Living with an alcoholic

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Introduction

The vast and still-growing literature about clinical, biochemical, endocrinological and psychiatric aspects of alcoholism is clear evidence of a continuing interest in this subject, and although the small print about individual enzymes may yet remain to be written, a fair understanding exists of alcoholism as a medical condition. There is also an extensive literature on different aspects of the family of the alcoholic, which is again clear evidence that the role of the family in alcohol-related problems is perceived as important. Unfortunately, much of the research and therefore much of the literature, is strictly compartmentalized. The 'spouse' of the alcoholic has been the subject of much study, and this usually means the wife of a male alcoholic and only rarely and recently, the husband of a female alcoholic. Her role, for example in causing alcoholism and in encouraging its continuance, has been explored (the disturbed personality hypothesis), as have her responses to living with it (sociological stress theory). The children of alcoholics, although described as the 'forgotten' children and even as the 'unseen' or 'neglected' problems, are also not neglected as far as research is concerned, although most of it reports 'specific' childhood problems, supposedly resulting from having an alcoholic as a parent (El-Guebaly and Orford, 1979).

There has, however, been an unfortunate tendency to ignore the fact that there is probably very little that occurs uniquely in the alcoholic family and the assumption of causality has often obscured complex relationships between alcoholism, poverty, psychopathy and family disorganization. Moreover, there has been a failure in this highly specialized field to relate to other research on families in crisis from other causes. The neat organization of research into separate topics such as wives, husbands, and children ignores the concept of the family as a whole, and so it is perhaps not surprising that very little research gets beyond more or less meaningful statistics and does not manage to convey the least idea of what life is like in the family of an alcoholic. Some recent

research, however, has been carried out using the framework of systems theory, which asserts that in order to understand individual behaviour it is essential to understand the significant group in which a person lives, the relationships within that group and the importance of any particular individual's behaviour in maintaining the group or system (Paolino and McCrady, 1977). A unified approach such as this brings some hope at least of increasing our understanding of what living with alcoholism really entails.

It is perhaps worth mentioning that although it is the immediate family, usually spouse and children, who actually cohabit with the alcoholic, a much bigger group, including members of the extended family, friends and neighbours 'live' with him or her too and their responses may have a significant effect on life in that smaller family group. Whereas many chronic illnesses may produce expressions of concern and positive gestures of support and sympathy, alcoholism is often perceived by society as the patient's fault—if not now, at any rate, at some time in the past. The response is often a punitive rejection, not only of the alcoholic, who is not perceived as a patient, but also of the family who, ashamed of the behaviour of one of its members, may become withdrawn and isolated. It can be argued that such societal rejection is a way of controlling a form of behaviour that is considered undesirable and disadvantageous and one wonders whether the scanty research on alcoholic families is further evidence of this rejection.

Patterns of drinking

Although the existence of different patterns of drinking by alcoholics has long been acknowledged, it is only recently that the implications of this for family life have been recognized. Characteristically, male alcoholics mostly drink outside the home, often in pubs and are more likely to come home drunk, whereas female alcoholics tend to drink at home, often solitarily and steadily throughout the day. They are less likely to become intoxicated and may be able

sufficiently to control their drinking so that they can cope with basic household jobs and sober up ready for when the family returns home in the evening (Wilson and Orford, 1978). Although this can only be an approximate description and alcoholics should not be typecast, it is easy to imagine the anxiety and apprehension with which the homecoming of a probably drunk father is awaited in the evening, or the dread with which children come home after school, wondering what they will find and whether their mother has been able to shop or prepare a meal for them.

Conflict

Marital conflict is undoubtedly a common characteristic of life in an alcoholic family, although this is not meant to imply that the conflict is necessarily a consequence of alcoholism and it could just as easily be its cause. Whatever the sequence of events, poor marital relationships and a high rate of marital breakdown in comparison with controls are reported in alcoholic families (Paolino and McCrady, 1977). Statistics, however, cannot convey the reality of life in a family in which quarrelling and arguing are going on for much of the time. In Cork's (1969) study of 115 children, one or both of whose parents were being treated for drinking, 98 reported parental fighting and quarrelling as their main concern compared with only 7 who worried about drinking or drunkenness. Although quarrels and arguments may often be about drinking, other sources of conflict include money, gambling and actual or threatened infidelity. Children living in this environment may side with one parent, may try to act as peacemaker, or may withdraw from the scene, even if they cannot avoid hearing the ongoing quarrels. They may be unwilling to go to school, believing that if they stayed at home, they could perhaps prevent an argument, or if they are at school, may not be able to concentrate, worrying over arguments and probably tired from lack of sleep.

