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ASSESSING FAMILY TREATMENT IN
ALCOHOLISM AND CHEMICAL DEPENDENCE TREATMENT

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy
in the Graduate School of The Ohio State University

by

Christine N. Gerber, A.B., M.A.

* * * * *

The Ohio State University

1986

Dissertation Committee:

Susan Jones Sears, Ph.D.
James Wigtil, Ed.D.
Donald Haefele, Ph.D.

Approved by

Adviser
College of Education
Department of Human Services Education
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CHRISTINE N. GERBER

1986
For Members of My Family
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VITA

October 29, 1936

Born in Washington, D. C.

1958

A.B., Dunbarton College of the Holy Cross, Washington, D.C.

1963

M.A., The Ohio State University, Columbus, Ohio

1986

Ph.D., The Ohio State University, Columbus, Ohio

1958-64

Teacher, Academy of the Holy Cross, Rockville, Maryland

1970-79

Manager and Chief Accountant, RAG Estate, Columbus, Ohio

1979-82

Developer and Director, SAMARITAN CORPORATION, Columbus, Ohio

1980-82

Counselor, Maryhaven, Inc. Columbus, Ohio

1982-83

Program Director, Heritage Institute/Brookwood, Columbus, Ohio

1983-present

Executive Director
Brookwood Recovery Center/Parkside Columbus, Ohio
FIELDS OF STUDY

Undergraduate:

Studies in math, physics, theology, philosophy

Graduate:

Studies in Counseling, Professors Susan Sears, James Wigtil
Studies in Psychology, Professor Bruce Walsh
Studies in Research, Professor John Kennedy
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CHAPTER I

ASSESSING FAMILY TREATMENT IN

ALCOHOLISM AND CHEMICAL DEPENDENCE TREATMENT

Introduction

Alcoholism and chemical dependence are social problems that seriously affect millions of families across the United States and throughout the world (Steinglass, 1978). Use is associated with specific subsidiary crisis such as unemployment, desertion, non-support, and imprisonment (Jackson, 1978), as well as family violence and child abuse (Byles, 1978).

The average alcoholic is a man with a job, home, and a family. Most alcoholics are living with their families, are employed, and are trying to live respectable lives. There are over nine million alcoholics in this country with three and one-third million between the ages of 14 and 17. Industry in the United States loses more than four billion dollars per year because of unrecognized drug addiction. These diseases are fast becoming the nation's number one health problems. The National Institute on Alcoholism and Alcohol Abuse Information Services
(NIAAA, 1981) included the following data in its report to congress:

1. 20% of males and 10% of females interviewed reported symptoms of alcohol dependence
2. 3% were unemployed and 97% were employed
3. 30% were manual laborers; 34% were professionals; 25% were white collar workers
4. 30% were females and 70% were males

The Office of Technology and Assessment (1982) reported that the cost of alcoholism and alcohol related problems was 120 billion dollars (Healy, 1985). Healy also noted that 40-60% of our hospital beds are occupied with individuals that are there with secondary diagnosis. The primary one was alcoholism.

The years between 1969 and 1979 noted some dramatic changes in the patterns of drug usage in the United States (Hein and Cohen, 1979). They studied over 76,000 youths and concluded that opiate use was more prominent in the first half of the decade and cannabis was more prominent in the second. Seventy-six percent of their sample has used cannabis. Some longitudinal studies reached approximately the same conclusion (Kandel, 1978; Jessor, Chase, and Donovan, 1980). The study by Josephenson and Rosen (1973) concluded that cannabis increased in a several year period from 19% to 48%. The significance of this increased use, indicated by these studies, is the correlation this has with
multiple drug use and cannabis (Kandel, 1978; Jesser et al., 1980; Smart & Fejer, 1973).

A 1979 Gallup Poll found one person in four, 24% of those interviewed had been adversely affected by alcoholism and/or chemical dependence. Use is a significant factor in many fires, drownings, accidents, etc. NIAAA and U. S. Department of Human Resources report to Congress (1983) indicated that alcohol and other drugs were involved in the following:

1. 23,000 highway accidents and deaths per year
2. 72% of robberies
3. 52% of violent husbands; 38% of abusive parents
4. 18,000 accidental deaths; 10 million injuries
5. 86% of offenders and 40-60% of victims in homicides
6. 72% of offenders and 79% of victims of assaults
7. 50% of perpetrators of rape
8. 69% of drowning victims
9. 64% of suicide attempts; over 10,000 suicide deaths

Of the 90 million persons in the United States who use mood altering chemicals, 15% die as a result of their use. It is estimated that 10% of all people are affected by the use of a spouse, child or close relative. A 1980 National Survey of high school seniors conducted by the University of Michigan's Institute for Social Research indicated that 93% of the students had used alcohol. Sixty percent indicated they had used cannabis and 30% had used some other illegal drug.
A result of the significant use of drugs in the United States has prompted the nomenclature to refer more and more to chemical dependence, when discussing these diseases. According to the National Association of Alcohol and Drug Abuse (Healy, 1985), the most used drugs are alcohol, cannabis, and cocaine. Alcohol still remains the number one drug of choice in today's society and is the only one that within just 20 minutes has passed through every organ in our bodies with the potential of damaging every one of these organs (Healy, 1985).

Purpose of the Study

The purpose of this study was to determine whether family treatment assisted clients in the identification of social patterns of interaction so that they could deal with these issues in on-going therapy. The scope of the investigation included alcoholic and chemical dependent clients who were voluntary admission for inpatient treatment for their diseases. Comparisons of data collected from family treatment participants with non-participants were conducted. This included an analysis of differences in social interaction variables due to levels of treatment and group.

Family treatment is designed to provide a clearer, more practical focus on the social environment and social patterns of interaction of the identified patient. It is designed to enable the client in discerning ways in which dysfunctional behavioral patterns may be changed by breaking through the strong denial
system of the dependent client so that issues can be identified. Inappropriate and unhealthy patterns of interaction can then be changed or replaced for healthier patterns of behavior and communication. Thus the social system or the family unit can be provided an opportunity to become a healthier environment in which recovery from these diseases can be maximized.

Research Hypotheses

Specifically, the descriptive, comparative study was designed to examine the following hypotheses:

HYPOTHESES 1: Alcoholics, who participate in family treatment, differ in their patterns of interaction and communication from alcoholic who do not participate.

HYPOTHESES 2: Chemical dependents, who participate in family treatment, differ in their patterns of interaction and communication within the family system from chemical dependents who do not participate.

HYPOTHESES 3: Alcoholics who participate in family treatment, differ in their patterns of interaction and communication from chemical dependents who participate in family treatment.
Conceptual Framework

Working within a framework to establish associations between family treatment and the psychological and social needs of a client is difficult as no theory is elegantly predictive. A theory, however, is needed even if it must later be abandoned (Mercer & Kohn, 1980; Kandel, 1978). Clausen (1978) disagrees, stating that deviance and drug abuse must necessarily be atheoretical because what is being investigated is the changing social meaning attached to alcohol and drug use and the decisions an individual makes in regard to such meaning.

A persistent problem in alcoholism and chemical dependence research is the lack of consensus on concepts and terminology. Bacon (1976) stated that we seem to be talking about different things under different labels. Jellinek (1952) proposed five different types of alcoholism that he labeled with the first five letters of the Greek alphabet. He argues that alcoholism is a true disease, having effects on all areas that comprise the total life space of an individual. This seems to be the only theory that has persisted over time even though little research has been accomplished that lends quantitative support to it.

The concept of dependence is an elusive one. The majority of attempts to classify and define the dependent personality have used the Minnesota Multiphasic Personality Inventory (MMPI). Prior to 1960 the early literature shows that the lack of a profile pattern precluded a quantitative description of the
generalized alcoholic or chemical dependent (Sutherland, Schroeder, & Tordella, 1951; Syme, 1957). After 1960, research has described what is now generally believed to be a profile which characteristically describes the alcoholic and the drug dependent personality (Penk & Robinowitz, 1974; Curless, 1970; Eshbaugh, 1978).

Prior to 1970 little research had been done on the family of the dependent person and the relationship of the family to treatment of the client. Since 1970, research has focused on treating the family members as well as the client. A national survey of over 2,000 drug treatment programs in which alcohol was the number one drug of choice, yielded results strongly suggesting that clinicians in these settings were turning in significant numbers towards experimenting with family involvement in therapy (Coleman & Dabis, 1978). Hansen (1976) concluded that studies to this date had not proven that family treatment was better than anything else but at least some evidence was present that it assisted the prognosis of quality recovery. Davis (1980) stated that, although unsubstantiated as yet, there was a widely accepted notion that recovery from alcoholism and chemical dependence was facilitated when mates sought help for themselves. Rae (1972) indicated that the MMPI profile, as well as family interaction factors, could be used as predictors of prognosis.
Significance of the Problem

The fact that alcohol and polydrug consumption is increasing among both males and females can no longer be ignored by clinicians and researchers. Our society is becoming more aware of the negative consequences that are a direct result of the use, abuse, and dependence on alcohol and other mood altering chemicals. Education, prevention, intervention, and treatment depend on an accurate assessment of the nature of the problem and of the physical, social and psychological implications surrounding the dependent client.

The measure of alcoholism and of chemical dependence is difficult because of the ambiguity and the tendency to deny and minimize the problems. A client usually has difficulty in self-concepts and with relationships with others. Clients show both a tendency to form social relationships and yet have difficulty in maintaining them. A high portion of clients are threatened by members of their family system with expulsion from that system. A characteristic attitude would be to minimize or deny these threats and the social problems that are embodied therein. The self description of most clients indicates a preponderance of self-confident, extroverted, affiliative characteristics coupled with features of social pathology and alienation. Therefore, conflicting tendencies toward sociability and isolation are seen.

Family treatment provides clients with the opportunity to look at this denial system and to identify areas that need to be
addressed in on-going treatment. The tendency for minimization of the problems of communication, alienation, and expulsion coupled with a strong desire for commitment, intimacy and affiliation can be addressed by this special form of treatment. These social patterns are measured by the Family Environment Scale (FES). Research outcome may have far reaching implications for treating the alcoholic and the chemical dependent clients.

