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Muammer Cetingok, Ph.D. Major Professor

We have read this thesis
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Dr. Kate Mullins, Ph.D., Full Professor

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Date

THE RELATIONSHIP BETWEEN FAMILY FUNCTIONALITY AND ADDICTION

A Thesis

Presented for the

Master of Science

in Social Work

Degree

The University of Tennessee, Knoxville

Frank W. White

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DEDICATION

This thesis is dedicated to my father and mother, Dr. and Mrs. Warren N. White Sr., whose support and help made this degree possible; and to the memory of Dr. Carl S. Wilks, a committed and caring professor who was a tremendous inspiration.

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ABSTRACT

This research examined the relationship between family functionality and addiction. It explored seven dimensions of family functionality as defined by the Family Assessment Device (FAD). The FAD was administered to 154 addicted subjects who were hospitalized at local chemical dependency facilities in the Memphis metropolitan area. They were asked to respond to the statements on the FAD based upon their families of origin. The same procedure was employed with a random sample of 304 general population subjects selected from the Memphis metropolitan area. The scores for both groups were compared for a statistically significant difference using a two tailed t-test for independent samples. This t-test was two tailed because this study did not imply direction in the nature of the relationship, it only attempted to ascertain if a relationship existed.

The results showed a strong statistical relationship between family functionality and addiction. The random sample showed statistically better family functioning than did the addicted population in relation to their families of origin. It was concluded that a relationship does exist between family functionality and addiction, however; the nature of the relationship is not resolved by this research.

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INTRODUCTION

This research study examined the relationship between family functionality and addiction. There are many theoretical definitions of addiction based upon psychological and medical perspectives as revealed by the literature. This study utilized one by Johnson, Snibbe, and Evans (1975). They defined addiction as follows: "The state in which an individual is physically and/or psychologically dependent upon a drug. Use continues in the face of adverse effects on the individual and his environment." In this study the term drug was used to include alcohol, licit, and illicit substances. For the purpose of this research, addiction was operationalized as any adult, eighteen and older, who was being treated as an inpatient or aftercare patient at a local chemical dependency clinic. A comparison group was utilized for the purpose of testing. This group consisted of a random sample selected from the Memphis metropolitan area's general population. For the purpose of clarity, this comparison group will be referred as the general population. It can not be claimed that this group is completely free of addicted individuals nor can it be stated that these individuals did not have an addicted family member(s).

However, since this was a true random sample of the Memphis population, it can be claimed that the percentage of addicted individuals is no more than that of the general population. Likewise, the addicted population was selected from primarily public treatment facilities which may have an impact on the findings and characteristics of that group. In addition, both groups were requested to respond to the Family Assessment Device (FAD) (appendix A) based on their families of origin. This involved the subjects perceptions and recollections about their families. The limitations of both sample groups will be discussed in detail in the assumptions and limitations section of chapter one. Family functionality has been defined by Westley and Epstein (1969) as the transactional and systematic properties of family interaction as opposed to the intrapsychic characteristics of the individual family members. An operational definition of family functionality was established for this study through the FAD. The FAD assesses family functionality by means of an anchored scale which measures seven dimensions of family interaction.

Addiction is of widespread public concern costing millions of dollars each year in treatment, lost earnings, productivity, and erosion of the family unit. However, a conceptual understanding of the antecedents and consequences of addiction, does not seem to be very clear. The problem is further complicated by the situation that

some antecedents may also be seen as the consequences of addiction. Exploring some of the related concepts to addiction results in a list of variables clearly antecedent in nature. For example, recent medical research by Blum et al.(1990) claims to have identified a genetic component having a possible link to the pleasure center of the brain, which causes excessive pleasure seeking activities. Other related concepts such as maturation and family functioning can however, be seen as both antecedent and consequential to addiction. Huba and Bentler (1980) for example, support the notion that maturation plays a key role in the type of substances adolescents choose to abuse. Along with this, peer pressure has long been used to explain deviance among adolescents and this concept is supported by Glynn (1981). He advocates the idea that peer pressure can influence the use of substances in adolescents and young adults, possibly leading to addiction. Although these variables are presented as antecedents in these studies, it is equally plausible that they are also consequences of addiction. Therefore, for those variables whose position may not be clearly located on the conceptual paradigm for addiction, it seems that a logical approach would be to study their relationship with addiction without any reference to their being defined as antecedents or consequences.

This dilemma not withstanding, this study focused exclusively on the relationship between family functionality

and addiction variables. This study does not make any substantive statement about which variable comes first, but rather looks into the relationship in an exploratory context. However, in the phrasing of the hypotheses addiction reads as if it is the antecedent variable simply for the purposes of hypothesis testing.