Violence

An extension and accompaniment of the quarrelling and arguing is violence, although among many studies reporting violence in alcoholic families, clear operational definitions are rare. Two areas in particular have claimed most attention—wife battering and child abuse. For example, Orford *et al.* (1976) in a study of 100 male alcoholics reported that 72 of their wives had been threatened by their husbands and 45 had been beaten. Gayford (1975), studying the problem of battering from a different point of view, found that on 44 occasions out of 100 cases of battering, the woman had been beaten only after the man had been drinking. It has also proved extremely

difficult to establish the prevalence of child abuse by alcoholic parents. In theory it seems probable; the image of the drunken father beating his children for minor misdeeds springs readily to mind and indeed has become part of the folklore of alcoholism. In support of this hypothesis, Young (1964) reviewed 300 families in which there had been child abuse or neglect and found that drinking had been a primary family problem in 62%. Smith, Hanson and Noble (1973), however, found significantly more psychopathy but not alcoholism among the parents of battered pre-school children admitted to hospital than among the parents of children admitted for other emergencies. In general, there is a lack of well designed studies with adequate controls and there have been few attempts to establish whether child abuse is actually related to alcoholism, or whether both problems arise because of other family circumstances, such as poverty, unemployment or family disorganization. The important relationship between child abuse and alcohol intoxication (rather than alcoholism) remains to be investigated (El-Guebaly and Orford, 1979), and although most of the literature about violence in relation to alcoholism is about the alcoholic husband or father, in the 11 families studied by Wilson and Orford (1978), the mothers were as likely as the fathers to be violent. In one of the families they report that it was the mother's drinking that provoked the non-alcoholic stepfather to violence. Generally, however, it is the drinking parent who is violent, and Keane and Roche (1974) attempted to assess the effect of such violence on the development of the children. They found that among children with alcoholic fathers, both boys and girls whose fathers were also violent showed significantly more symptoms of development disorder, than those whose drinking fathers were not violent. Once again, valuable and careful research does not convey the essence of what it must be like for a child to live in an atmosphere of violence. Even if they are not physically harmed, they may be involved in tidying up after fights. Moreover, dealing with injuries and violence at such close quarters cannot fail to be a frightening experience.

Communication

In addition to overt conflict and violence, communication within the alcoholic family group can be disordered in more subtle ways. Wilson and Orford (1978) in their sensitive study commented on the regularity with which their clients referred to the 'atmosphere' in their families. The atmosphere, and communication itself, may be greatly affected by the presence or absence of the alcoholic and whether he or she is drinking or drunk. In some families the atmosphere may become tense and strained when the

alcoholic is drinking and communication may be reduced to a minimum; the children, for example, may retreat to their own rooms to avoid communication and more specifically perhaps, to avoid provoking an argument with a parent whom they recognize as unpredictable.

Wilson (1980) also reports that in some families where the man is the problem drinker, he may become isolated because of a coalition between mother and children, which may persist whether he is drinking or sober, or be relaxed when he is not drinking. In contrast, although a female drinker might be similarly rejected when drinking, a tight coalition did not seem to develop between father and children and the mother was again included within normal family communication when she was sober. This observation, if confirmed in a larger sample, might suggest that it is easier for children to maintain a close relationship with a drinking mother than with a drinking father, opposing the widely held belief that an alcoholic mother cannot form close emotional ties with her children (Wilson, 1980).

Although withdrawal and rejection may be the more usual response to a drinking parent their relaxed and disinhibited behaviour may enable other members of the family to be more relaxed too and communication may then be more free and easy. Such a response might be positively reinforcing for drinking behaviour. Similarly Hersen, Miller and Eisler (1973) using video-tape, observed verbal and non-verbal interactions of alcoholics and their wives and noticed that the wives tended to look at their husbands more during discussions of drinking-related topics than at other times; these authors also suggest that the wife's attention in this way might support drinking.

