the questionnaires used in the study. All subjects in the 15-24 age group were invited to participate in the study subject to the requirement that they had lived with family within six months of starting the program. The questionnaires were completed within 24 hours of admission and before the start of the in-treatment program. By way of measuring program effects the questionnaire was again administered at the end of the program. It may be important to note that nine of the twelve who did not complete questionnaires at the end of the program had in fact left the program before its completion.

Each Y.A. was matched with a non-alcoholic young adult in regard to age, sex, and socio-economic status. An age difference within twelve months was provided for in matching pairs. The same S.E.S. level was used to effect matching, with the highest occupational level applicable to the household held as representative of the subject's S.E.S. Close matching was possible for the demographic variables of age, socio-economic status and gender, since there were at least three control questionnaires to every one Y.A. questionnaire completed. It is noted that there were only seven pairs of females (23% approx.) in the study. The percentage of females in the 15-24 age group admitted to the

two treatment centres over 1979-1984 period was 21% approx.

Nine subject questionnaires were eliminated because of incomplete data. Where it was possible to match a building contractor with another contractor in the construction field, with the same S.E.S., this match was used in preference to m[redacted]hing another occupation with the same level S.E.S. b[redacted] different fields.

4. RESULTS AND CONCLUSIONS

The present chapter is organized as follows: each hypothesis is restated to aid reader recall, then a description of the analysis performed to test the hypothesis is discussed. Thereafter, with reference to the calculations performed and the tables of relevant data the conclusions which are possible to make, are made.

As with all studies, certain related research questions or counter-explanations could be advanced. In order to answer these questions or to rule out counter-explanations for the findings, a series of additional calculations were performed. These additional calculations and the reasons for doing them and the implications of these results are included after the main findings.

A summary follows to end the chapter.

Hypotheses

HO_I: Young alcoholics characteristically perceive themselves as *disengaged* within the family system.

Analysis: In order to test if young alcoholics perceived themselves as more disengaged within the family system than non-alcoholic young adults, a test of significance of the differences of proportions for correlated samples was performed. In essence the scores on the cohesion dimension for the alcoholic and the control groups have been grouped as per the FACES II norms (refer Fig. 2) for cohesion, and presented in Table 2.

Table 2
Disengagement on Cohesion Dimension: Alcoholic and Control Groups on FACES II (1982)

	Disengaged	Separated	Connected	Enmeshed	Total
Alcoholics	20	4	5	1	30
Controls	2	15	9	4	30

z = 2.913

It was noted that 20 of the 30 (66.7%) alcoholic young adults perceived themselves as *disengaged* within the family system as compared to 2 of the 30 (6.7%) young adults of the control group. The groupings on cohesion in Table 2 were converted into proportions and collapsed into two groups, "disengaged" and "other". These proportions, in terms of "disengaged" and "other", were set in a 2x2 table. Using McNemar's formulation to determine the standard error (Ferguson p. 188, 1981), a test of significance of the difference of proportions (correlated samples) was performed. A "Z" value of 2.913 was derived for the difference between the proportions *disengaged* in the two groups.

Conclusion: This level of significance is well above $Z_{.05} = 1.96$ for a two-tailed test, and confirms HO_I i.e., the young alcoholics in this study characteristically perceive themselves as disengaged within the family system.

HO_{II}: Young alcoholics significantly more than non-alcoholic young adults perceive relationships within the family system as being less adaptable, or more *rigid*.

Analysis: The scores on the adaptability dimension of family functioning for both groups have been grouped as per the adolescent norms in FACES II (refer Fig. 2) for adaptability, and presented in Table 3.

Table 3
Rigidity in Families on the Adaptability Dimension: Alcoholic and Control Groups on FACES II (1982)

	Rigid	Structured	Flexible	Chaotic	Total
Alcoholics	13	8	7	2	30
Controls	6	12	9	3	30
$z = 2.26$					

On the adaptability dimension 13 of the 30 (43.3%) families of the young alcoholics were categorized as *rigid*, as compared to 6 of 30 (20.0%) for the control group. The groupings on the adaptability dimension in Table 3, have been converted to proportions and collapsed into two groups, "rigid" and "other". As before, these proportions in terms of "rigid" and "other" were set in a 2x2 table. Employing McNemar's formula for the standard error, a test of significance of the differences of proportions of correlated samples was performed. A "Z" value of 2.26 was derived for the difference in the proportions of families categorized as *rigid*.

Conclusion: Since this value exceeds $Z_{.05} = 1.96$ two-tailed, HO_{II} is confirmed, i.e. young alcoholics when compared to non-alcoholics, perceive the relationships within their family systems as less adaptable, or more

rigid.

HO_{III} satisfaction for the Y.A. is significantly less for the Y.A. compared to the non-alcoholic young adult.

Analysis: This hypothesis follows Olson's statement (FACES II, 1982) that "by comparing the perceived - ideal discrepancies for each person, it is possible to assess each individual's level of satisfaction with their current family system." To test if the level of family satisfaction for the Y.A. was less for the alcoholic group when compared with the control group, a "t" test of the significance of the difference between two means for correlated samples was performed. In effect the differences between the *as is* and *ideal* scores for cohesion and adaptability for both the alcoholic and the control groups were determined and the "t" values derived employing "the difference method" (Ferguson, 1981). Table 4 shows the mean divergence on cohesion for the alcoholic group as 18.9, and the mean divergence for the control group as 7.9.

Table 4

Mean Divergencies on Cohesion (as is - ideal)
Alcoholic and Control Groups

	Y.A.	Control Group
N	30	30
$\bar{x}$	18.9	7.9
S.D.	10.6	5.84

t = 4.864

Table 5 shows the mean divergences on the adaptability dimension as 15.86 for the alcoholic group and 10.96 for the control group.

Table 5
Mean Divergencies on Adaptability (as is - ideal)
Alcoholic and Control Groups

	Y.A.	Control Group
N	30	30
$\bar{x}$	15.86	10.96
S.D.	8.6	6.56
t = 2.085		

The difference between the divergences on cohesion is significant at $t(29)=4.86$, ($p < .001$). The difference between the mean divergences on adaptability is significant at $t(29)=2.085$, ($p < .05$).

Conclusion: Accordingly, HO_{III}, which states that family satisfaction for young alcoholics is less than family satisfaction for non- alcoholic young adults is supported on both the cohesion and adaptability dimensions of family functioning.

HO_{IV}: The young alcoholic's perceptions of family functioning in terms of cohesion and adaptability will not change significantly post-treatment in a treatment program

not oriented to Family Systems Therapy.

Analysis: To test for the significance of difference of the mean scores, pre and post treatment, a "t" test for correlated samples was again used on the cohesion and adaptability measured *as is* and *ideal*. Table 6 presents the mean scores on FACES II "pre" and "post" the treatment program for eighteen of the thirty young alcoholics in the study.

Table 6
Mean Scores on FACES II pre/post Treatment Program for Young Alcoholics

	Pre		Post		
	Mean	S.D.	Mean	S.D.	"t"
Cohesion (as is)	44.9	8.1	48.8	8.3	1.88
Adapt. (as is)	39.2	8.3	41.1	6.9	1.037
Cohesion (ideal)	63.5	7.0	67.5	6.7	2.555*
Adapt. (ideal)	55.5	4.2	54.4	4.6	0.969
N = 18			* p <.05		

The cohesion *as is* mean score, 44.9, pre-treatment, was compared to cohesion *as is* post-treatment, 48.8, and found to be non-significant. Similarly, the difference between adaptability *as is*, pre-treatment, 39.2, and adaptability *as is* post-treatment, 41.1, was also non-significant. The difference between adaptability, as *ideal*, 55.5, pre-treament, and adaptability as *ideal*, 54.4, post-treatment was also non-significant.