Definition of Terms

Because of the confusion over nomenclature in the field of dependence, certain terms need to be clarified and defined. They are as follows:

1. **Alcoholism** is a primary, progressive, predictable, and fatal disease (American Medical Association, 1956). The essential features of alcohol dependence are either a pattern of pathological use or impairment in social or occupational functioning due to alcohol; and, either tolerance or withdrawal. Alcohol dependence has also been called alcoholism (DSM III).

2. **Chemical dependence** requires only evidence of tolerance or withdrawal, except for cannabis which, in addition, requires evidence of social or occupational impairment from the use of the substance, or a pattern of pathological use (DSM III). Chemical dependence is diagnosed for clients whose drug of choice is a mood-altering chemical other than or in addition to alcohol.
3. **Family** means the body of persons who live in one house . . . a group of closely related individuals (Webster, 1985). Members of the client's conjugal, familial, or social unit who are closely interfacing with the client are members of the client's family system.

4. **Family treatment** means the family week treatment which is the conjoint education and therapy for client and family member(s). It focuses on the observation of roles, relationships, communication patterns, conflict, control and commitment within the family system as well as self-responsibility for one's own recovery.

5. **Social patterns of interaction and communication** are those forms of communication, relationships, behaviors, control, and commitment that are present within the family interactions. These include but are not limited to the following:
   a. **Communication** means the ability to express one's feelings openly and without fear of reprisal.
   b. **Conflict** means the amount of stress, anger, aggression, and alienation within the family members.
   c. **Commitment** means the amount of cohesion, assistance, and support family members provide one another.
d. **Control** means the amount of ability to exercise judgment over the expression of pathology as well as the amount of rules within the family unit.

e. **Self-responsibility** means the degree of interdependence without dominating another family member. It is the self-acceptance of one's behaviors and commitment to recovery for self.

6. **Minnesota Multiphasic Personality Inventory** was selected to provide pre-test measurement for these patterns of interaction and communication within the family system. This instrument was chosen because researchers had indicated it could provide family systems information (Sines, 1984). Scales selected were:

a. **Family problems** which measure the home situation.
   
   e.g. "There is little love and companionship in my family compared to other homes."

b. **Manifest hostility**, which measures the amount of hostile and aggressive impulses. e.g. "I resent having anyone take me in so cleverly that I have had to admit that it was one on me."

c. **Dependency**, which assesses the strengths of the client's dependency needs. e.g. "Criticism or scolding hurts me terribly."
d. **Dominance**, which identifies the client who is dominant in the interpersonal relationships. e.g. "I am easily downed in an argument."

e. **Control**, which assesses the ability to impulses and self-responsibility over one's own pathology. e.g. "I resent anyone taking me in so cleverly that I have had to admit that it was one on me."

7. **Family Environment Scale** was selected as the post-test measurement for these patterns because it is highly correlated to the MMPI's family problems scale (Bloomquist & Harris, 1984). Scales selected were:

a. **Cohesion**, which measures the commitment, help and support the family members have for and with one another. e.g. "Family members really help and support one another."

b. **Expressiveness**, which measures the openness and ability to express feelings directly. e.g. "Family members often keep their feelings to themselves."

c. **Conflict**, which assesses the expressed anger, aggression and alienation with the family member's interaction. e.g. "We fight a lot in our family."

d. **Independence**, which assesses the assertiveness and self-direction of the family members. e.g. "In
our family we are strongly encouraged to be independent."

e. **Control**, which assesses the rules and regulations within the family system. e.g. "Family members are rarely ordered around."

**Limitations of The Study**

There are several limitations to this study that need to be considered. They are as follows:

1. Random selection and assignment to groups was not done. The sensitive nature of the clients in this particular setting did not permit this.

2. Accurate diagnoses of the primary disease is another limitation. The self-report data from the client is not always accurate and is problematic (Elliott & Ageton, 1980). The primary diagnosis is the control factor in determining whether a client is included in the sample population. The client must have a primary diagnosis of alcoholism or chemical dependence. Concurrent psychiatric diagnosis are not considered but may be present in the client.

3. This study does not address the ethnic, social mores, or the pathology of other members of the family system. These intervening variables may affect treatment outcome (Pattison, 1981).
4. Age, education and sex have not been controlled for in this study. This is a deliberate attempt to compare this population with the NIAAA national sample mentioned earlier in this chapter. Age, education and race are the demographic factors that affect the MMPI. However, Lachar et al. (1978) suggests that, although the effects of these variables are quite evident in a general psychiatric population, the experience of alcohol and drug use and dependence has a greater effect on the MMPI profile thus overriding the effects often found to be related to race and age.

Summary

Alcoholism and chemical dependence are epidemics in this country and are of such magnitude that they exacerbate many other problems. They are primary diseases which are progressive, predictable and treatable. If not treated, they are fatal. They affect all aspects of a client's life space including the physical, social, psychological, spiritual, intellectual, occupational and family systems. The more data that are collected which provide information and understanding about treating these illnesses, the greater the opportunity for prevention, intervention, and recovery following treatment.

Literature is sparse regarding the relationship between a primary diagnosis of alcoholism or of chemical dependence and family treatment used to identify patterns of interaction and
communication within the family system of the identified patient. Recovery can be either enhanced or impeded if the patterns of behaviors, communication and interpersonal interactions are not examined by the client. By generating more information about correlations between family treatment and the differences in patterns of interaction and communication within the family system, which participants have from non-participants, researchers and clinicians can be aided in understanding the antecedents and consequences of dependence, as well as the importance of involving the family members in the client's treatment. Through the research method, clinicians can learn more about how a client changes and what some of the factors may be that influence that change. Through the research process, the clinician can see and understand the client more clearly.

The identification of patterns of interaction and communication within the family system is important. By breaking through their denial clients can develop healthier environments in which recovery can be maximized. Progression of these diseases and the pathology associated with them, can thus be halted.
CHAPTER II
REVIEW OF THE LITERATURE

Introduction
This chapter reviews the literature concerning the etiology of alcoholism and of chemical dependence, their connection to family therapy, family involvement in treatment of these diseases, use of the MMPI and FES in the available research conducted on this client population, and the interrelationships of these topics: An ERIC search, an on-line Psychology search, and a Sociology search were conducted. Available literature has been reviewed.

Alcoholism and chemical dependence are diseases. Diverse types of psychopathology seem associated with them. Preu (1944) indicated that one of the indications of the psychopathic personality was drug addiction and/or chronic alcoholism. Skinner (1982) states that alcoholism is the development of dependency related to psychopathology such as: hypochondriasis, thinking disorders, persecuting ideas, anxiety, and depression. Over the decades researchers have found that drug dependents, including those dependent on alcohol, do indeed present a multiplicity of symptoms, traits, and disorders of varying
degrees of severity. Further clarification of concepts surrounding these diseases is provided in this review.

Family therapy research and family involvement in the treatment of the dependent client is sparse and is a relatively unchartered area for researchers. Social scientists generally agree that the personality is developed and is influenced by some adverse experience early in life. Penk et al. (1979) concluded that addicts typically come from families that stress achievement and inhibit expression. They were speaking of addicts as being those individuals dependent on mood-altering chemicals other than alcohol. Drug abusers tend to recreate in their conjugal families the social environments of their families of origin. This concept supports the need for treatment oriented toward the family system and not treatment just for the identified patient.

Researchers have searched for the basic MMPI profile produced by the alcoholic and by the drug dependent. A review of the literature has documented studies focusing on these issues. Studies have compared the profile characteristics of various samples of alcoholics and drug dependents and research strategies have included comparisons of these populations with a variety of controls, as well as within the between groups.

The FES has been used in research connected with these diseases but it is sparse. McElfrish (1979) indicated that more disturbed patients with elevations on the MMPI on two or more scales came from families characterized by more conflict and less
cohesion, expressiveness, independence, and organization, FES scales.

The research and resulting theory on addiction and dependence do not have a large history of quantitative validations to exemplify the problems that arise when attempts are made to connect the disease or medical model with personality subtypes and family systems. Both statistical and acturarial research have been converging in so far as identifying personality subtypes. The findings, however, are equivocal.

Alcoholism and Chemical Dependence

There is no single, easy definition of alcoholism and chemical dependence. Focus today is placed on what they are and not why they are. There are some who view dependence as a social illness; some who view it as a psychological illness; and, others who view it as a disease. Most clinicians in the field of alcoholism and chemical dependence have ascribed to Jellinek's view that these dependencies are complex diseases. In accepting the disease concept, one need not rule out the other variables. The social, psychological, spiritual, physical, and intellectual aspects of a client are so integrated that they are all part of the recovery process for the dependent client. The social and psychological factors resulting from the effects of these diseases are complicated issues. If a family unit or the identified client is to recover, all of these aspects of the client need to be addressed.
There is nothing so practical as a good theory. Understanding what kind of illness these are has important practical implications in preventing and in treating the illness. Philosophy and goals of treatment, coupled with attitudes regarding the dependent client's environment, depend on a clinician's theory about these diseases.

The American Medical Association (1956) declared that alcoholism was a disease with specific symptoms and a predictable course. The United States Department of Health, Education, and Welfare (1981) defined this disease as affecting four areas of a person's life:

1. Social, marital, or interpersonal relationships
2. Legal
3. Health
4. Loss of control

Pattison (1977) views the disease as a multifaceted syndrome known as alcoholism. Addiction is more than physical and learned patterns of behaviors and goes much deeper than mere psychological issues. He believes that human behavior is a complex result of physical, psychological, social learning, and spiritual factors.

Royce (1981) had a working definition of alcoholism and chemical dependence. He stated that these were chronic illnesses or disorders characterized by some loss of control, resulting in
habituation or addiction, or they caused interference with life functions such as family, health, legal or professional.