Ways of coping

Against the background of strained communication and conflict there are the practical realities of coping with daily life. For example, if it is the husband who is the alcoholic, he may lose his job so that the wife has to take a full-time job (if she can get one), to provide for the family. At the same time as continuing to run the house she probably has to assume new responsibilities in other areas such as paying the rent and other bills, and carry the burden of responsibility for the children single-handed. In addition there may be unpredictable crises directly related to the alcoholism—unconsciousness, violence, incontinence. For the husband whose wife is alcoholic the problems are similar. Financial problems may assume less importance but it can be very difficult for a man with a demanding job to deal with the details of domestic routine. Whoever is having to cope they are usually having to do so from a fairly

isolated position, often lacking the support of friends and family because of the sense of shame if the alcoholism were to be exposed. The complexity of the problem is compounded by the emotional state of the non-alcoholic, coping partner, suffering not only from anxiety about the problems he/she is having to deal with, but also from guilt about his/her own role in bringing them about. It is almost surprising that the responses to such nightmarish situations have been studied and classified but Jackson (1954) for example, suggested seven stages of adjustment by a wife to her husband's alcoholism: 1. Attempts to avoid and deny the problem. 2. Attempts to eliminate the problems; increased social withdrawal. 3. Family disorganization. 4. Attempt to reorganize, with the wife taking control. 5. Efforts to escape the problem; possible separation. 6. Wife and children reorganize without the husband. 7. Recovery and reorganization of the family with sober father. In fact it seems unlikely that there would be in every case an orderly response to such an unpredictable situation and other studies have suggested that different stages of alcoholism produce different stresses and different forms of coping behaviour. Broadly these can be described as defensive coping in which the problem is ignored because it cannot be effectively resolved and direct coping, when positive steps are taken to alter the situation. A form of defensive coping is the type of coping behaviour described by Orford *et al.* (1975) as 'withdrawal within marriage' in which the wife avoids her husband as much as possible. Other types of coping behaviour described by Orford *et al.* are safeguarding family interest where the wife assumes many of her husband's former responsibilities, 'acting out', 'attacking' (including divorce as the final attack), and protecting the alcoholic husband.

Children

It is not only the non-alcoholic partner who has to take on different roles within the family group. Children, too, often have to assume a responsibility unusual for children of their age. They may, for example, be expected to contribute in very practical ways to the running of the household—by doing shopping or regular chores at home. Older children may have to take considerable responsibility for caring for younger siblings, so that they are forced into a parental role at a very young age. Although at first it seems hard that such burdens should be placed on children because of parental alcoholism, it is possible that a greater measure of responsibility than normal may be beneficial for some children, helping them to grow up into self-reliant and independent individuals.

In fact, household responsibilities are likely to be the least of the problems facing these children. Far

more serious is the general atmosphere of anxiety and tension, the conflict and sometimes the violence. Furthermore, it may be difficult for them to form close friendships; bound by the conspiracy of silence about alcoholism, they cannot talk freely of their home and family to friends, they often feel unable to invite them home and may then be unwilling to accept invitations that cannot be reciprocated (Wilson and Orford, 1978). Above all, the unpredictability of living with an alcoholic would seem to be particularly stressful for children. On their return from school, for example, they might find their parents drunk or drinking, sober or unconscious, the house may be in the same state of disorder as when they left it in the morning, or everything may be ready for their evening meal; they may be reprimanded for something that was ignored the day before. Children, like their non-drinking parents, have a range of different ways of coping. They learn to ignore provocative remarks in order to prevent serious arguments; they may not only withdraw to their rooms but even barricade themselves in. They may go out of the house at difficult times and older children may see leaving home as their only solution (Seixas, 1980). The whole situation seems such a far cry from the secure environment advocated for children that it is perhaps surprising that quite large numbers of children of alcoholics do develop into stable adults (Velleman and Orford, 1981).