However, the difference between cohesion as *Ideal*, 63.5, pre-treatment, and cohesion as *Ideal*, 67.5, post-treatment, was significant.

Conclusion: At $t(17)=2.110$, ($p < .05$), only cohesion measured post-treatment, at the *Ideal* level of family functioning, was significant. Accordingly, the hypothesis was only partly met i.e. there has been measurable change post-treatment in the perception of an *Ideal* level of family functioning on the cohesion dimension for the young alcoholic.

Commentary Regarding Related Research Issues

As a first step, a non-directional "t" test was used to measure significance between differences of the mean scores of the control group and the FACES II (1982) norms on cohesion and adaptability. This was done in order to establish whether the mean scores for the control group (n=30) were comparable to the mean scores on cohesion and adaptability for the FACES II norm group (n=416), (i.e. $H_0: \mu_1 - \mu_2 = 0$ against $H_1: \mu_1 - \mu_2 \neq 0$); that the norms on FACES II (1982) could be applied in the study.

Another "t" test, "difference method", was used to determine the significance of the difference of the mean scores on FACES II of the alcoholic and control groups. This was done to measure the presumed differences in perceptions of the two groups.

Correlation coefficients were also computed as a measure of the relationships between the demographic variables (Age, Socio-Economic Status, Gender) and the variables marking the four parameters of family functioning, (cohesion and adaptability *as is* and cohesion and adaptability *as ideal*) for the two groups in this study.

Also, Olson has stated that no statistically significant differences were found between the mean scores for adolescent males and females on FACES II (1982). This no-sex difference was evaluated for both groups on the assumption that young alcoholics would present statistically significant gender differences in their perceptions of family functioning. A two-way analysis of variance with repeated measures (gender x parameters of family functioning) was computed to reveal that no statistical differences did exist.

Finally, a Chi-square (test of independence) was computed to determine the relationship of alcoholism to the level of family functioning in the two groups.

Comparison of Means

To determine if the mean scores of the control group and the FACES II norm group (refer Fig. 2) were comparable, a non-directional "t" test was performed.

Table 7 presents the mean scores on FACES II for the alcoholic and control groups with the adolescent norms on FACES II indicated.

INSERT TABLE 7 HERE

Table 7

Mean Scores on FACES II for Alcoholic and Control Groups (with FACES II Adolescent Norms indicated)

	Young Alcoholics		Control Group		FACES II Adolescents	
N	30		30		416	
Age	19.4 yrs		19.4 yrs		19.2 yrs	
		S.D.		S.D.		S.D.
Cohesion (as is)	44.8	11.0	56.9	6.8	56.3	9.2
Adaptability (as is)	38.9	8.5	44.1	6.7	45.4	7.9
Cohesion (ideal)	63.7	6.4	65.4	7.2	n/a	n/a
Adaptability (ideal)	54.8	3.9	54.8	5.7	n/a	n/a

Mean Scores - Control group and FACES II norms compared

The mean scores on cohesion and adaptability for the control group were in fact very close to the FACES II norms; 56.9 for the control group and 56.3 for the FACES II norm group on cohesion, and 44.1 and 45.4 on adaptability, for the control and FACES II norm group respectively.

The "t" tests on these differences yielded a "t" value on cohesion of 0.227 and a "t" value on adaptability of 0.906. With critical "t"=1.96 ($p < .05$) there were no grounds for rejecting $H_0: \mu_1 - \mu_2 = 0$, i.e. no significant differences exist between the mean scores of the control group and the adolescent norms in FACES II (1982).

Mean Scores - Alcoholic and Control groups compared

In order to determine the significance of differences in the perception of family functioning on the four parameters of FACES II a series of "t" tests were performed using the difference method (Ferguson, 1981).

The mean scores (refer Table 7) on the cohesion dimension, evaluated *as is*, were 44.8 for the alcoholic group and 56.9 for the control group. On the adaptability dimension evaluated *as is*, the scores were 38.9 and 44.1 respectively.

When cohesion and adaptability were assessed at an *ideal* level of functioning, the differences between the groups were less obvious. The mean scores on cohesion for the alcoholic and control groups were 63.7 and 65.4 respectively; similarly, the scores on the adaptability

dimension were 54.8 and 54.8 respectively.

The differences at an *as is* level of family functioning on the cohesion scores between the two groups yielded a "t" value of 5.316, and on adaptability a "t" value of 2.352. At an *ideal* level of family functioning, the differences on cohesion yielded t=0.895 and on adaptability, t=0.026.

On the basis of these "t" values and with critical t(29)= 2.045, ($p < .05$) the findings were:

a. There were significant differences in the perceptions of family functioning, perceived *as is*, between the alcoholic and control groups;

b. There were no significant differences in the perceptions of family functioning, perceived *as ideal*, between the alcoholic and control groups.

In summary, the groups diverged on their perceptions of family functioning when evaluated *as is*, and converged on what they desired as an *ideal* level of family functioning. In the latter case, the young adults of both the alcoholic and control groups seemed to want "the same thing" for family functioning.

Correlation Analysis

Correlation coefficients were computed in order to determine relationships between the variables in the study, identified as family function variables (FACES II parameters) and demographic variables (Age, Socio-Economic Status (S.E.S) and Gender). The intercorrelations have been computed separately for the alcoholic and control groups and

are presented in Tables 8 and 9 for the alcoholic and control groups respectively.

INSERT TABLES 8 & 9 HERE

Intercorrelations: Y.A. Group on FACES II -Table 8

Significant correlation coefficients ($p < .05$) were indicated for:

1) Socio-economic status and cohesion (as is) at $r=-0.430$. [*Note*. Border-line significance is indicated for S.E.S. with adaptability (as is) $r=-0.351$, $p = .057$].
2) Cohesion (as is) with adaptability (as is) correlates at $r=0.855$.
3) Cohesion (as is) with cohesion (ideal) correlates at $r=0.384$.
4) Adaptability (as is) with cohesion (ideal) correlates at $r=0.448$.

For purposes of analysis these intercorrelations were grouped into:

a) demographic (Age, S.E.S., Gender) and family function (cohesion and adaptability) intercorrelations
b) intercorrelations between family function variables i.e. cohesion and adaptability perceived (as is) and cohesion and adaptability perceived as (ideal).

Demographic and Family Function Intercorrelations

An inverse relationship was indicated for socio-economic status (S.E.S.) with the other variables in

Table 8

Intercorrelations

Age, S.E.S., Gender, Cohesion and Adaptability parameters and Mean Scores and Standard Deviations for Alcoholic Group

	1	2	3	4	5	6	7
1. Age	1.000						
2. S.E.S.	-0.203	1.000					
3. Gender	0.150	-0.225	1.000				
4. Cohesion-as is	0.107	-0.430*	0.088	1.000			
5. Adaptability-as is	0.126	-0.351	0.152	0.855*	1.000		
6. Cohesion-Ideal	0.083	-0.283	0.154	0.854*	0.448*	1.000	
7. Adaptability-Ideal	-0.129	-0.216	-0.020	-0.040	0.073	0.218	1.000
Means				49.867	38.900	63.767	54.867
Standard Deviation				11.035	8.534	6.433	3.947

*p < 0.05 n=30

the study (see Table 8). At $p < .05$ level of significance, S.E.S. was significantly associated with cohesion (as is), at $r = -0.430$, and with adaptability (as is) at borderline significance at $r = -0.351$ ($p = .057$).

In effect, the higher the S.E.S., the lesser the cohesion and adaptability perceived *as is* in family functioning by the Y.A.

Intercorrelations-Family Function Variables

The cohesion and adaptability parameters evaluated *as is* in this group were highly associated; at $r = .855$, 73% of the variance of the cohesion variable could be predicted from the adaptability variable.