The way one defines the etiology has important implications for the nature of the research findings. Thus far, research had yielded inconsistent results and few generalizable findings. This is partially due to the diverse causal factors on which researchers have focused.

Alcoholism and the Family System

Many researchers have tried to find the cause of this disease but there seems to be relatively few studies which have specifically focused on the family systems of those who abuse alcohol (Mayer, 1980). Field theory views that the individual disturbance in dependence flows out of the interpersonal dynamics operating within the family system and that the disturbance fulfills a dynamic function for that particular system. This theory emphasized a reciprocal interaction rather than a linear cause and effect (Lewin, 1954).

Marital and family conflict may evoke, support, and maintain alcoholism as a symptom of family system dysfunction, as a coping mechanism to deal with family dysfunction, and as a consequence of dysfunctional family styles, rules, and patterns of alcohol use. In this case, alcoholism is not the cause of family dysfunction but the effect of family dysfunction (Kaufman, 1985). He indicated that co-alcoholism is a pattern that develops in family members of the alcoholic. In the initial
stage of alcoholism, there is denial, guilt, and some withdrawal on the part of the co-alcoholic. In the middle stage there is hostility, disgust, pity, preoccupation with protectiveness and shielding of the alcoholism. In latter stages withdrawal, hostility, and suspiciousness become generalized to one's total environment. We see the spouse and family build up many defenses that create problems when and if the alcoholic gets sober. If the alcoholic stops drinking, the spouse no longer fights about drinking but about whether drinking will resume (Kaufman & Pattison, 1981).

Alcoholism is seen by Esser (1981) as distress in the family unit and as a consequence of disturbed interaction patterns, specifically family communication patterns. Jansen (1980) states that cause and effect are difficult to determine within a family system and a more constructive approach would be to look at the interactive effect. Dinaburg (1977) suggests that alcoholism serves as a significant communication channel since in some families free exchange of information about feelings is minimal. The alcoholic pattern provides an acceptable means for venting emotions and perhaps avoiding issues.

Conley (1980) looked at configuration as an etiological factor in dependence. He concluded that only children and last borns of large sibships were more heavily represented in the population he studied. He suggests that dependent personality traits may mediate the relation of ordinal position and
alcoholism. The social development of only children and of last borns in these large sibships could involve relatively little pressure for independence and impulse control. This pattern of socialization may increase susceptibility of alcoholism and chemical dependence (Conley, 1980; Majumdar et al., 1980).

Keller (1976) states that this disease cannot appear in a person apart from others, get worse without the help of others, or continue in isolation from other people. Mayer (1980) sees the misuse of drugs as a result of the need for distancing from the family.

Kaufman (1984) studied family social systems and alcoholism. He concluded that there are four main types of interactions in the alcoholic family unit. These are: functional families, neurotic families, disintegrated families and absent families. Each family type needs to be recognized so that appropriate treatment can be applied to the particular type.

Chemical Dependence and the Family

The early literature concerning the family and drug abuse focused on the symbiotic tie between mothers and their drug dependent sons and the absence or uninvolvment of fathers. In a comparative study conducted by Attardo (1965) of the mothers of drug addicts, schizophrenics, and normal adolescents, the mother's symbiotic need for the child was found to be highest in the mothers of drug abusers. Weidman (1983) indicated that youths involved in substance abuse are also involved in pseudo-
individuated relationships with their mothers who are psychologically and emotionally unavailable while their fathers are peripheral.

Kaufman (1980) conducted a four year study of 75 families of drug abusers. He concluded that 88% of the mothers were emotionally enmeshed with their drug-abusing children, mainly sons, to the extent that their happiness and emotional pain were totally dependent on the behavior of and closeness with these children. Although 43% of the fathers were absent or emotionally disengaged from the drug abuser and the entire family, 41% of the fathers were enmeshed with the drug abuser as well as the total family.

Stanton and Todd (1982) summarized the qualities of the dysfunctional family system in drug abusers, which distinguishes them from other dysfunctional families. They concluded the following:

1. High frequency of multigenerational chemical dependence
2. Primitive and direct expression of conflict
3. An illusion of independence in the abuser because of active involvement in a drug-oriented peer group
4. Mothers with symbiotic child-rearing practices, extending into the abuser's later life
5. An extreme incidence of premature, unexpected deaths
6. Addiction is a pseudoindividuation that maintains family ties through a facade of defiance and independence.

Kaufman (1985) indicated that alcoholics tend to become dysfunctional later in life than hard core drug abusers. With this younger group of individuals, the families have not yet established long-term ties to their own families of procreation and thus the family emphasis is on the drug abuser and not on other members of the family. When the dependent person is an older alcoholic, the families have already dealt with the growing absenteeism from a parental role and the replacement by teenage sons and daughters. Older abusers of physician-prescribed drugs are quite similar to alcoholics. Cocaine dependents are generally at a midpoint between alcoholics and drug dependents in their family relationships. Thus Kaufman (1985) stated that it is not the substance of choice that determines family patterns but rather the age and family role of the substance abuser. With combinations of alcohol and various drugs, it becomes more difficult to relate specific family patterns to specific substance.

Family Involvement in Treatment

Those therapists who use family treatment know that it works (Coleman & Davis, 1978). However, this knowledge is not sufficient proof of effectiveness. Not all family treatment is the same and thus it may become more difficult to generalize from
one program to another. We are just beginning to enter a phase of scientific evaluation which may provide the quantitative information that proves the efficacy of family treatment.

Relatively little information is available regarding family involvement or family therapy in the treatment of alcoholism and chemical dependence. Several studies have examined the wives of dependents, their personality, and their involvement in treating the identified patient. Kogan and Jackson (1964) found that the role of the wife influences the course of her husband's treatment. It would seem that a crucial variable in prognosis is the wife's capacity to appropriately manage the marital difficulties. Wright and Scott (1978) indicated that a wife's participation in treatment improved the chances of her husband remaining drug free. Meeks and Kelly (1970) noted that in response to the treatment of one family member, other family members tried to sabotage or to become a part of the treatment as if they had a stake in the illness.

Both social and sexual disturbances affect prognosis (Rae, 1972), the former more powerfully than the latter. In the absence of any disturbance, Rae indicated that the wife's influence in terms of her personality type is negligible. Barry et al. (1967) examined differences between male alcoholics who had good, moderate, and poor adjustments in marriages and found that the groups' averages were quite similar when he compared their MMPI profile scores. They examined the profiles of 52 married
male alcoholics and found the scores on scale 4 (Pd) discriminated with a high degree of confidence between marriages listed as well-adjusted and those judged as moderate or as poor. When comparing the marital status of alcohol dependents, Hoffman (1972) stated that the married status showed the least pathology on the MMPI. Jansen and Nickles (1972) found that the MMPI did not discriminate between single and multiple admission patients. When they compared single and married status categories, the subjects had significantly higher mean scores in the single category than the married category on scales F, 4, 8, and 0.

With the exception of Steinglass (1980), Kaufman (1980), and Kaufman and Kaufman (1981) most studies of the families have not addressed the changing relationships between stages of alcoholism and the interactions of the family system. After the initial denial stage, families seem to over react. They begin to adapt by excluding the alcoholic member. Finally, they may stay enmeshed and fused with the dependent member, swinging in and out of cycles of neurotic reengagement and chaotic disengagement (Steinglass, 1980).

Alcoholism and the Minnesota Multiphasic Personality Inventory

Perhaps the most important variable in treatment research is accurate diagnosis of the client. This can be quantified by accurate diagnostic instruments such as the MMPI. Since alcoholism qualifies as a serious illness, attempts have been
made to contrast alcoholics with non-alcoholics in order to obtain a better understanding of the alcoholic client.

The MMPI has been used in numerous studies in looking at the alcoholic profile. Recent conclusions are that several scales are indeed predictive of alcoholism. The mean average profile of alcoholics has most frequently shown the highest scores on scales 2 (Depression) and 4 (Psychopathic Deviate) (Curlee, 1970; Huber & Donahey, 1975; Kammier et al., 1973; Lowe & Thomas, 1976).

Although the 2 (D) and 4 (Pd) code type often has been the dominant MMPI profile among alcoholics, several other high points have also been described (Paige & Zapella, 1969) and all have included one or both of these scales. Some of the high point profiles indicated by other researchers have been combinations of 2 (D), 7 (Psychasthenia) and 4 (Pd) (Skinner et al., 1974; Whitelock et al., 1971; Gilberstadt & Durker, 1965). Eshbaugh et al. (1978) found numerous subtypes in their study and yet this 2-7-4 code type was one of the major types listed in their sample. Hathaway and Neehl (1951) stated that this 2-7-4 code type showed poorly controlled anger, emotionally unstable personality, and overt forms of emotional expression when they were presented with frustrating situations.

Another variation of significance in the literature is the code type of high scores on scales 4 (Pd) and 9 (Hypomania) producing a 4-9/9-4 code type (Gilberstadt & Durkes, 1965; Goldstein & Linden, 1969; Meeks et al., 1974). Hado and Barker
(1976) indicated that no simple profile was indicated of alcoholism in their sample but there was a slight tendency for alcoholics to score higher on scales 4 (Pd) and 9 (Ma).

Gilberstadt and Durkes (1965) described this 4-9/9-4 code type as immature, rebellious, hostile, and impatient.

Chemical Dependence and the Minnesota Multiphasic Personality Inventory

As is true for alcoholism, the chemical dependent has low self-esteem. Heavy cannabis usage is highly correlated with lack of self-esteem (Jessor & Jessor, 1977). In addition to this poor self-concept, some researchers believe that the self-reports of the drug abuser indicates more psychotic profiles than that of the alcoholic.

Frequently, the drug abusers have been found to have profiles that can be characterized as psychopathic and neurotic. Gilbert and Lombardi (1967) and Stein and Rozynko (1974) indicate that their sample had MMPI profiles elevated on scales 2 (D), 4 (Pd), 8 (Sc), and 9 (Ma). Penk and Rabinowitz (1974) indicated a psychotic 2-8/8-2 code type for polydrug abusers. Schooler et al. (1972) reported that male polydrug abusers obtained higher elevations on F, 4 (Pd), 8 (Sc), and 9 (Ma) compared to psychiatric patients. The female portion of their sample scored higher on scales 4 (Pd) and 9 (Ma).