Despite all the research, however, what still remains obscure is which components or variables of life in an alcoholic family have particularly adverse effects and conversely which might help children to cope with what is obviously a difficult situation. Such questions and their answers have great practical implications. With problems such as alcoholism, where the concept of 'cure' let alone its achievement is difficult, learning how to manage the whole situation to minimize the damage to the group as a whole and particularly to the children, might be of the greatest value. It has been suggested, for example, that what may be crucial is the way in which the non-drinking parent copes. If he, or more usually she, copes well, the difficulties with which the child is faced are correspondingly reduced. If, however, the non-drinking spouse finds the problems overwhelming and makes excessive emotional demands of the children, the effect of alcoholism in the family is undoubtedly magnified.

Implications for treatment

Coupled with the growing awareness of the effect of alcoholism on the whole family has come increased understanding of the way in which the family interacts not only with the alcoholic but also with alcoholism and how the family can contribute to, or

can actively sabotage, treatment. It is not intended here to comment on different treatments for alcoholism but an understanding of the underlying theoretical concepts leads on to an understanding of how different forms of intervention may be more or less helpful to the family living with alcoholism.

In the traditional, biomedical approach the alcoholic is offered the 'sick' role and individual treatment, whether pharmacological, behavioural or group therapy with other alcoholics. This traditional illness model, not very different from that of other purely medical conditions, does not involve the family to any great extent. The spouse may be interviewed, usually for confirmation of the history, and the existence of children is noted together with any evident problems. The family as a whole is never really considered. Although alcohol withdrawal and detoxification of the alcoholic can be achieved in isolation, this can hardly be considered a satisfactory end-point of treatment and resumed problem-drinking when the patient returns to family life means that other factors have to be taken into consideration. Predictably, and perhaps logically, there has been a movement towards the use of family therapy in alcoholism. In this theoretical framework, the alcoholic is not regarded as the sick patient but rather as the 'labelled victim' of the family and drinking behaviour is seen as a way of stabilizing and protecting the family (Steinglass, 1977). It follows that the goal of abstinence is only of secondary importance and that indicators of successful therapy include better forms of communication, reduced conflict and better social functioning. From the point of view of the non-drinking members of the family improvement in these areas would represent a vast reduction in the stress of living with alcoholism and would tend to reduce the harmful effects on children.

The organizations of Alcoholics Anonymous and Al-Anon seem to represent in practical terms a meeting place for these two apparently disparate views. On the one hand is the fundamental precept that alcoholism is a disease and that the alcoholic is a sick person who requires treatment. On the other hand, in Al-Anon, the non-alcoholic member is encouraged to make a 'searching and fearless moral inventory' of themselves, to take positive steps to correct faults and shortcomings and to make amends to those they have harmed (Al-Anon, 1981). Their impotence over alcohol and alcoholism is emphasized and they are encouraged to become detached from their partner's problem, not attempting to control it and not responding to it. This approach, made against a religious/spiritual background and concentrating on personal development and maturity, seems very different to blaming the family problems on the 'illness' of one member. Whatever the contradictions, Al-Anon provides a caring and

supportive group with a wealth of shared experience. Not only is the social isolation of the alcoholic family relieved but the ventilation of problems, feelings, events etc. identified as being a very helpful experience, is positively encouraged. Less well known than Al-Anon is Alateen, the junior organization for adolescent members of alcoholic families, which provides similar support for a group, which, because its needs are largely unidentified, has usually been offered nothing at all.

Al-Anon, however, does not meet the needs of everyone living with alcoholism and it is unlikely that family therapy, however valuable in helping many families to deal with their problems, will ever be available for all those who might need it, or indeed that it would be suitable for all families. In some families, for example, one or more members may refuse to participate in any sort of therapy and sometimes, if marital breakdown is inevitable, help may be more usefully directed towards helping a family to come to terms with this and to minimize harm in this way (Wilson, 1982). Other families cope adequately, if not perfectly, if just one person, whether a professional in the field or a member of the community, is available to lend a hand in times of crisis and to listen and to share the anxiety. What should be avoided is a variety of 'helping agencies' all independently 'helping' one family: for example, a psychiatrist treating the alcoholic patient, the General Practitioner giving tranquillizers to the non-alcoholic partner, one child attending the Child Guidance clinic and a Social Worker or Health Visitor keeping a watchful eye on a child on the 'At Risk' register. Such a situation, which can arise very easily, provides superficial responses which may create even deeper divisions in a family already stretched to the limit.

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