The other correlation coefficients (indicated by *) marked significant associations between the cohesion (ideal) variable and the cohesion (as is) variable, at $r = .384$; and the cohesion (ideal) variable and the adaptability (as is) variable, at $r = .448$. However, the degree of predictability indicated for the variance between these variables are of the order of 15% and 20% respectively.

Intercorrelations: Control Group on FACES II - Table 9

Table 9 shows significant associations between:

1) cohesion (as is) and adaptability (as is), at $r = .505$,
2) cohesion (as is) and cohesion (ideal), at $r = .480$,
3) adaptability (as is) and adaptability (ideal), at $r = .469$.

Table 9 Intercorrelations

Age, S.E.S., Gender, Cohesion and Adaptability parameters, and Mean Scores and Standard Deviations for Control Group

	1	2	3	4	5	6	7
1. Age	1.000						
2. S.E.S.	-0.203	1.000					
3. Gender	0.142	-0.165	1.000				
4. Cohesion-As is	-0.075	-0.145	-0.095	1.000			
5. Adaptability-As is	-0.258	0.256	-0.284	0.505*	1.000		
6. Cohesion-Ideal	0.141	-0.273	0.020	0.480*	0.221	1.000	
7. Adaptability-Ideal	-0.192	0.175	-0.156	-0.013	0.469*	0.363	1.000
Means				56.967	44.100	65.400	54.800
Standard Deviation				6.814	6.740	7.246	5.753

*p < 0.05 (n=30)

The intercorrelations were grouped as before into:

a) demographic and family function intercorrelations

b) intercorrelations - family function variables.

Demographic and Family Function Intercorrelations

The non-significance of any associations between Age, S.E.S. and Gender and the family function variables established minimal association between these variables.

Intercorrelations - Family Function Variables

For the control group the association between the cohesion and adaptability (as is) parameters, was found to less significant. At r=0.505, only 26% of the variance of one parameter could be be predicted from the variance of the other.

The adaptability (as is) and adaptability (ideal) parameters were also associated (r=0.469),as well as cohesion *as is* and cohesion *ideal* (r=0.480) were associated, but at a lesser degree of predictability of variance i.e. 22% and 23% respectively.

To summarize, S.E.S. does not affect the results in a major way. Nonetheless, S.E.S. was shown to be related to cohesion.

Gender was found to be without significant association with the variables in the study, hence not implicated as causing differences in perceptions of family functioning.

Age was also not implicated as causing differences in perceptions of family functioning.

Gender Differences

Gender differences between young male alcoholics and young female alcoholics were examined to determine if there were sex differences in the findings.

A two-way analysis of variance (gender X parameters of family functioning) was computed for this purpose. As can be seen from Table 10

INSERT TABLE 10 HERE

the non-significance of the gender and interaction effects show that there are no gender differences on the four parameters of family functioning.

Thus, it may be concluded that gender or sex difference was not a confounding factor in the study. It may be interesting to note that Olson's findings were that no statistically significant sex differences were determined on FACES II (1982).

It should be noted that the "F" ratios on cohesion and adaptability measuring group effects between the alcoholic and control groups were significant at p=0.000 on cohesion and at p=0.013 on adaptability. However, these findings on the *as is* parameters are redundant with the results of the "t" test on the comparison of mean scores, alcoholic and control groups.

Alcoholism and Level of Family Functioning

Given what was established on the cohesion and adaptability dimensions of family functioning, was the relationship between the alcoholism of the young adult and his perceptions of family functioning in fact significant?

Table 10

"F" Ratios and "P" Values on Two-way Analysis of Variance with Repeated Measures - Gender X Y.A. and Control Groups on Cohesion and Adaptability Parameters

Source of Variation	Cohesion as is		Adaptability as is		Cohesion ideal		Adaptability ideal	
	"F" Ratio	P	"F" Ratio	P	"F" Ratio	P	"F" Ratio	P
Gender Differences	0.003	0.958	0.378	0.544	0.146	0.706	1.282	0.267
Group Differences (Alcoholics/Control)	23.622	0.000*	6.971	0.013*	0.896	0.352	0.009	0.923
Gender X Group Interactions	0.406	0.529	1.513	0.229	0.056	0.814	0.069	0.794

* $P < .05$

A Chi-square value was computed to determine the degree of the relationship. Following Olson (1982), the categories of families designated by the alcoholic and control groups were grouped by the level of functioning into three classes i.e. Balanced, Mid-range and Extreme. Table 11 shows these groupings for the alcoholic and control groups.

INSERT TABLE 11 HERE

The groupings in the table show the differences in perception of family functioning between the two groups as marked by negative skewness in the alcoholic group, with fourteen families at the extreme level, eight at mid-range, and eight categorized as balanced; and by positive skewness in the control group with seventeen families categorized as balanced, eleven at mid-range and two at the extreme level.

These groupings were then cross tabulated to yield Chi-Square significant at 0.0017, i.e. alcoholism in the young adult is significantly associated with families at the extreme level of functioning.

To summarize, the related research questions were determined as follows:

The sampling distribution of the means between the control group and the FACES II norming sample was normal (i.e. $H_o: \mu_1 - \mu_2 = 0$).

The mean scores on FACES II of the young alcoholic group and the control group differed significantly on the *as is* parameters of family functioning. No significant differences were determined on the *ideal* parameters.

Table 11

Family Types grouped by level of functioning (FACES II), for Young Alcoholics and Control Group

Level	Family Type	Y.A.	Control Group	Y.A.	Control Group
Balanced	Flexibly Separated	2(6.6%)	4(13.3%)		
	Flexibly Connected	4(13.3%)	3(10.0%)		
	Structurally Connected		3(10.0%)		
	Structurally Separated	2(6.6%)	7(23.3%)	8	17
Mid-Range	Flexibly Disengaged	1(3.3%)			
	Chaotically Separated		1(3.3%)		
	Chaotically Connected	1(3.3%)	1(3.3%)		
	Flexibly Enmeshed		2(6.6%)		
	Structurally Enmeshed		1(3.3%)		
	Rigidly Connected		2(6.6%)		
	Rigidly Separated		3(10.0%)		
	Structurally Disengaged	6(20.8%)	1(3.3%)	8	11
Extreme	Chaotically Disengaged				
	Chaotically Enmeshed	1(3.3%)	1(3.3%)		
	Rigidly Enmeshed				
	Rigidly Disengaged	13(43.3%)	1(3.3%)	14	2
		30	30	30	30

Chi-Square 12.714 D.F.2 Significance 0.0017

Correlation coefficients measured significant relationship between S.E.S. and the cohesion (as is) parameter, and borderline significance for S.E.S. and adaptability (as is) parameter. Age and Gender were without significant association with the other variables in the study. A high degree of association was indicated between the cohesion and adaptability (as is) variables in the alcoholic group, with lesser associations indicated for the control group.

There were no gender differences indicated in the findings of the study.

Alcoholism was significantly associated with "extreme" levels of family functioning.

A summary of the decisions made by the author to accept or reject the major hypotheses in the study is presented in Table 12 following. Discussion of these decisions and the related questions follow in the next chapter.

Table 12

Summary of conclusions regarding the tested hypotheses.

Hypothesis	Decisions	
	Accept	Reject
HO_1: Young alcoholics characteristically perceive themselves as disengaged in the way they relate within the family system.		

HO_{II}: Young alcoholics perceive their families as being less adaptable i.e. more rigid, than non-alcoholic young adults.

HO_{III}: Family satisfaction in terms of the perceived-ideal divergencies on cohesion and adaptability, is significantly less for the young alcholic compared to the non-alcoholic young adult.

HO_{IV}: The perceptions of family functioning in terms of cohesion and adaptability, will not change significantly for the young alcoholic in an in-treatment program not oriented to Family Systems Therapy.