Examining the relationship between family functionality and addiction appears warranted since the family is the unit most hurt by the problem of addiction. If social work practitioners knew the nature of this relationship, then individual and family clients might be handled more efficiently in order to curb the behavior of addiction or direct family functioning in the desired direction. Certainly, family functionality gives sanction to a variety of behaviors including addiction. For example, children who observe parental figures dealing with stress and problems through drug and alcohol consumption receive a nonverbal message condoning this behavior. On the other hand, addiction, which may completely develop outside the family environment, might have effects on the development and socialization patterns in the family. Family functioning might be just as much influenced by addiction as addiction is influenced by family functioning.

CHAPTER I

STATEMENT OF THE PROBLEM

1.Purpose of the Study

Specifically, this study was conducted to examine the relationship, if any, between family functionality and addiction. It attempted to explore the nature of this relationship by testing hypotheses about family functionality across seven dimensions, among a sample of subjects from the addicted treatment population and a random sample of subjects from the general population, i.e. by ascertaining their perceptions of family functionality as it relates to their families' of origin. The term functionality was defined through the FAD (please see appendix A), a standardized scale used to assess the functionality of a family unit. In this study the FAD examines the functionality of the subjects families' of origin across seven dimensions, problem solving,

communication, roles, affective responsiveness, affective involvement behavior control and general functioning. The family of origin was defined as the family unit in which the subject was raised consisting of parental figures and siblings. The hypotheses in this study were centered around these dimensions in the context of the family of origin, and were stated as follows:

1. Subjects from the general population will rate their families healthier on the dimension of family problem solving than subjects from the addicted population.

2. Subjects from the general population will rate thier families healthier on the dimension of family communication patterns than subjects from the addicted population.

3. Subjects from the general population will rate their families healthier on the dimension of family role behavior than subjects from the addicted population.

4. Subjects from the general population will rate their families healthier in the dimension of family affective responsiveness than subjects from the addicted population.

5. Subjects from the general population will rate their families healthier in the dimension of family affective involvement than subjects from the addicted population.

6. Subjects from the general population will rate

their families healthier on the dimension of family behavior control than subjects from the addicted population.

7. Subjects from the general population will rate their families healthier in the dimension of family general functioning than subjects from the addicted population.

The use of the term "healthier" is borrowed from the developers of the FAD scale who use it to indicate higher and/or better levels of functioning across the dimensions of family functionality. This will be discussed in detail in the instrumentation section.

2. Need for the Study

This investigation attempted to contribute to knowledge surrounding the relationship between family functionality and addiction. Current literature does not give a clear conceptual understanding of this relationship with the exception of certain studies, and even then the discussion is incomplete. Rees and Wilborn (1983) studied the parental practices of parents who had adolescents with substance addiction in their families. One of the variables they examined was family communication which was also

scrutinized in this study. They found the parent's methods of communication with their offspring to be inconsistent and distorted. However, what was not made clear was if these communication patterns existed prior to the addiction or came about as a consequence of the addiction. Therefore, the relationship between these two variables remains undefined in that it is not known if the distorted communication is a cause or a consequence. Furthermore, other aspects of family functioning were not considered in this study. Additional studies have indicated a lack of any relationship between addiction and family functionality. Binion (1982) concluded that families of drug addicts do not necessarily show any severe pathology in family functionality. This implies that families with addicted members are just as functional as families without any addicted members. She did admit addicted families have problems but these problems are not unlike the problems of general families. Similarly, Pollock et al. (1990) found no significant relationship between behavior control and alcoholism. They reported that having an alcoholic father did not statistically increase the likelihood of physical abuse towards male children.

Additional studies have produced different findings and have dealt with the problem under consideration in a more direct manner. Liepman, et al. (1989) reported a general improvement in family functionality when alcoholic husbands

ceased ethanol consumption. Likewise, Barnes (1984) concluded that well functioning, nurturing families were a significant deterrent to adolescent addiction.

Thus, there is a need to further the knowledge base in the area of addiction and family functionality. There is also a need to disentangle the current conflicting investigations and to examine specifically, variables associated with family functionality and addiction. This investigation can not completely fill all these needs but can begin to help shed some light, at least, on the relationship between family functionality and addiction.

Another contribution of this research is related to social work clinical practice with the families and their addicted members. By clarifying this relationship between family functionality and addiction, social workers might be able to handle addicted individuals and/or their families in a more effective manner in the future. This study can not completely define the nature of this relationship, but it can begin to work toward that end.

In summary, the necessity of this investigation can be illustrated through two areas: 1) the current knowledge base can be expanded in regards to family functionality and addiction, 2) clinical practice would also benefit from additional knowledge about this relationship.

3. Assumptions and Limitations

This study assumed that both groups of subjects provided unbiased data in response to items on the FAD. In addition, assumptions were made that regardless of race, gender, income, education level, age, marital status, or type of addiction a relationship exists between family functionality and addiction. Furthermore, it was assumed that due to the large number of subjects in each sample the data are representative of their respective populations.