Recent data suggest that polydrug abusers are not homogeneous in their self-description on the MMPI. Lachar et al.
(1978) stated that when hallucinogens, cocaine, or cannabis were the preferred drug of choice, normal limits were most frequent on the MMPI. They also indicated that the polydrug abusers describe themselves as experiencing significantly more psychiatric symptomatology than did either the alcoholics or the heroin users. The drug abusers, when compared to the alcoholics, were less naively defensive, scoring lower on the L scale and scoring higher on the FAM scale, indicating poorer family relations than did the alcoholics in the sample.

Overall (1973) reported that if the MMPI scales of 4 (Pd) and 9 (Ma) were elevated relative to scales 3 (Hy) and 7 (Pt), then the MMPI profile would suggest illicit drug use. If scales 3 (Hy) and 7 (Pt) were elevated in addition to these scales, the profile suggests alcoholic. Other MMPI data obtained from alcoholics and drug abusers demonstrated marked similarities of group overall profiles (Black & Heald, 1975; Goldstein & Sappington, 1977).

Alcoholism, Chemical Dependence and the Family Environment Scale

There are two basic methods of evaluating family function: self-completed family questionnaires, and an objective rating scale. Moos' FES is a self-report type of family evaluation. Moos indicated that the family factors that predict better function after treatment include greater cohesion and decreased conflict and control.
The FES can provide a clear, practical focus on one's present family system. As such, it has been used with both the alcoholic and the chemical dependent populations in researching family environments. Moos and Moos (1981) indicated that certain demographics affect the scales on the FES. As age and length of marriage increase, there is a slight tendency for a decrease in independence. Education and occupational status are positively related to cohesion, expressiveness, and independence. As family size increases, so does the control scale.

The FES can be used to describe and compare the social unit of single individuals or of the family unit as a whole. Used therapeutically, it can facilitate change in the family environment. Panio (1977) investigated the role of the family in the rehabilitation of drug abusers. He analyzed individual FES profiles and the congruence of perceptions among family members on a case-by-case basis. He applied this information to treating the addiction problems. Some advantage of using information in this manner would include being able to structure and focus family therapy sessions on each family member's perceptions of the similarities and differences of the family unit.

When studies have looked at the differences between environment of normal families and of distressed families, the most consistent finding is that distressed families are seen as having less cohesion and expressiveness and more conflict (Lange, 1978; Scoresby & Christensen, 1976; White, 1978; Young et al.,
1979). Distressed families tend to be less well organized, less oriented toward achievement, independence, and religious activities and less concerned with intellectual and recreational pursuits.

Filstead (1979) indicated that alcoholic patients in a residential treatment program and their family members had below average scores on cohesion, expressiveness, independence and above average score on conflict. The non-alcoholic spouse in this study tended to see more conflict and less cohesion than did the alcoholic partner. Moos & Moos (1981) stated that families in which there were more concern for one another, in which there were more organization, less conflict and less control tended to have a more positive treatment outcome. Reynolds (1982) compared program completers with non-completers and determined that family environment should not be accepted without qualification. In studying 52 alcoholics and their scores on the FES, he concluded that marital status was not predictive of treatment outcome. Rassmussen (1979) found that the family environments of 35 successfully treated alcoholic women were low on conflict. They were close to average on cohesion, expressiveness, and independence.

Family functioning was poorer among relapsed alcoholics than among recovering alcoholics or community controls (Moos et al., 1981). This study indicated that family environments of alcoholics were strongly affected by the personal functioning of
both the alcoholic and their partner. Families in which the alcoholic reported more alcohol consumption and drinking related problems also complained of more anxiety and depression. With those who had more arguments, the scales of cohesion and expressiveness showed lower scores. These subjects also showed less agreement about their environments.

Finnery et al. (1981) stated that when he tested his alcoholic population with the FES, family systems with higher scores on conflict and lower scores on cohesion tend to report more anxiety, depression and physical symptoms. Families with lower scores on expressiveness showed more depression.

Family Environment Scale and the Minnesota Multiphasic Personality Inventory

Little information was found by this researcher pertaining to using the MMPI and FES together. Four studies were located: McElfrish, et al. (1979); Pattison (1981), Bloomquist and Harris (1984) and Sines (1984).

The first two studies had as a focus the individual client. The two remaining studies had as a focus, the instruments themselves, and made attempts at determining the validity and reliability of these instruments as they related to one anothers. Because this present research uses the MMPI as a pre-test and the FES as a post-test, these studies are included in the review of the literature.
The validity of the MMPI has been in question despite its wide use in the counseling settings but has gained some credence for assessing family problems. The FES is a client's perception of the family environment and interaction patterns. The strength derived from analyzing these two instruments in conjunction with one another is of importance.

McElfrish, et al. (1979) indicated that the extent of psychiatric disturbance shown by patients was related to the characteristics of their family environments. Specifically, more disturbed patients, as indexed by elevations on two or more of the clinical scales of the MMPI, came from families characterized by more conflict and less cohesion, expressiveness, and organization, FES scales.

Pattison (1981) studied the differences in measures of personality and family environments among black and white alcoholics. He concluded that blacks differed appreciably on the FES from whites. Blacks rated social climates more favorably than did the whites. Blacks did not differ significantly on the MMPI from their white counterparts. A review of studies done on racial bias, shows that racial bias in the MMPI varies as a function of sampling, with bias more likely when normal blacks are compared with normal whites but not when abnormal groups are compared.

Bloomquist and Harris (1984) looked at the MMPI in assessing and predicting problems within the family of the alcoholic. They
stated that the MMPI's family problem scale was the best overall scale of the MMPI. They conducted a correlational analysis between the MMPI's family problems scale and the scales of FES as criterion measures, and concluded that this scale was highly reliable and valid with the individual's perception of interpersonal family relationships. The Pearson Product Moment Correlation Coefficient between the MMPI's family scale and the FES scale differs for each of the FES scales. Significance was achieved to a high degree of power for each of these correlations. Further discussion of these correlations can be found in Chapter III.

Sines (1984) administered the MMPI and FES to 183 subjects in order to test the concurrent validity and predictive validity of the MMPI and the FES. Two sets of multiple correlations were calculated between the standard scores on the MMPI and FES scales for both males and females. Results showed that the FES scales were not highly redundant with MMPI variables. The researcher indicated that while the relative independence of the two instruments is not sufficient basis for assuming incremental validity of the FES, it is a necessary condition for the existence of additional predictive value.

Summary

The review of the literature has dealt with the concepts of alcoholism and chemical dependence, their terminology and etiology. They are viewed as diseases that are primary,
progressive, predictable, and treatable. If not treated, they are fatal.

Although researchers and clinicians do not always agree on the causal factors associated with these diseases, it appears that the family environments play a substantial role in the illness, its progression and the recovery prognosis. Alcoholism and chemical dependence affect others in the identified patient's social system. As is evidenced in the literature, significant others sometimes are so deeply affected that they believe that they have a stake in the treatment of the dependent client. They may try to sabotage or become involved in treatment of the client to the degree that they are unwilling or unable to look closely at self and to see the part they have played in the disease's progression.

The MMPI has been used in studies conducted on the alcoholic population in order to determine a profile predictive of alcoholism. Fewer studies have been conducted on the drug dependent client in order to determine the profile that would be predictive of chemical dependence. MMPI research indicates that diagnosis and treatment prediction outcome are not absolute and conclusive using this instrument alone. However, it can be concluded that the majority of research does indicate that the MMPI profile can be used in substantiating diagnosis of these diseases. The most predictive profile for alcoholism is a combination of 2 (Depression), 4 (Psychopathic-Deviate) and 9
(Hypomania). The most predictive for diagnosing chemical dependence are combinations of 2 (Depression), 4 (Psychopathic-Deviate), 7 (Psychasthenia), 8 (Schizophrenia) and 9 (Hypomania).

Four studies were located that conjointly use the MMPI and the FES. Two were client focused and two were instrument focused. Although the literature is extremely sparse, both Bloomquist and Harris (1984) and Sines (1984) have provided some additional information regarding the reliability and validity of these two instruments. The MMPI's family problems scale is highly correlated with all of the FES scales.

The field of family treatment in alcoholism and chemical dependence is in its infancy. Studies to date do not indicate which family dysfunction is specific to drug dependence and which is specific to alcohol dependence. However, research does indicate that family treatment seems to be superior to other forms of treatment for these diseases (Coleman & Davis, 1978).

This research and analysis of clients participating in family treatment with those not participating is designed to provide additional data to add to this growing body of knowledge on family therapy as it pertains to alcoholism and chemical dependence. Any additional base-line data provided, from studying this client population, can aid clinicians in providing more specific treatment plans and goals for the client, can aid educators in looking at the special education needed in the training of therapists working with this special population, and
can aid program developers in planning short term and long term treatment programs. The studies reviewed in this chapter provided little in the way of definitive evidence concerning the etiology, treatment, or correlations between treatment and the family system. However, they do provide information regarding some of these correlations which merit further investigation.
CHAPTER III
METHODOLOGY

Introduction

Improvement in family functioning through family therapy is highly desirable and often critical for recovery from alcoholism and chemical dependence. One of the widespread and generally accepted beliefs in the alcoholism and chemical dependence fields is the fact that these diseases have a negative and often destructive impact on the family system; and on patterns of interaction and communication within the system. Filstead (1979) indicated that interpersonal relationships, personal growth and structural arrangements for family functioning are impacted by these patterns within the family environments. The belief that the family is adversely affected by the behaviors of the dependent client as the disease progresses is based primarily on clinical impressions, speculations, and research, which varies in quality and degree of validity. A corollary to the belief that families and clients are adversely impacted by these diseases is the fact that most clinicians believe that family members and the identified client are affected in a positive manner by family treatment. This corollary is widely held in the field of alcoholism and chemical dependence by Weigscheider (1982), who is
a proponent of family roles and relationships and interactional patterns within the alcoholic family; Black (1984), who is a clinician and researcher on the patterns of interaction within the adult children of alcoholics; Filstead (1979), who focuses on the family environments of the dependent client; and, Kaufman (1980, 1984, 1985), who has studied the types of alcoholic and chemical dependent families.