5. DISCUSSION

In this study the young alcoholic identified disengagement and family system rigidity as the pre-eminent features of his family life. This was not altogether unexpected since the more evident the alcoholic behavior becomes the more likely is the Y.A. to move to a disengaged position as the alcoholic behavior impacts on relationships both inside and outside the family system. The more disengaged the Y.A. becomes, the more likely is he to move to symptomatic behavior, with alcoholism homeostatic to the family's functioning.

In terms of family relationships the young alcoholic may be completely isolated. Additionally, any attempt to control or limit the alcoholic behavior may simply contribute to his perception of rigidity in the family system.

Some explanation of this isolation may be found in Minuchin's (1974) position that rigid boundaries surrounding the marital sub-system typically produce problems of disengagement, such as minimal parent/child interaction, and a sense of isolation for the young adult in the family system. The findings of this study also find reflection in the observation that rigid boundaries are often a characteristic feature of alcoholic families (Landau & Stanton, 1983; Kaufman & Kaufmann, 1977; Steinglass, 1971b).

However, to generalize to all young alcoholics as perceiving themselves as isolated or alienated within their

family systems would require more definitive research than this study provided. Horman (1979) also identifies isolation and alienation as characteristic features of the young alcoholic's lifestyle. However,he sets youthful alcoholism in the larger dimension of the socio-political system. Alcoholism in the young he saw as reflecting a certain socio-political malaise in which youth is isolated and alienated, with the alcoholism being "used to suppress intense feelings of anxiety and depression associated with feelings of powerlessness, normlessness and meaninglessness"(p. 280).

Given the degree of disengagement and family system rigidity evaluated *as is* by the Y.A., one expectation was that the young alcoholic would have over-compensated in reporting on what he wanted family functioning to be on FACES II. Instead, the Y.A. in this study marked a level of family functioning similar to the *ideal* of his non-alcoholic counterpart. The difference in perception between the two groups was clearly limited to the *as is* level of family functioning.

What FACES II defined was a very specific *place* within the family system for the Y.A. He was "disengaged", and perceived himself in a family characterized by "rigid" organizational relationships. This was supported by the finding that the "level of satisfaction" with family was significantly lower for the Y.A. than for the non-alcoholic young adult. A related finding that an extreme level of

family functioning was highly associated with alcoholism in the young adult served to underline the dysfunctional family system context for the Y.A.

It should be noted that Olson (1982) has suggested that the evidence points to fewer problems of dysfunction for families functioning at extreme levels "as long as all family members like it that way" (my emphasis). It is not clear if Olson's assessment included alcoholic families.

The key to therapy here is the perceptual context of the Y.A. It is important to note that "where" the family systems therapist directs therapy is determined more by the nature of the family's interaction "in session" than by a diagnostic assesment of the family's functioning.

Given the high correlation (.855) indicated between the cohesion and adaptability contructs, viewed *as is*, it is conceded that the Y.A. looking at his family "the way it is", may indeed hold a distorted view of the reality of his family's dynamic functioning.

But the reality of the family's dynamic functioning would vary in relation to the person completing FACES II; would reflect the therapist's perception of the family's dynamic funtioning.

What is indicated, given the perceptual context of the Y.A. as the "identified patient", is a direction and a focus for the family systems therapist; a recognition that change in the perceptual context of the Y.A. would require change in the organizational relationships of the family system;

that change would require a focusing on the "mechanisms" in the family's organizational structure that maintain, or are maintained by, the alcoholism of the Y.A.

Treatment Implications

In family systems theory, specific organizational structures determine the nature of the relationships within the family system. By reviewing the dimensions of ongoing family functioning for the young alcoholic the therapist derives a context for the alcoholism or patterns its systemic functioning. Therapeutic strategies are less problematical. For example, whether the family is seen as *rigidly disengaged* or *chaotically enmeshed* (Refer Fig. 2) will determine direction for the therapist. In the one case the therapist may attempt to move the family into some degree of *connected(ness)* with the young adult, as an initial phase of therapy. In the other case, he may direct therapy towards a shift from *enmeshment* to *separate(ness)*. It is to the "reality" of the Y.A. that the family systems therapist must direct his rehabilitative strategies.

For this study, the findings related to HO_I, HO_{II}, and HO_{III} can be accepted as defining for young alcoholics a particular reference frame within the context of the family system. Separately and together these findings indicate direction and focus for the family systems therapist treating the alcoholism of the young adult. While this is not an indication that Family Systems Therapy will be effective with the Y.A., the therapist is in a position to

match his therapeutic thrust with the developmental level and the family stage context of the young adult. The Circumplex Model allows this kind of diagnostic positioning on the part of the therapist. There is "less groping in the dark".

It is noted that while the data pointed to clear differences in the perceptions of young alcoholics and non-alcoholic young adults regarding family functioning viewed *as is*, the data also pointed to similarities in what both groups wanted for family functioning. In fact there were no significant differences established at the *ideal* level of family functioning between the two groups. The findings on FACES II post-treatment, HO_{1V}, acquire added significance here. These findings (refer Table 6) were i) that there were no significant changes in the perception of family functioning at the *as is* level, and ii) that there was a significant shift on cohesion at the *ideal* level of family functioning. The Y.A. had in fact shifted from being "connected" pre-treatment to being "enmeshed" post-treatment (refer Fig. 2).

The non-significance of the cohesion and adaptability parameters measured *as is* on FACES II pre/post was not unexpected since therapy at the Henwood and Claresholm centres was not geared to the restructuring of the organizational relationships within the family system (refer HO_{1V}).

The implications for therapy follow. In this instance, the nature of the organizational relationships of the family system has been ignored or not included in the therapy. It is a contention here that the underlying issues of family dysfunction require to be addressed if the Y.A. is to perceive change on the level of family functioning evaluated *as is.*

The second finding on FACES II post treatment, that there was a significant change on cohesion at an ideal level of family functioning, or where the Y.A. was wanting to be in his family system, i.e. enmeshed, has very specific implications for the family systems therapist. The shift from being "connected" pre-treatment, to being "enmeshed" post-treatment, places the Y.A. at another extreme on the cohesion dimension (refer Fig. 2) and would indicate a dysfunctional situation for the Y.A. on rejoining the family system. Therapy would have to be focussed on achieving some sort of "balance" in the systemic relationships for the Y.A. While such a shift is a positive indicator for the ongoing relationship of the Y.A. with his family, in terms of his willingness to change, one can only speculate in the circumstances that the alcoholic behavior becomes less problematic in relation to his desire to enter into new or changed relationships with family members, and to stay "connected", within his family system.

Whether the change in the perceptual context of family functioning may have derived simply from three weeks of

"sobriety and clearer thinking", or can be attributed to program effect would require more definitive research. However, it does raise the issue of a treatment approach specific to the family context of the young alcoholic since the identified patient, the "rehabilitated" young adult, would be re-entering the family system he perceives as dysfunctional after treatment in the clinic.

A Note on FACES II

The main findings on the correlation analysis (refer to Tables 8 & 9) were that the cohesion and adaptability constructs viewed *as is*, were i) highly associated (.855) for the Y.A. group, and moderately associated (.505) for the control group; and ii) that cohesion and adaptability were not significantly associated, measured *ideal*, for either the Y.A. or the control group.

The non-significance of the relationships between the cohesion and adaptability parameters, measured *ideal*, would support the cohesion and adaptability contructs as "reliable, valid and independent" (Olson 1982). For the findings at the *as is* level, Y.A. group, it is suggested that a possible explanation for the association between cohesion and adaptability derived from the degree of isolation experienced by the Y.A., (refer to Tables 2 & 3) with anger and resentment finding reflection in his evaluation of family functioning.

For the control group, the association between the cohesion and adaptability parameters is less marked. It is

suggested that for this group a more normal family situation applied and if family functioning evaluated *as is* was perceived as satisfactory or better on one parameter this positive perspective would transfer to the other parameter as a "halo effect". The significant associations at the *as is* level suggested the possibility that negative and or positive attitudes towards family were being reflected in the evaluation of family functioning "the way it is"; the correlation coefficient values, .855 for the alcoholic group, and .505 for the control group would seem to indicate the relative intensity of these feelings.

It must be emphasized that these suggestions derive from the author's interactions with the subjects in the study (post FACES II) and are purely speculative.

Recommendations for Further Research

It became apparent during the course of gathering data that further investigation was indicated for the following:

1. Only the young adults' perceptions of family functioning were used in this study. A more definitive application of FACES II would include the perceptions of family members.
2. Family functioning was only measured on FACES II and thus cannot be said to have been examined fully. A broader investigative approach such as combining in-depth interviews with FACES II seems indicated.
3. The study seemed to indicate a more complex network of variables affecting the assessment of family functioning

- a more definitive version of FACES II or another instrument could be used to investigate family functioning.

4. Extended research is indicated using Family Systems Therapy in the rehabilitation of the Y.A. within the context of an in-treatment program.

Conclusions

The review of the literature suggests that there is no rehabilitative focus in the treatment of alcoholism specific to the young alcoholic. This in spite of the fact that a growing number of researchers recognize "differences" between the alcoholism of the young adult and the alcoholism of the older adult.

In this study it is hypothesized that because drinking is so widespread in the society and an accepted social norm, the Y.A. in a family context is representative of family dysfunction. While this seems to suggest that the reality of the family's history and systemic organization is limited to the young alcoholic's perspective the view is offered that it would be equally valid to deal with this perspective as deal with any other. The findings of the study support the contention that change in the young alcoholic's perception of his role and the inter-relationships within his family system may be an important factor in his rehabilitation.

More pertinent to the study is the fact that in the treatment of alcoholism in the young adult significant linkages with the family systems context of the young alcoholic may have been ignored in current treatment practices.

The dual findings of this study -- that the Y.A. saw his family system as dysfunctional while at the same time he was wanting a more normal family environment -- provide some support for the theoretical stance formulated for this study, i.e. that focusing on the family's organizational relationships is inherently part of the treatment approach to the rehabilitation of the Y.A.

The findings may also suggest the development of a clinical treatment perspective in which the young adult is viewed in the context of his family, and the relevance of his perceptions of the inter-relationships and roles within his family system given due weight.

More specifically, continued exploration of the F.S.T. approach would seem supported by the relative clear-cut depiction of the family system of the Y.A. as "disengaged" and "rigid" in this study. The therapeutic direction which derives from such a finding supports the use and further exploration of the Circumplex Model in the treatment of alcoholism in the young adult. However, some caution seems indicated given the degree of correlation established between the cohesion and the

adaptability dimensions of FACES II.

This study also operationalized key concepts in family systems theory in a clinic setting by demonstrating the applicability of the FACES II (Olson 1982) as an evaluative and therapeutic instrument in alcoholism therapy.

While the study is by no means definitive in the assessment and treatment of the young alcoholic, given the size of the sample and the particular character of the client population of the Henwood and Claresholm rehabilitation clinics, it does point to an area of research in F.S.T. for the therapist working with young adults having problems with alcohol abuse.

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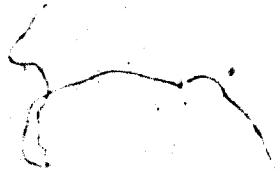
7. APPENDICES



APPENDIX A

ASSESSMENT AND SCREENING

AADAC

APPENDIX A

ALBERTA ALCOHOLISM AND DRUG ABUSE COMMISSION

ASSESSMENT FORMAT

1982

I READINESS

Readiness explores the reason clients seek treatment and their expectations on entering treatment. It helps assess how motivated the client is for treatment.

1) Reasons for Seeking Treatment

How did you hear about this programme?

What made you seek treatment at this particular time?

_____ A. FAMILY PRESSURE

What does your family think about you seeking treatment?

_____ B. LEGAL PRESSURE

Have you had any legal problems? e.g. impaired driving, etc.

_____ C. PEER PRESSURE

Have your friends ever encouraged you to seek treatment?

_____ D. STREET PRESSURE

Do you have a place to stay?

Is anything unusual happening on the street scene recently?

_____ E. JOB PRESSURE

Are you having difficulties at work?

Were you sent here by your employer? If so, what kind of progress do you have to show in treatment in order to keep your job?

_____ F. MEDICAL PROBLEMS

Do you have any medical problems?

Has your doctor said your medical problems are related to your drinking and suggested you reduce/stop drinking?

G. INTERNAL PRESSURE

Did you decide to come for treatment on your own?

What were the reasons for your decision?

2) Previous Treatment Experience

A) Previous Treatment

Have you ever attempted to stop drinking/using drugs without any outside help?

If treated previously:

i) What was the type of treatment?

_____ counselling _____ antabuse _____ AA

ii) Were you in treatment more than once? —

B) Treatment Outcomes

What was it like?

What changes did it bring about?

i) Satisfaction:

What did you like about the treatment?

Who or what was helpful to the client in these programmes?

(a) In what way did you find the counsellor to be helpful? Not helpful?

(b) What about the experience did you find helpful? Not helpful?

(c) What did you gain from the experience?

ii) Dissatification:

What did you dislike about the treatment?

How did you handle it?

iii Reasons for termination:

What were the reasons or circumstances for leaving?

II ALCOHOL/DRUG USE PATTERN

Alcohol/Drug Use Pattern explores the extent and pattern of the client's use of chemicals. It helps determine the treatment and relapse prevention strategies.

1) Development of Drinking/Drug Problem

A) Age of First Drink/Drug Use:

How old were you when you drank/took drugs for the first time? _____

B) Problem Alcohol/Drug Use:

How old were you when drinking/using drugs became a "real problem"? _____

C) Evolution of Present Pattern:

Did you arrive at present level of drinking/drug use _____ gradually over a long period of time?

OR

_____ by sudden rapid increase (several months or less)?

D) Special Circumstances:

Were there any special circumstances that led your drinking/drug use to become a problem? _____

2) Usual Drinking/Drug Use Pattern

A) Type of Alcohol/Drug User

Periodic, Binge Drinker/Drug User (drinks/uses drugs heavily on a binge every so often with periods of little or no drinking/drug use between binges).

About how long does your binge usually last?

_____ hrs. _____ days _____ wks. _____ mos.

About how much time goes by between drinking bouts?

_____ days _____ weeks _____ months

OR

3) Client and Counsellor Expectations

A) Client Expectations

i) Attitudes:

Often people have mixed feelings about coming for treatment, how do you feel about being here? (embarrassed, nervous, resentful)

Do you think you need treatment?

ii) Expectations:—

What do you think treatment involves?

Given what you know about the programme, what do you anticipate will give you the most difficulty?

How long do you expect treatment to take?

What do you expect it will be like for you next week? Next month? In six months? When you leave treatment? (Provide information about the programme if necessary.)

B) Counsellor Expectations

Discuss the following with the client:

- What the client and you expect regarding involvement of others in treatment - spouse, friends, employer.
- The counsellor-client roles and responsibilities.
- Confidentiality.
- Prepare the client to handle how he might handle situations when he is thinking about drinking or has a drink.

Steady, regular drinker/drug user (continuously drinks/uses drugs more or less the same amount on a day-to-day basis).

Are there any particular days of the week during which you drink/use drugs more than on other days?

_____

Are there any particular reasons which contribute to your drinking/using drugs more on those days?

_____

B) Locations

Where do you usually drink/use drugs?

The Most		The Least
_____	tavern/bar	_____
_____	restaurants	_____
_____	in own home/apartment	_____
_____	in other people's homes	_____
_____	at work	_____
_____	private club	_____
_____	social events	_____
_____	while driving	_____
_____	outdoors	_____
_____	other, specify _____	_____

C) Social Settings

With whom do you usually drink/use drugs?