Because of the underlying theory about recovery from these diseases and the relationship the client's environment has with prognosis, it was the purpose of this study to assess whether clients who have participated in a week of family treatment will differ in their patterns of interaction and communication from non-participants. Data resulting from this study may provide additional information that can be used for client treatment goals, program planning and provide direction for further areas of research.

This Chapter deals with the methodological issues surrounding this study. It includes the research setting, population, sample, instrumentation, including the MMPI and the FES, procedures and statistical analysis.

Research Setting

The treatment center from which the data are provided is located in a metropolitan area of over one million people. The primary business and industry of the surrounding area are banking, education, insurance, and government. The building is
situated in the middle of 11 acres in a wooded countryside and is of Georgian Colonial design. It has accommodations for 50 clients and their families.

The medical director of the center was the sole diagnostician for the participants of this study. He has had over 17 years experience in diagnosing and treating alcoholism and chemical dependence. His diagnosis is based on a complete medical examination and evaluation, which includes a drug screen at time of admission, as well as the clients self-report data regarding the chemical of choice.

Population

One hundred twelve clients were part of the initial sample population. Ninety-five clients comprised the final data sample. Twelve of the original participants were not included in the final data because; 1) three were administered a different form of the MMPI; 2) two were administered the FES after discharge from the program and not prior to discharge; and, 3) seven original participants left the program against staff advice.

Participants were included in this study provided that: 1) they were voluntary admission for inpatient treatment; 2) they had a primary diagnosis of either alcoholism or of chemical dependence; 3) they were initially assessed as needing a full treatment program; and, 4) they were willing to be included in the statistical data being generated.
Sample

Out of the 95 participants, 50 were alcoholic and 45 were chemical dependent. Family participants included 34 alcoholic and 29 chemical dependents. Non-family treatment participants included 16 alcoholics and 16 chemical dependents. Table 1 provides the demographics of both the experimental group and the control group.

This sample included 70% males and 30% females in the participants. Thirty of the participants were single, 17 were divorced, 43 were married and 5 were separated or widowed. Ethnic considerations included 12 blacks and 43 caucasions. Thirty-seven of the participants were white collar workers, 43 were blue collar workers and 15 were unemployed, including both students and housewives. Educational level varied. This study contained 22 participants who had not completed high school, 40 had obtained a high school education and 33 had received at least two years of college or more.

Instrumentation

It is suggested that families with dependencies on mood-altering chemicals are more conflictual, have poorer communication patterns, tend to be non-cohesive, impede and/or prevent the participation of family members in personal growth and are more disorganized than normal families (Filstead, 1979). Some social patterns of interaction within the family include conflict, commitment, cohesion, alienation, affiliation, control,
Table 1
Sample Population Demographics N=95

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<tr>
<th>DEMOGRAPHICS</th>
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</tr>
<tr>
<td>2 yrs. college plus.</td>
<td>12</td>
<td>11</td>
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</table>
self-responsibility. These patterns can be measured by the Minnesota Multiphasic Personality Inventory (MMPI) and the Family Environment Scale (FES). These instruments were chosen because, as indicated in the research section, scales from the MMPI were found to be highly correlated with the scales from the FES, ranging from .01 to .001 (Bloomquist & Harris, 1984; Sines, 1984).

The subscales from the MMPI that most closely related to the interactional patterns and communication within the family system of the identified client were selected as pre-test measurements. These scales were:

1. **Family problems**, which measures the home situation and the amount of love that the clients perceives is present. e.g. "There is little love and companionship in my family compared to most homes."

2. **Manifest hostility**, which measures the amount of hostile and aggressive impulses present in the client. e.g. "I resent having anyone take me in so cleverly that I have had to admit that it was one up on me."

3. **Dependency**, which assesses the strengths of the client's dependency needs. e.g. "Criticism or scolding hurts me terribly."

4. **Dominance**, which identifies the client who is dominant in the interpersonal relationships. e.g. "I am easily downed in an argument."
5. **Control**, which assesses the degree to which the client has control over the expression of their pathology. e.g. "At times I feel like swearing."

The FES was selected because: 1) it most closely covered the various dimensions of social patterns and interaction and communication with the family unit; 2) it was not pathologically focused and, 3) there were comparative data on normal and distressed families. The dependent variables and post-test measurements are scales from the FES. They are as follows:

1. **Cohesion**, which measures the commitment, help and support of family members have for and with one another. e.g. "Family members really help and support one another."

2. **Expressiveness**, which assesses the openness and ability to express feelings directly. e.g. "Family members often keep their feelings to themselves."

3. **Conflict**, which assesses the expressed anger, aggression, and alienation within the family member's interactions. e.g. "We fight a lot in our family."

4. **Independence**, which assesses the assertiveness and self-direction of the family members. e.g. "In our family we are strongly encouraged to be independent."

5. **Control**, which assesses the amount of rules and regulations within the family unit. e.g. "Family members are rarely ordered around."
Table 2 provides a summary of the FES and MMPI by scale and description.

**Minnesota Multiphasic Personality Inventory (MMPI)**

There is little doubt that the MMPI is the most used psychological instrument available in clinical and counseling settings (Tyler & Walsh, 1979). A PRACTICAL GUIDE FOR THE MMPI by Graham (1981) indicates that it was designed to assess some major personality characteristics or traits that affect personal and social adjustment. It is an inventory containing some 550 statements, covering a range of subjects. It takes approximately 60 minutes to complete. There are three validity, ten clinical, ten content, eleven research and one MacAndrew scale. The content, research and MacAndrew scale are subsumed within the ten clinical scales. This study used the content scales and research scales of family problems, manifest hostility, dependency, dominance, and control.

The validity scales are concerned with faking the protocol. The clinical scales were developed by comparing the responses of persons judged to be normal with persons classified in given diagnostic groups.

**Reliability**

Because of the common item content included in the scales of the MMPI, rather high interscale correlations are obtained. Buros (1982) reports that the MMPI shows considerable evidence of
<table>
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<tr>
<th>SCALE</th>
<th>FAMILY ENVIRONMENT SCALE</th>
<th>MINNESOTA MULTIPHASIC PERSONALITY INVENTORY</th>
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<tbody>
<tr>
<td></td>
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<td>DESCRIPTION</td>
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<tr>
<td>COHESION</td>
<td>The degree of commitment, help and support family members provide one another.</td>
<td>The extent of the home situation and problems connected with this setting.</td>
</tr>
<tr>
<td>EXPRESSIVENESS</td>
<td>The extent to which family members are encouraged to act openly and express their feelings directly.</td>
<td>The amount of hostile and aggressive impulses, resentments, and anger within an individual.</td>
</tr>
<tr>
<td>CONFLICT</td>
<td>The amount of openly expressed anger, aggression, and conflict among family members.</td>
<td>The amount and strength of the individual's dependency needs.</td>
</tr>
<tr>
<td>INDEPENDENCE</td>
<td>The extent to which family members are assertive, self-sufficient, and make their own decisions.</td>
<td>The identification of who is dominant in interpersonal relationships.</td>
</tr>
<tr>
<td>CONTROL</td>
<td>The extent to which set rules and procedures are used to run family life.</td>
<td>The degree to which an individual has control over the expression of their pathology.</td>
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</table>
the test's reliability for various groups. Over 60% of new psychiatric admissions were found to be highly correlated with the given scales from the MMPI. The MMPI manual states that a high scores on a given scale has been found to predict positively a corresponding final clinical diagnosis. A summary of research studies concerned with the questions of diagnostic reliability and validity for the MMPI concludes that this instrument is not sensitive enough to discriminate within abnormal populations (Buros, 1982).

Validiy

The validity of the MMPI is still in doubt. The diagnostic groups used to build this instrument were based on questionable and perhaps inaccurate psychiatric classification. The total number of items and the number of items that involve pathological content are both excessive. In contrast, items relevant to variables considered important in current personality theories are excluded or are deemphasized (Shertzer & Linden, 1979). The standard deviation for the MMPI is ten and the mean is 50.

Family Environment Scale (FES)

The FES was developed by Rudolph Moos in 1974 and is a self-report instrument consisting of 90 items. The answers are true or false and it takes 15-20 minutes to administer. The simplicity of administration, the relative enexpensiveness of the test and the limited test taking time are additional reasons for using this instrument as the post-test dependent variables. The
FES is conceptually organized around the dimensions of family life of relationships, personal growth and maintaining the family system. The Real form (R) was used in this study and measured a client's perception of the conjugal or nuclear family system as viewed at time of discharge from residential treatment.

Normative data on form R were collected on 1,125 normal and 500 distressed families, 220 of which were alcohol and chemical dependents. Distressed families scored lower on cohesion, expressiveness, and independence and higher on conflict and control than did normal families (Moos, 1981). This same scoring pattern is anticipated in this present study. Lachar, et al. (1978) indicated that volunteers appear more psychologically unhealthy. Additionally, the family week treatment program is designed to assist participants in breaking through the denial about the problems within the family system. Therefore, scores for family treatment participants should be lower on cohesion, expressiveness, and independence, and higher on conflict and control than for non-participants.

**Reliability and Validity**

Test-retest reliability of the FES are all in an acceptable range, varying from a low of .68 for independence to a high of .86 for cohesion. Internal consistencies are still within an acceptable range for all ten scales. The intercorrelations of scales indicate that they measure distinct though somewhat related aspects of family social interaction and communication.
patterns. Cohesion and conflict and independence and control are two pairs of inversely related scales. When cohesion is scored low, conflict will be high and when independence is scored low, control will score high.