The Most		The Least
_____	alone	_____
_____	with spouse	_____
_____	with other relatives	_____
_____	male friends only	_____
_____	female friends only	_____
_____	friends of both sexes	_____
_____	people I meet after drinking	_____
_____	business associates	_____

(NOTE: A card sort may be used for sections B) and C))

Do any people you live with drink/use drugs?

_____ Yes _____ No

Do you ever feel pressured because of their drinking/drug use?

_____ Yes _____ NO

D) Use of Other Drugs

i) Do you regularly use any other drugs? Specify?

ii) Do you use a combination of drugs? Specify?

E) Associated Activities

When drinking, do you usually:

_____ smoke
_____ gamble
_____ participate in a hobby/social activity? Specify:

_____

F) Periods of Abstinence

i) What has been the longest period of time during which you did not drink/use drugs?

_____

ii) What would you say is the main reason(s) why you stop drinking/using drugs?

_____

_____

iii) What would you say is the main reason(s) you start drinking/using drugs after a period of abstinence?

_____

_____

3) Reasons for Drinking/Drug Use

A) What are the main reasons you drink/use drugs?

B) Are you aware of any inner thoughts or feelings within you which "trigger off" your desire to take a drink/use drugs?

C) Are there any particular situations which would be most likely to make you feel like drinking/using drugs?

D) What is the most positive or desirable effect of alcohol/drugs for you?

i) When you are actually drinking/using drugs (card sort)

ii) On your life as a whole

4) Extent of Problem

(see Intake Form for extent of problem.)

A) How would you describe the general drinking habits of each of your parents?

Mother		Father
	not applicable	
	nondrinker (abstinent)	
	occasional or light social drinker	
	moderate or average social drinker	

_____	frequent or heavy social drinker	_____
_____	alcoholism problems	_____

B) Do you sometimes take a drink in the morning, before breakfast?

_____ Yes _____ No

C) Do you find that you are <u>unable</u> to stop drinking, once you have had one or two drinks on any occasion?

_____ Yes _____ No

D) After drinking for a period of time, have you ever had any of the following experiences?

_____ a hangover
_____ nausea and/or vomiting
_____ an episode of the "shakes"
_____ a "blackout" (lapse of memory for events which occurred while drinking)
_____ vague feelings of fear or anxiety
_____ a convulsion or seizure
_____ the "D.T.'s" (when you saw, felt, or heard things that were not really there)

E) Has drinking, in your opinion, been the cause of any of the following events in your life?

_____ losing a job or jobs
_____ getting arrested
_____ becoming divorced or separated
_____ losing a personal friend or friends
_____ being broke or in financial debt
_____ having a serious medical problem

specify:

_____

III RELATIONSHIPS

Relationships considers the client's relationships with others, how the client's alcohol/drug use has affected these relationships and what implications these relationships have for treatment.

1) Closest Relationships

A) Quality of the Relationship

i) Who is the person you feel closest to?

ii) How long have you known each other and been close?

B) Feelings About the Relationship

i) How do you feel about this person?

ii) What do you like best about the relationship?

2) Family Relationships (Parents, Siblings)

When you were growing up, what was your family life like?

- Were there any major family problems? - (alcohol/drug problems, brutality, etc.)
- Were there any unusual situations that you remember as you were growing up that still bother you? - (death, accidents, etc.)
- Was there anyone that you were particularly close to?
- What is your present relationship with your family (parents, siblings)?

3) Family Relationships (Spouse, Children, or Parents if Single)

- What is your relationship with your present family?
- To what extent do you think it has been affected by your alcohol/drug use?
- What are the strengths of your marriage?

- What are the weak points in your marriage?
- Any previous marriages and circumstances?

4) Social/Group Relationships

- What are your social activities and how do you feel about mixing with people? - (insecure, follower, leader, etc.)
- What part does alcohol/drug use play in your social activities? - (clubs, sports, community groups, etc.)
- What do you think friends think of your alcohol/drug use?
- If you choose not to drink again, how do you feel about socializing without alcohol/drugs?

5) Relationships with Members of Same and Opposite Sex

A) Relationships

- How do you get along with men (women) in general?
- Do you have male (female) friends?
- Which of the sexes do you get along with better? For what reasons?
- With which do you spend the majority of your time?

B) Sexual Orientation

- What is your major sexual orientation? - (gay, straight, bisexual)
- How important do you feel that sex is in comparison with other aspects of a relationship?
- Have you ever had any concern regarding sex?
- Are you aware how alcohol/drugs affect sex?

IV RATIONALITY

Rationality assesses the client's mental status. It attempts to determine if any emotional problems are associated with alcohol/drug use (either before or after) or not. Based on that information, the client's physical and/or emotional health may need to be checked out further.

1) Extreme Mood Swings

A) Depression

- Have you ever felt really down, hopeless, depressed?

B) Mania

- Have you ever felt really hyped up?

C) Mixed Depression and Mania

- Have you ever had periods of ups and downs when you had marked changes in your sleeping or eating?
- Determine the pattern, length, and progression

2) Suicide

- Have you ever thought of harming or killing yourself?
- Is this a problem at this time?

3) Strong Feelings or Impulses

- Do you often act on the spur of the moment without considering the consequences? - (e.g. - get angry and fight, eat too much, spend too much, drink/use drugs)

4) Potential for Violence

- Have you ever harmed anyone? What were the circumstances and were they related to alcohol/drug use?

5) Physical Health

- How recent was your last physical examination?
- Has your doctor ever indicated that you have any health problems such as diabetes, hyperthyroid, etc.?

6) Self Image

- How do you generally feel about yourself at this time? - (e.g. no confidence, depressed, etc.)
- What do you think your feelings are related to? - (alcohol/drug use or other)

V Resources

In addition to exploring the client's problems, it is important to explore his strengths and the resources that are available to him in his community. The client's resources may be used as a base for a treatment plan - the resources may be gradually built up so the client realizes his potential for handling more areas.

1) Personal

A) Job

- What kind of job do you have and are you interested in that area?
- How do you usually approach your job? - (e.g. work hard, hustle, often absent, etc.)
- How do you get along with the people you work with?

B) Education

- What kind of job skills/training do you have?

C) Interpersonal Skills

- (Covered in Relationships to determine ability to get along with others - e.g. sociable, humor etc.)

D) Leisure Activities

- Do you have any free time activities not involved with alcohol/drugs?
- What activities interest you and do you know how to pursue these interests? - (e.g. sports, music, cultural,etc.)

E) Health

- How is your health? Do you have any concerns?

F) Finances

- Do you have a regular source of income?
- HOw do you handle your finances? - (e.g. debts, bills, etc.)

2) Family and Friends

- This information is covered in Relationships to determine who is supportive and with whom activities and supports can be developed.

3) Client-Counsellor Relationship

- One resource available to the client is his relationship with his counsellor - a relationship in which risks can be taken and new behaviors tried. In order to be accomplished, the counsellor must set the tone and encourage the client to be free to give the counsellor feedback as well as get feedback.

4) Community Resources

- A variety of resources are available to the client in the community - both counselling and social support, e.g. counselling, AA, recreational, cultural. It is important to determine what supports the client needs during and following treatment and match the available community supports to the client's need or treatment.

APPENDIX A1

BRIEF SCREENING INSTRUMENT

NAME: _____ DATE: _____

ALCOHOL USE QUESTIONNAIRE (MAST)

The following questions concern information about your use of alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

Please answer every question. If you have difficulty with a statement then choose the response that is mostly right.

These Questions Refer to the Past 12 Months

		Circle Your Response	
1)	Do you feel you are a normal drinker? ..... (By normal we mean you drink as much or less than the average person.)	Yes	No
2)	Do friends or relatives think you are a normal drinker?	Yes	No
3)	Have you attended a meeting of Alcoholics Anonymous (AA) because of your drinking?	Yes	No
4)	Have you lost friends or girlfriends/boyfriends because of your drinking?	Yes	No
5)	Have you gotten into trouble at work because of your drinking?	Yes	No
6)	Have you neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	No
7)	Have you had delirium tremens (DTs), severe shaking, heard voices or saw things that weren't there after heavy drinking?	Yes	No
8)	Have you gone to anyone for help about your drinking?	Yes	No
9)	Have you been in a hospital because of drinking?	Yes	No
10)	Have you been arrested for drunk driving or driving after drinking?	Yes	No

MAST - 10 SCORING KEY

Item 1.	Yes (0)	No (1)
Item 2.	Yes (0)	No (1)
Item 3.	Yes (1)	No (0)
Item 4.	Yes (1)	No (0)
Item 5.	Yes (1)	No (0)
Item 6.	Yes (1)	No (0)
Item 7.	Yes (1)	No (0)
Item 8.	Yes (1)	No (0)
Item 9.	Yes (1)	No (0)
Item 10.	Yes (1)	No (0)

Add up the score (0 or 1) for each item to yield the Total Score (range 1 to 10).

MAST - 10 INTERPRETATION

MAST - 10 SCORE	DEGREE OF PROBLEMS RELATED TO DRINKING	SUGGESTED ACTION
0	No Problems Reported	None at This Time
1 - 2	Low Level	Monitor, Re-assess at a Later Date
3 - 5	Moderate Level	Further Investigation
6 - 8	Substantial Level	Intensive Assessment
9 - 10	Severe Level	Intensive Assessment

BRIEF SCREENING INSTRUMENT

NAME: _____ DATE: _____

DRUG USE QUESTIONNAIRE (DAST - 10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana, hashish), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement then choose the response that is mostly right.

These Questions Refer to the Past 12 Months	Circle Your Response	
1) Have you used drugs other than those required for medical reasons?	Yes	No
2) Do you abuse more than one drug at a time? ...	Yes	No
3) Are you always able to stop using drugs when you want to?	Yes	No
4) Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5) Do you ever feel bad or guilty about your drug use?	Yes	No
6) Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7) Have you neglected your family because of your use of drugs?	Yes	No

		Circle Your Response	
8)	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9)	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? ...	Yes	No
10)	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.,)?	Yes	No

DAST - 10 SCORING KEY

Item 1.	Yes (1)	No (0)
Item 2.	Yes (1)	No (0)
Item 3.	Yes (0)	No (1)
Item 4.	Yes (1)	No (0)
Item 5.	Yes (1)	No (0)
Item 6.	Yes (1)	No (0)
Item 7.	Yes (1)	No (0)
Item 8.	Yes (1)	No (0)
Item 9.	Yes (1)	No (0)
Item 10.	Yes (1)	No (0)

Add up the score (0 or 1) for each item to yield the Total Score (range 1 to 10).

DAST - 10 INTERPRETATION

DAST - 10 SCORE	DEGREE OF PROBLEMS RELATED TO DRINKING	SUGGESTED ACTION
0	No Problems Reported	None at This Time
1 - 2	Low Level	Monitor, Re-assess at a Later Date
3 - 5	Moderate Level	Further Investigation
6 - 8	Substantial Level	Intensive Assessment
9 - 10	Severe Level	Intensive Assessment

BRIEF SCREENING INSTRUMENT

CAGE DRINKING QUESTIONS

1) Have you ever felt you ought to cut down on your drinking?

2) Have people annoyed you by criticizing your drinking?

3) Have you ever felt bad or guilty about your drinking?

4) Have you ever had a drink first thing in the morning to steady your nerves and get rid of a hangover? ("eye-opener")

Interpretation

Two or more positive responses suggest sufficient evidence of alcohol abuse to warrant further investigation.

Source: Mayfield, D., McLeod, G., and Hall, P. The CAGE questionnaire: validation of a new alcoholism screening test. American Journal of Psychiatry, 1974, 131, 1121-1123.

APPENDIX B

RAW SCORES

Appendix B

Raw Scores on FACES II - Young Alcoholics

Subject	Age	S.E.S.	Gender	As is		Ideal	
				Cohesion	Adaptability	Cohesion	Adaptability
1	16	4	F	63	55	74	56
2	16	4	F	54	45	63	61
3	16	4	M	50	44	50	51
4	17	4	M	71	61	73	64
5	17	4	F	54	36	55	53
6	17	2	M	54	39	66	50
7	17	4	M	48	43	47	47
8	18	3	M	55	47	69	59
9	18	4	M	67	50	72	63
10	18	1	M	58	45	62	50
11	19	4	M	58	45	69	59
12	19	1	F	62	46	74	59
13	19	4	F	63	47	65	51
14	19	4	M	55	51	60	63
15	19	3	M	56	37	65	50
16	19	1	M	52	41	63	55
17	19	4	M	56	43	75	59
18	19	1	M	67	48	75	62
19	19	3	M	56	48	65	55
20	20	2	M	62	46	61	52
21	21	1	M	59	32	65	45
22	21	3	M	41	32	66	66
23	22	1	M	67	40	68	48
24	22	2	M	45	42	77	59
25	22	2	M	61	36	72	47
26	22	3	F	56	48	[illegible]	54
27	22	4	M	48	33	[illegible]	53
28	23	3	F	55	56	[illegible]	61
29	23	4	M	52	42	59	49
30	24	4	M	64	45	70	49
n= 30Means				44.8	38.9	63.7	54.8
		S.D.		11.0	8.5	[illegible]	3.9

Appendix B

Raw Scores on FACES II - Control Group

Subject	Age	S.E.S.	Gender	As is		Ideal	
				Cohesion	Adaptability	Cohesion	Adaptability
1	16	4	F	45	37	54	59
2	16	4	F	26	30	57	52
3	16	4	M	56	48	66	61
4	17	4	M	37	27	63	54
5	17	4	F	38	35	63	56
6	17	2	M	41	30	45	51
7	17	4	M	49	46	69	51
8	18	3	M	44	39	66	58
9	18	4	M	48	41	63	58
10	18	1	M	46	43	62	58
11	19	4	M	34	37	66	52
12	19	1	F	71	55	75	51
13	19	4	F	40	37	69	55
14	19	4	M	42	32	58	49
15	19	3	M	40	24	62	49
16	19	1	M	60	50	62	60
17	19	4	M	38	40	68	57
18	19	1	M	51	40	71	55
19	19	3	M	32	27	73	60
20	20	2	M	46	48	65	56
21	21	1	M	42	38	71	57
22	21	3	M	61	51	72	51
23	22	1	M	59	46	70	57
24	22	2	M	31	30	60	55
25	22	2	M	60	55	69	56
26	22	3	F	40	28	62	59
27	22	4	M	45	39	55	45
28	23	3	F	44	40	59	59
29	23	4	M	21	28	58	56
30	24	4	M	59	46	60	49
n= 30		Means		56.9	44.1	65.4	54.8
		S.D.		6.8	6.7	7.2	5.7

Appendix B

Raw Scores on FACES II -- Eighteen Young Alcoholics Pre & Post Treatment Program

				Pre				Post			
				As Is		Ideal		As Is		Ideal	
No.	Age	S.E.S.	Gender	COH	ADAPT	COH	ADAPT	COH	ADAPT	COH	ADAPT
1	16	1	F	45	37	54	59	51	39	57	59
6	17	4	M	41	30	45	51	33	33	57	51
7	17	4	M	49	46	69	51	49	37	70	50
9	18	4	M	48	41	63	58	53	48	76	58
10	18	1	M	46	43	62	58	55	36	64	52
11	19	3	M	34	37	66	52	37	36	70	50
13	19	3	F	40	37	69	55	48	40	64	52
15	19	2	M	40	28	62	49	63	50	71	56
16	19	1	M	60	50	62	60	48	50	68	53
17	19	4	M	38	40	68	57	53	46	74	61
19	19	3	M	32	27	73	60	36	36	76	61
20	20	2	M	46	48	65	56	58	50	69	53
21	21	1	M	42	38	71	57	41	36	71	57
23	22	1	M	59	46	70	57	52	39	55	53
25	22	1	M	60	55	69	56	59	55	77	62
26	22	3	F	40	28	62	59	46	32	63	47
27	22	4	M	45	39	55	45	42	36	64	48
28	23	4	F	44	40	59	59	54	41	70	57
		Means		44.9	39.2	63.6	55.5	48.8	41.1	67.6	54.4
		S.D.		8.1	8.3	7.0	4.2	8.3	6.9	6.7	4.6

APPENDIX C

FACES II AND INTERRELATED CONCEPTS

Confidential

Please answer all questions. The data you supply will help to complete a research project on how families function.