The Correlation Between the Family Environment Scale and the Minnesota Multiphasic Personality Inventory

Two research studies, as indicated in Chapter II, have provided correlations between the MMPI family problems scale and the FES scales. Bloomquist and Harris (1984) examined the validity of the MMPI family problem scale. Relationships between this scale from the MMPI and the criterion measures provided by the FES are examined by a correlational analysis. Findings suggested that the MMPI family problems scale is a reliable and concurrently valid measure of an individual's perception of interpersonal family relationships. The findings also indicated that this scale was the best overall of the MMPI's scales. The Pearson Product Moment Correlation Coefficient differs for each of the FES scales but significance was reached for each. The following data indicated that the correlation coefficient was the significant for the MMPI's family problems scale with the FES scales:
<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
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Sines (1984) administered the FES and MMPI to 183 subjects in order to determine differences in the correlations between the MMPI's family problems scale and the FES scale. Sines found that the MMPI had concurrent validity with a person's perception of the family environment measured by the FES scales. Additionally, he concluded that the FES scales were not highly redundant with the MMPI variables although they did contain some of the same concepts.

Family Treatment

The treatment program that these instruments measure is designed to assist participants to let down their defenses, let pain emerge, begin to experience some positive feelings, accept the family illness as well as one's part in its progression, and then make a commitment to on-going recovery for oneself. The denial process is so powerful that family members, as well as clients, normally do not comprehend the dynamics of either the illness nor of the social patterns of interaction and communication within the family.
Family treatment has as a goal, the breaking through of this denial so that participants are able to identify specific patterns of communication and behaviors that are unhealthy and/or dysfunctional. Family treatment is designed to incorporate a vigorous family involvement in the treatment process for the alcoholic and the chemical dependent. When one family member adopts an unhealthy behavioral pattern of interaction, the entire family is affected negatively. A newer, healthier environment and different patterns of interaction and communication can then be achieved so that recovery for all members of that system can be maximized.

Participants in this study volunteer to participate in a week of family treatment accompanied by member(s) of their family system. This member may be a parent, child, spouse, sibling, or a close intimate friend who has had close interactions with the identified client during the disease's progression. Family week treatment normally occurs during a client's third week of residential treatment.

Education and therapy are the two major areas of focus for this week of treatment. The goal is to provide education first, therapy second and then ask for commitment from the participants for on-going recovery. Cognitive restructuring of the experiences of alcoholism and chemical dependence, coupled with group support, can bring about crisis resolutions through the identification of patterns of communication and behaviors, as
well as prevention through this same process. Table 3 provides a summary of Family Treatment Program by day, activity, and psychological variables.

Day 1 (Monday): The family members begin their education and orientation into the dynamics of the diseases of alcoholism and chemical dependence. The first day's education is specifically directed towards assisting participants in understanding the progression of the disease and how this has related to their own changes in behaviors. During the evening on Monday, time for self reflection during which "I" statements are written, provides the family members opportunity to focus on self responsibility in communication. Such statements as I deserve . . . , I feel . . . , I regret . . . , etc. begin the process for the family members' direct communication skill-building as well as awareness of the issues, they may wish to address with the client during this week. Statements presented in this manner enable family treatment participants to communicate with one another on a feeling level is a non-accusatory, non-judgmental manner. Defensiveness, denial, minimization, and blame are thus lessened. The learning of how to appropriately ask for what is wanted and needed in the relationship begins with these "I" statements.

Day 2 (Tuesday): The education in group processes begins. Family members experience their own group prior to the first conjoint therapy group with the identified patient. They are
<table>
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provided a "crash course" in group dynamics. Enabling concepts are confronted as family members interact with one another. The first conjoint session is held on Tuesday evening. This is a very carefully planned session during which the clinician asks group members to begin with one another a newer form of communication that is more positive and healthier. Prior interactions may have been hostile, alienating, conflictual and threatening. This is acknowledged by the clinician, but participants are asked to set this aside and trust this newer approach to communication. After this first conjoint session, family members and clients return to their small groups and they process what they have just been experiencing in order to alleviate the fears and anxiety that this first encounter seems to generate in the family treatment participants.

Day 3 (Wednesday): Family week continues with additional conjoint therapy. "I" statements are presented along with specific areas of conflict. Costs and losses each has experiences, as the progression of the disease has had its impact on the family unit, are discussed and processed. As exploration of these costs and losses takes place, group members see the commonality among the group, thus building cohesion among the participants. This cohesion acts as a catalyst towards resolution of issues. Anger, control, dependency, inappropriate behaviors are seen, acknowledged, and processed. The uncomfortable feelings are lessened. In the evening psychodrama
provides even further opportunity to deal with these uncomfortable feelings and self ownership of feelings is beginning to be a conscious act.

Day 4 (Thursday): The morning is spent in conjoint open group education and processing. Roles, relationships, and learned patterns of behaviors are explored. These are viewed in light of childhood roles and patterns of behaviors that may have been brought into the present relationship. This activity is designed to assist the participants in seeing that not all of the present difficulties present in their relationships are directly a result of the progression of these diseases. They may have been a result of learned behaviors carried into the family system. As these difficulties may be deeply seated within the individuals participating in family treatment, they are placed aside to be processed in on-going therapy. Conjoint therapy time is spent in processing those issues that are a direct result of alcoholism and chemical dependence. The underlying theme of Day 4's activities is self-responsibility in recovery. Family treatment participants are asked to attend the evening's self-help group meeting that most appropriately fits their needs. This is a further reinforcement of the individual's need for self-responsibility in getting healthy.

Day 5 (Friday): The client and family member collaborate on a relapse prevention contract. This contract is designed to provide a safe vehicle for continuing the healthier forms of
communication that have been learned during family week. Behaviors that are inappropriate can thus be addressed openly and without fear of repercussions. The contract outlines the specific areas that may be addressed should the possibility of relapse be present. During the afternoon, closure takes place, opportunities for each participant to express concern for, thanks to, and appreciation for others, as well as commitment to one's own direction, is provided all participants. Clients return to the regular treatment program to continue their therapy and family members transfer to continuing care. The regular treatment program is summarized in Appendix A.

Procedures

In order to organize the data gathering for this study with minimal client involvement so as not to detract from their primary goal of treatment for their diseases, the following procedures were established:

1. At time of admission to residential treatment client consent was obtained. Each client participating in the data being gathered was given the MMPI within three days following admission to residential treatment. The MMPI was computer scored and the results of the scores were sent to medical records to be included in the research file. At the time of receiving the MMPI scores, the personnel would gather all of the
demographic data on the client and place on the client's card file.

2. The FES was administered 24 hours prior to discharge from residential treatment. These were hand scored and the scores were sent to medical records to complete the research card on the participating client. A notation was made at this time as to the client's participation or non-participation in family treatment.

3. The anonymity of the client was insured. Each participant was informed that any information used in this study would be protected under the Privacy Act of 1974. This means that self-report data, scores on the instruments, diagnosis, and involvement in treatment would be confidential. Data collected from the center were in statistical form and did not include any references to the client's means of identification.

Statistical Procedures

In order to examine the hypotheses and maintain as much statistical precision as possible, three procedures were conducted. They were as follows:

1. A multivariate analysis of variance (MANOVA) was conducted in order to examine the pre-treatment differences between the experimental group and the control group. The dependent variables for these MANOVAs were the MMPI pre-test scales described in the
instrumentation section of this chapter. Each of the scale were examined by this MANOVA. Post hoc comparisons for the combination of all scales included: Hotelling-Lawley Trace, Wilk's Criterion and Pillai's Trace (Kennedy, 1979). Comparisons due to levels of participation which included family treatment participants and non-participants were accomplished.

2. A Pearson Product Moment Correlation Coefficient was established through a correlational analysis between the MMPI pre-test scales and the FES post-test scales (Kennedy, 1979).

3. An analysis of covariance (ANCOVA) was conducted in order to examine the differences between family treatment participants and non-participants. The covariates were the MMPI pre-test measures and the dependent variables for the ANCOVAs were the post-test measures from the FES. The ANCOVA was performed that tested the two main effects of group and treatment. A Scheffe' test was used when needed as a post hoc procedure (Kennedy, 1979).

Summary

This chapter examined the methodological issues surrounding this study. The instruments used contained the elements of family patterns that addressed the hypotheses. Validity and reliability of the instruments were encouraging. The sample
appeared to have qualities that lend themselves to research. Information regarding the administration of the instruments and resultant data yielded confidence.

Conceptually, attention was given to the selection of variables that would fit the goals of family treatment. Chapter III discussed the statistical framework that would provide the information needed to examine the hypotheses. Chapter IV will provide the summary of the statistical analysis in light of the hypotheses from Chapter I.
In order to assess whether alcoholics and chemical dependents, who participate in family treatment, differ in their patterns of interaction and communication within the family system from non-participants, data needed to be generated. The Minnesota Multiphasic Personality Inventory (MMPI) and the Family Environment Scale (FES) were the two instruments selected to provide the measurements. Prior research had indicated that the MMPI and the FES scales correlated (Sines, 1984), especially the MMPI's family problems scales with the scales from the FES (Bloomquist and Harris, 1984). The MMPI scales used as pre-test measures were family problems, manifest hostility, dependency, dominance, and control. The FES scales used as post-test measures were cohesion, expressiveness, conflict, independence, and control.

In order to examine the hypotheses and establish statistical precision, three procedures were performed:

1. A multivariate analysis of variance (MANOVA) was conducted using the MMPI pre-test measures as dependent variables so that pre-treatment differences could be
determined. The experimental group and the control group were compared through these MANOVAs.

2. A correlational analysis was conducted in order to examine the relationship between the MMPI pre-test scales and the FES post-test scales.