1. First Name _____ 2. Sex: Male ____ Female ____

3. Date of Birth ____ ____ ____ (D M Y) 4. Age: ____

5. Were you awarded a High School Diploma? Yes ____ No ____

If No, tick as appropriate below:

a) Completed Grade 10 and above ____
b) Did not complete Grade 10 ____
c) Other _____
(Please specify e.g. Plumber Apprenticeship)

6. What is your father's occupation: _____

(Be specific e.g. School - Bus Driver, Dept. Store Appliance Repairman, Elementary School Teacher)

7. Your Father

a) is employed by (type of company) _____ (Eg. Computer Sales)
b) is self employed ____
c) is currently unemployed ____

8. What is your mother's occupation: _____

(Be specific e.g. Housewife, Hospital Nurse, Child Psychologist, Supermarket Cashier)

9. Your Mother

a) is employed by (type of company) _____ (Eg. Dept. Store)
b) is self employed ____
c) is currently unemployed ____

____ ____ ____
(Date Completed)

Thanks for your cooperation.

Appendix C

FACES II ITEMS

by

David H. Olson, Joyce Portner, and Richard Bell

1. Family members are supportive of each other during difficult times.
2. In our family, it is easy for everyone to express his/her opinion.
3. It is easier to discuss problems with people outside the family than with other family members.
4. Each family members has input in major family decisions.
5. Our family gathers together in the same room.
6. Children have a say in their discipline.
7. Our family does things together.
8. Family members discuss problems and feel good about the solutions.
9. In our family, everyone goes his/her own way.
10. We shift household responsbilities from person to person.
11. Family members know each other's close friends.
12. It is hard to know what the rules are in our family.
13. Family members consult other family members on their decisions.
14. Family members say what they want.
15. We have difficulty thinking of things to do as a family.
16. In solving problems, the children's suggestions are followed.
17. Family members feel very close to each other.
18. Discipline is fair in our family.
19. Family members feel closer to people outside the family than to other family members.
20. Our family tries new ways of dealing with problems.
21. Family members go along with what the family decides to do.
22. In our family, everyone shares responsibilities.
23. Family members like to spend their free time with each other.
24. It is difficult to get a rule changed in our family.
25. Family membes avoid each other at home.
26. When problems arise, we compromise.
27. We approve of each other's friends.
28. Family members are afraid to say what is on their minds.
29. Family members pair up rather than do things as a total family.
30. Family members share interests and hobbies with each other.

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Appendix C

FACES II ANSWER SHEET

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INSTRUCTIONS: Complete Part I completely, and then complete Part II. Please answer all questions, using the following scale.

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

PART I:

How Would You Describe Your Family Now?

1. ___	2. ___		
3. ___	4. ___		
5. ___	6. ___		
7. ___	8. ___		
9. ___	10. ___		
11. ___	12. ___		
13. ___	14. ___		
15. ___	16. ___		
17. ___	18. ___		
19. ___	20. ___		
21. ___	22. ___		
23. ___	24. ___		
25. ___	26. ___		
27. ___	28. ___		
29. ___			
30. ___			

PART II:

How Would You Like Your Family TO BE?

31. ___	32. ___		
33. ___	34. ___		
35. ___	36. ___		
37. ___	38. ___		
39. ___	40. ___		
41. ___	42. ___		
43. ___	44. ___		
45. ___	46. ___		
47. ___	48. ___		
49. ___	50. ___		
51. ___	52. ___		
53. ___	54. ___		
55. ___	56. ___		
57. ___	58. ___		
59. ___			
60. ___			

36 +	12 +	36 +	12 +
___ − Sum 3, 9, 16, 19, 25, 29	___ − Sum 24 & 28	___ − Sum 3, 9, 16, 19, 25, 29	___ − Sum 24 & 28
___ + Sum all other odd numbers plus item 30	___ + Sum all other even numbers except item 30	___ + Sum all other odd numbers plus item 30	___ + Sum all other even numbers except item 30
___ TOTAL COHESION	___ TOTAL ADAPTABILITY	___ TOTAL COHESION	___ TOTAL ADAPTABILITY

Appendix C

Family Cohesion Dimension: Interrelated Concepts

	Disengaged	Separated	Connected	Enmeshed
Independence	High independence of family members	Moderate independence of family members	Moderate dependence of family members	High dependence of family members
Family Boundaries	Open external boundaries; closed internal boundaries; rigid generational boundaries	Semi-open external and internal boundaries; clear generational boundaries	Semi-open external boundaries; open internal boundaries; clear generational boundaries	Closed external boundaries. Blurred internal boundaries. Blurred generational boundaries
Coalitions	Weak coalitions; usually a family scapegoat	Marital coalition clear	Marital coalition strong	Parent-child coalitions
Time	Time apart from family maximized (physically and/or emotionally)	Time alone and together is important	Time together is important. Time alone permitted for approved reasons	Time together maximized; little time alone permitted
Space	Separate space both physically and emotionally is maximized	Private space maintained; some family space	Family space maximized; private space minimized	Little or no private space at home
Friends	Mainly individual friends seen alone; few family friends	Some individual friends; some family friends	Some individual friends; scheduled activities with couple and family friends	Limited individual friends; mainly couple or family friends seen together
Decision-Making	Primarily individual decisions	Most decisions are individually based; able to make joint decisions on family issues	Individual decisions are shared. Most decisions made with family in mind	All decisions, both personal and relationship must be made by family
Interest and Recreation	Primarily individual activities done without family; family not involved	Some spontaneous family activities; individual activities supported	Some scheduled family activities; family involved in individual interests	Most or all activities and interests must be shared with family

Source: Olson 1979

Appendix C

Family Stability Dimension: Interrelated Concepts

	Chaotic	Flexible	Structured	Rigid
Assertiveness	Passive and Aggressive Styles	Generally Assertive	Generally Assertive	Passive or Aggressive
Control	No Leadership	Equalitarian with fluid Changes	Democratic with stable Leader	Authoritarian Leadership
Discipline	Laisser-faire Very lenient	Democratic Unpredictable consequences	Democratic Predictable consequences	Autocratic Overly strict
Negotiation	Endless negotiation; Poor problem-solving	Good negotiation; Good problem-solving	Structured negotiations; Good problem-solving	Limited negotiations; Poor problem-solving
Roles	Dramatic role shifts	Role-making and sharing; Fluid change of roles	Some role sharing	Role rigidity; Stereo-typed roles
Rules	Dramatic rule shifts; Many implicit rules; Few explicit rules; Arbitrarily enforced rules	Some rule changes; More implicit rules; Rules often enforced	Few rule changes; More explicit than implicit rules; Rules usually enforced	Rigid rules; many explicit rules; Few implicit rules; Strictly enforced rules
System Feedback	Primarily positive loops; Few negative loops	More positive than negative loops	More negative than positive loops	Primarily negative loops; few positive loops

Source: Olson 1979