3. An analysis of covariance (ANCOVA) was conducted in order to examine the hypotheses listed in Chapter I.

Statistical Procedures and Findings

1. MANOVA procedures were performed in order to examine the pre-treatment differences between the experimental group and the control group using the MMPI pre-test scales as the dependent variables. Each of the variables were found to be not significant: family problems ($F = 2.65; p \leq 0.12$); manifest hostility ($F=0.01; p = 0.94$); dependency ($F=0.43; p \leq 0.51$); dominance ($F=0.61; p \leq 0.44$); and control ($F=0.30; p \leq 0.58$). The post hoc comparisons for the combined scales were also not significant: Hotelling-Trace ($F=0.93; p \leq 0.47$); Pillai's Trace ($F=0.93; p \leq 0.47$), and Wilks' Criterion ($F=0.93; p \leq 0.47$).

2. A correlation analysis to determine the Pearson Product Moment Correlation Coefficient was conducted in order to examine the relationship between the MMPI pre-test scales and the FES post-test scales. As indicated in Chapter III, Bloomquist and Harris (1984) indicated
that the MMPI's family problems scales was highly correlated with the FES scales as follows: cohesion (p ≤ 0.001); expressiveness (p ≤ 0.001); conflict (p ≤ 0.001); independence (p ≤ 0.001); and control (p ≤ 0.01). The results of the correlation analysis for all of the pre-test scales with the post-test scales indicated that these scales, as scored by the clients in this study, were also significantly related as follows:

a. MMPI's family problems was significantly related to cohesion (p ≤ 0.004), expressiveness (p ≤ 0.0001), conflict (p ≤ 0.002), independence (p ≤ 0.02) and control (p ≤ 0.02).

b. MMPI's manifest hostility was significantly related to the FES scales of cohesion (p ≤ 0.01) and expressiveness (p ≤ 0.03) and approached significance for conflict (p ≤ 0.07) and control (p ≤ 0.07).

c. MMPI's dependency was significantly related to the FES scale of control (p ≤ 0.006).

d. MMPI's dominance was significantly related to the FES scale of control (p ≤ 0.006).

e. MMPI's control scales was significantly related to FES scales of cohesion (p ≤ 0.007), expressiveness (p ≤ 0.002), conflict (p ≤ 0.01) and independence (p ≤ 0.01).
Table 4 provides a summary of the Pearson Product Moment Correlation Coefficients and the probabilities of significance for each of the MMPI scales used and the FES scales used.

3. To further increase the statistical precision ANCOVAs procedures were used to compare the covariates from the MMPI pre-test measures with the FES post-test measures due to main effects of group and treatment. Table 5 through 9 list the ANVOCA results for each of the FES dependent variables. Table 10 provides a summary of the dependent variables from the FES means and standard deviations by groups and treatments. Table 11 provides the summary of the MMPI covariate's means and standard deviations. The results of these analyses will be presented by the three hypotheses.

HYPOTHESES 1: Alcoholics, who participate in family treatment, differ in their patterns of interaction and communication within the family from alcoholics who do not participate in family treatment.

The FES variable of cohesion did not produce a significant effect for group and treatment ($F=0.60; \text{df}=1, 86; p \leq 0.44$) (see Table 5). Alcoholics, who participated in family treatment ($M=48.71$), scored lower on this variable than non-participants ($M=50.63$) (see Table 10). Significance was not achieved.
Table 4

Pearson Product Moment Correlation Coefficients and Probabilities of Significance for the Minnesota Multiphasic Personality Inventory and the Family Environment Scale Variables

N=95

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### Table 5

**Analysis of Covariance for Family Environment Scale**

**Cohesion by Group and Treatment**

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Analysis of Covariance for Family Environment Scale Expressiveness by Group and Treatment

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Analysis of Covariance for Family Environment Scale
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Table 8

Analysis of Covariance for Family Environment Scale
Independence by Group and Treatment

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Table 9

Analysis of Covariance for Family Environment Scale
Control by Group and Treatment

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<td>CONTROL</td>
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Table 10
Means and Standard Deviations for Family Environment Scale
by Groups and Treatments

<table>
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<tr>
<th>DEPENDENT VARIABLES</th>
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<th>MEANS</th>
<th>STD. DEV.</th>
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<td>50.63</td>
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<td>9.0985</td>
</tr>
</tbody>
</table>
### Table 11

Raw Means and Standard Deviations of Minnesota Multiphasic Personality Inventory Covariates by Groups and Treatments

<table>
<thead>
<tr>
<th>COVARIATES</th>
<th>GROUPS AND TREATMENTS</th>
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<th>MEANS</th>
<th>STD. DEV.</th>
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<td>12.4980</td>
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<td>chem. dep. in no fam trt</td>
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<td>60.25</td>
<td>9.7878</td>
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</tbody>
</table>
The FES variable of expressiveness did not produce a significant effect for group and treatment \((F=0.46; \text{df}=1,86; p \leq 0.50)\) (see Table 6). Alcoholics, who participated in family treatment \((M=49.44)\), scored lower on this variable than non-participants \((M=53.19)\) (see Table 10). Significance was not achieved.

The FES variable of conflict did not produce a significant effect for group and treatment \((F=0.10; \text{df}=1,86; p \leq 0.75)\) (see Table 7). Alcoholics, who participated in family treatment \((M=50.12)\), scored higher on this variable than did non-participants \((M=45.69)\) (see Table 10). Significance was not achieved.

The FES variable of independence did not produce a significant effect for group and treatment \((F=0.02; \text{df}=1,86; p \leq 0.89)\) (see Table 8). Alcoholics, who participated in family treatment \((M=49.96)\), scored lower on this variable than non-participants \((M=52.19)\) (see Table 10). Significance was not achieved.

The FES variable of conflict did not produce a significant effect for group and treatment \((F=0.10; \text{df}=1,86; p \leq 0.75)\) (see Table 7). Chemical dependents who participated in family treatment \((M=56.86)\), scored higher on this variable than did non-participants \((M=56.13)\) (see Table 10). Significance was not achieved.
The FES variable of independence did not produce a significant effect for group and treatment \( (F=0.02; \text{df}=1,86; p<0.89) \) (see Table 8). Alcoholics, who participated in family treatment \( (M=49.96) \), scored lower on this variable than non-participants \( (M=59.19) \) (see Table 10). Significance was not achieved.

The FES variable of control produced an interaction effect for group and treatment that approached significance \( (F=3.39; \text{df}=1,86; p<0.07) \) (see Table 9). Alcoholics, who participated in family treatment \( (M=49.50) \), did not differ in their score from non-participants \( (M=49.94) \) (see Table 10). Therefore, significance was not achieved.

Alcoholics, who participated in family treatment, differed in their patterns of interaction and communication within the family system from non-participants as predicted in Chapter III (see page 48). However, this was not statistically significant. Therefore the hypotheses was not supported.

HYPOTHESES 2: Chemical dependents, who participate in family treatment, differ in their patterns of interaction and communication within the family system from chemical dependents who do not participate in family treatment.

The FES variable of cohesion did not produce a significant effect for group and treatment \( (F=0.60; \text{df}=1,86; p<0.44) \) (see Table 5). Chemical dependents, who participated in family
treatment (M=38.97), scored lower on this variable than non-participants (M=46.50) (see Table 10). Significance was not achieved.

The FES variable of expressiveness did not produce a significant effect for group and treatment (F=0.46; df=1,86; p< 0.50) (see Table 6). Chemical dependents, who participated in family treatment (M=43.34), scored lower on this variable than non-participants (M=50.81) (see Table 10). Significance was not achieved.

The FES variable of conflict did not produce a significant effect for group and treatment (F=0.10; df=1,86; p< 0.75) (see Table 7). Chemical dependents who participated in family treatment (M=56.86), scored higher on this variable than did non-participants (M=54.13) (see Table 10). Significance was not achieved.

The FES variable of independence did not produce a significant effect for group and treatment (F=0.02; df=1,86; p< 0.89) (see Table 8). Chemical dependents, who participated in family treatment (M=45.66), scored lower on this variable than did non-participants (M=49.56) (see Table 10). Significance was not achieved.

The FES variable of control produced an interaction effect for group and treatment that approached significance (F=3.39; df=1,86; p< 0.07 (see Table 9). Chemical dependents, who participated in family treatment (M=50.69), scored higher on this
variable than did non-participants (M=43.13) (see Table 10). The
Scheffe' post hoc procedure did not produce significance.
Chemical dependents, who participated in family treatment,
differed in their patterns of interaction and communication
within the family system as predicted in Chapter III (see page
48). However, the difference was not significant. Therefore,
the hypotheses was not supported.

HYPOTHESES 3: Alcoholics, who participate in family treatment,
differ in their patterns of interaction and
communication within the family system from
chemical dependents who participate in family
treatment.

The FES variable of cohesion did not produce a significant
effect for group and treatment (F=0.60; df=1,86; p<0.44) (see
Table 5). Chemical dependents, who participated in family
treatment (M=38.97), scored lower on this variable than did
alcoholics who participated (M=48.71) (see Table 10).
Significance was not achieved.

The FES variable of expressiveness did not produce a
significant effect for group and treatment (F=0.46; df=1,86;
p<0.50) (see Table 6). Chemical dependents, who participated in
family treatment (M=43.34), scored lower on this variable than
did alcoholics who participated in family treatment (M=49.44) (see
Table 10). Significance was not achieved.
The FES variable of conflict did not produce a significant effect for group and treatment (F=0.10; df=1,86; p<0.75). (see Table 7). Chemical dependents, who participated in family treatment (M=56.86), scored higher on this variable than did alcoholics who participated in family treatment (M=50.12) (see Table 10). Significance was not achieved.

The FES variable of independence did not produce a significant effect for group and treatment (F=0.02; df=1,86; p<0.89) (see Table 8). Chemical dependents, who participated in family treatment (M=45.66), scored lower on this variable than did alcoholics who participated in family treatment (M=49.96) (see Table 10). Significance was not achieved.

The FES variable of control produced an interaction effect for group and treatment which approached significance (F=3.39; df=1,86; p<0.07) (see Table 9). Chemical dependents, who participated in family treatment (M=50.69), scored higher than alcoholics who participated in family treatment (M=49.50) (see Table 10). Scheffe' did not produce significance.

Chemical dependents, who participated in family treatment, differed in their patterns of interaction and communication within the family system from alcoholics who participated in family treatment as predicted in Chapter III (see page 48). However, the differences were not significant. Therefore, the hypotheses was not supported.
Summary

This chapter dealt with the data resulting from the statistical procedures performed in this study. The MANOVA produced no significance. The experimental group and the control group were, therefore, considered similar. The correlations between the MMPI pre-test measures and the FES post-test measures were found to be significant, supporting the theory that these instruments can be used together. The ANCOVA results of the FES dependent measures and the MMPI covariates, used to test main effects of group and treatment did not produce any results that were significant for family treatment participation. Therefore, the three hypotheses examined were not supported. Chapter V will discuss conclusions and recommendations resulting from this analysis.
Chapter V contains a summary of the purpose of this study, the procedures used to examine the hypotheses and the results of the data that were generated. In addition, conclusions and recommendations are made.

Summary of the Study

The purpose of this study was to examine whether alcoholics and chemical dependents, who participate in family treatment, differ in their patterns of interaction and communication within the family system from alcoholics and chemical dependents who do not participate. Ninety-five clients made up this sample. Sixty-three were family treatment participants and 32 were non-participants. Of the family treatment participants, 34 were alcoholic and 29 were chemical dependent. Of the 32 non-participants, 16 were alcoholic and 16 were chemical dependent.

The family treatment program was designed to assist participants to let down their defenses, to let pain emerge, and to begin to experience some positive feelings. Family treatment has as a goal the breaking through of the denial that participants normally have regarding patterns of interaction and communication within the family system. As the disease
progresses, patterns can be alienating, controlling, uncaring, cohesive, conflictual, and withdrawn. The identification of the unhealthy and/or dysfunctional patterns can be acknowledged, addressed and changed or altered for newer, healthier patterns of interaction and communication. Education and therapy provide cognitive restructuring of the experiences of alcoholism and chemical dependence and can bring about crisis resolution through the identification of those patterns that are inappropriate. These patterns were measured by the Minnesota Multiphasic Personality Inventory (MMPI) and the Family Environment Scale (FES). Pre-test measures from the MMPI were: family problems, manifest hostility, dependency, dominance and control. Post-test measures from the FES were: cohesion, expressiveness, conflict, independence, and control.

MANOVAs were performed using the MMPI pre-test measures in order to test pre-treatment differences. None of the MMPI variables achieved significance nor did the total of the scale achieve significance in the post hoc comparisons (p ≤ 0.47). It was concluded that pre-treatment groups were similar.

The MMPI pre-test measures and the FES post-test measures were examined to determine if they were correlated. The Pearson Product Moment Correlation Coefficients were found to be significant, ranging from p ≤ 0.03 to p ≤ 0.0004 (See Table 4).

Analysis of covariances (ANCOVAs) were performed in order to examine the hypotheses listed in Chapter I. The two main effects
of group and treatment were examined by these ANCOVAs, using the MMPI pre-test measures as the covariates and the FES post-test measures as the dependent variables. A Scheffe' test was used to determine significance for groups and treatments.

The data derived from the statistical analysis of these ANCOVA procedures yielded these findings:

1. Analysis of the data for the FES variables indicated that alcoholics, who participated in family treatment, did not significantly differ (p<0.05) from non-participants. The contrast of means indicated, however, that they did differ as predicted in Chapter III (p. 48) but this difference was not significant. Therefore, the hypotheses was not supported. Alcoholics, who participated in family treatment, did not differ significantly in their patterns of interaction and communication within the family system from alcoholics who were non-participants.

2. Analysis of the data for the FES variables indicated that chemical dependents, who participated in family treatment, did not significantly differ (p<0.05) from non-participants. The contrast of means indicated, however, that they did differ as predicted in Chapter III (p. 48) but this difference was not significant. Therefore, the hypotheses was not supported. Chemical dependents, who participate in family treatment, did
not differ significantly in their patterns of interaction and communication within the family system from chemical dependents who were non-participants.

3. Analysis of the data for the FES variables indicated that chemical dependents, who participated in family treatment, did not significantly differ ($p < 0.05$) from alcoholics, who participated in family treatment. The contrast of means, however, indicated that chemical dependents did differ as predicted in Chapter III (p. 48) but this difference was not significant. Therefore, the hypotheses was not supported. Chemical dependents, who participated in family treatment, did not significantly differ in their patterns of interaction and communication within the family system from alcoholics who participated in family treatment.

Conclusion

Taking into consideration the limitations listed in Chapter I and the extent to which the data from the research procedures were valid and reliable, as reported in Chapter III and IV, conclusions are drawn from this study.

Alcoholics and chemical dependents, who participated in family treatment did not significantly differ in their patterns of interaction and communication within the family system from non-participants. Neither did the alcoholic and the chemical dependent participants significantly differ from each other at
the .05 level of significance. This finding was contrary to the belief that family treatment makes a difference when treating the alcoholic and the chemical dependent (Coleman & Davis, 1979). However, the means indicated that family treatment participants did differ in their scores on the FES variables from non-participants and that chemical dependent participants did differ in their scores on these variables from alcoholic participants. Therefore, it may be concluded that:

1. Family treatment program may have been of insufficient length to effect changes in these patterns.
2. Family treatment program may not have been sufficiently different from other treatment modalities to effect significant changes.
3. The instruments chosen for this study may not have been of sufficient sensitivity to detect differential effects.

Recommendations

The following recommendations are suggested for utilization of this study for further research:

Program

1. Research is needed to discover if different lengths of treatment effect patterns of interaction and communication within the family system. Moos (1981) indicated that clients continue to change following their treatment of their disease. A follow-up study on
the present sample would enable a comparison to be made in six months and in 12 months to further determine differences.

2. Research is needed to determine programing needs for singles, divorced clients, and married clients. Patterns of interaction and communication within these types of family systems may differ. Treatment modalities that are more cogent to the specific family types would be of interest to clinicians and to developers of programs. Kaufman (1980) indicated that types of families have long been ignored in family treatment modalities. Therefore, research specific to these different types and needs of clients would be of interest.

Research

1. This study dealt with a small sample which was not randomly selected. It is recommended that this study be replicated on a larger scale with weighted random samples of alcoholics and chemical dependents.

2. It is recommended that this study be replicated and include women in sufficient numbers to examine gender differences for alcoholics and chemical dependents. Research is just beginning to focus on the differential effects on the family system when the client is female. Sandmaier (1980) indicated that women's alcoholism is
related to their lack of social power, inferiority, and conflicts about their sex roles. Further research in the identification of patterns of interaction and communication within the family system for women would benefit the individual client, program developers, and would add to a sparse body of information regarding gender differences of alcoholics and of chemical dependents.

3. Methodological issues discussed in this study; namely, the self-report data on the clients' chemical of choice, as well as any qualitative information provided by clients, merits further investigation. Research has indicated that the external validation of self-report data is problematic. For example, Elliott and Ageton (1980) began to examine the self-report data's reliability and validity in drug dependent clients. They found that the denial system seemed to prevent the rigorous honesty needed to establish the reliability of the client's self-report.

4. Kaufman (1985) indicated that the primary diagnosis of alcoholism and chemical dependence is sometimes in question. For some clients it is difficult to determine whether this primary diagnosis is an antecedent or a consequence of a concurrent psychiatric condition or diagnosis. Further research into the
diagnosis of concurrent issues connected with alcoholism and chemical dependence would be of interest.
APPENDIX A

OVERVIEW OF RESIDENTIAL TREATMENT
The philosophy of the treatment program in which the family treatment component was placed is that alcoholism and chemical dependency are diseases and that individuals are either alcoholic or chemical dependent when they repeatedly use mood-altering chemicals in a manner that impairs their physical, emotional, psychological, spiritual and intellectual health, and disrupts their social and economic position. The treatment program has three primary components: primary care, residential treatment during which family treatment takes place, and continuing care. The treatment program is a continuous one, lasting approximately two years. Clients are assisted in being restored to comfortable sobriety in which one is able to choose not to drink or use other mood-altering chemicals. A healthier productive life is the underlying goal of the program. In all cases, the primary goal is to help each client achieve and maintain total abstinence from alcohol and other drugs.

Upon admission to primary care, clients receive a complete medical evaluation and assessment. This phase of treatment normally lasts from two to five days during which a medical detox occurs. This is under the direction of physicians and registered nurses. Clients are required to be drug free of all medications except those prescribed to control seizures or other chronic conditions unrelated to these diseases.

Residential treatment begins with the transfer of the client from detox to the four week program. A psycho-social evaluation and assessment is completed and directions for treatment are established within the
Residential treatment begins with the transfer of the client from detox to the four week inpatient program. A psycho-social evaluation and assessment is completed and directions for treatment are established within the first two weeks. Intense individual and group therapies, a comprehensive educational program, and an orientation into the self-help groups of A.A./N.A./Al-Anon are among the therapeutic services provided.

During the third week of residential treatment clients may participate in the family week treatment. For those who do not choose to do so, attendance at the regularly scheduled activities is required. The fourth week is spent on planning a holistic recovery plan so that clients may live chemically free. Planning for reintegration into the family system, social environment, and work setting is carefully orchestrated so that anxiety can be minimal as they leave treatment.

Continuing Care is the third component of treatment and begins with the client's successful completion of residential treatment. For the first three months following discharge from residential treatment, clients attend weekly education and therapy sessions. At the end of the three months, their treatment plan is updated and a determination is made as to what their specific needs are at that time. Recovery needs and attendance at the weekly meetings is gradually reduced. Continuing Care is designed to assist clients in making a successful return to home, community, and job.
LIST OF REFERENCES


White, D. (1978). Schizophrenics's perceptions of family relationships. Doctoral Dissertation, Department of Education, St. Louis University, St. Louis, MO.