Another assumption related to the two different ways in which the FAD was administered to the groups. The general population responded to the scale via a phone interview while the addicted population responded in person at their treatment facilities. The assumption was made that these two different procedures would not effect the nature of their responses and still produce meaningful data. Also it was assumed that while the random sample from the general population may contain some addicted members, this would not significantly bias the data produced by this sample. Furthermore, although primarily private-nonprofit chemical dependency facilities in the Memphis area participated in this study, where low income and minority clients tend to be over represented, it was assumed that the ones participating

are representative of all the public and private-nonprofit and profit making agencies in the Memphis metropolitan area.

The above mentioned assumptions may also be seen as limitations to this research. First, addicted members presumably contained in the sample from the general population might also have been the ones responding to the telephone interviews and thereby confounding the comparative findings of the study. Probability still exists that their numbers may have been significantly large enough to produce erroneous data. Secondly, the differences in the administration of the FAD to each group may have also had an effect upon the results. It is possible that those on the phone felt freer to respond more or less honestly than those in the treatment facilities. The subjects tested on the phone had more privacy while the addicted subjects may have felt influenced by the staff member's presence. Furthermore, if an addicted individual were interviewed on the phone then he could have been in denial of any aspects of addiction as they effected his family of origin. In addition, if the individual on the phone were not addicted but came from a family touched by addiction, and that family or individual had not resolved these issues, then that subject's responses could also have been biased in some manner. Thirdly, the fact that all subjects were asked to respond to the FAD based on their families of origin may

also be seen as something of a hindrance. Information about one's family of origin may not have been available to immediate recall. Memory of one's family may take on a selective pattern as one grows older. For functioning people, memory can become shaped and colored with events that reinforce self esteem. Likewise, for those in crisis and being in treatment, there may be the tendency to seek excuses about their current state of affairs. Thus, they may have predominately negative memories about their families. In addition, therapists sometimes tend to add to this negative memory recall by seeking out the negative aspects in patient's lives. Further, these data are at best assumed be to representative of the Memphis area only, and they they can not be generalized to other metropolitan areas.

Lastly, there are fifteen inpatient chemical dependency/addiction facilities in the Memphis area, as determined by the Memphis Alcohol and Drug Council. Of these facilities, six participated in the study, and of the six, one was private-profit making and five were private nonprofit. It is also a limitation that not all the facilities participated, and five of the participants were private nonprofit facilities. Thus, the data produced could have been effected by 1) not having available all the clients of these facilities as study subjects, and 2) having the majority of the subjects come from possibly low socio-economic backgrounds. However, it should be pointed

out that some individuals may have been initially treated at private facilities, but did not complete the recovery process because most insurance will only pay for twenty eight days of treatment. Consequently, with no further insurance benefits, they may have been forced to complete their recovery at a public facility.

CHAPTER II

LITERATURE REVIEW

1. Historical Considerations

Addiction, in the past, had been treated as an isolated disorder. Little attention was paid to the psychosocial factors associated with addiction. It has only been in recent years that research investigations shifted their attention to view addiction as a multivariate syndrome whereby it is intertwined with other psychosocial variables.

However, some early studies on addiction did take into account the influence of social variables. Cooley (1909) and Mead (1934) both investigated the role of family and peers in the maintenance of addiction and other deviant behaviors. They concluded that these disorders were the consequence of available, deviant peer groups and role models, and not the family. McCord and McCord (1962) studied alcoholic adult males and their families of origin.

They reported the subjects rejected their mothers and disapproved of their fathers. The authors claimed that their investigation offers evidence that the family socialization process contributes to the development of ethanol addiction.

2. Survey of Recent Research

At this time the current literature presents some conflicting points of view in regards to the relationship between family functionality and addiction. Some studies do not support the notion that a relationship exists. Pollock et al. (1990) studied the effects of parental alcoholism and physical abuse on the development of antisocial behavior in their children. The authors examined 131 subjects who had alcoholic fathers and compared them with 70 subjects whose fathers were not alcoholics. They obtained the subjects by examining the birth records of 9,006 consecutive births between 1959 and 1961 at the State University Hospital in Copenhagen. They identified those with alcoholic fathers by examining the records of the Municipal Alcohol Treatment Clinic records and Danish hospitals. Next, they determined

if the subjects had experienced any physical abuse by interviewing each subject in a 1-3 hour structured interview by trained clinicians. The investigators also assessed if any antisocial behavior had developed through a 1-2 hour structured interview. In both the preceding interviews the questions were developed by the investigators rather than using any standardized assessment device. Lastly, they screened for criminal activity by examining police records of the subjects. Their findings did not yield any statistically significant results on physical abuse, antisocial behavior, or criminal behavior. In other words, having an alcoholic father did not increase the likelihood of being physically abused or developing antisocial behavior later in life. This particular study has relevance to the study of the relationship between family functionality and addiction in that it implies that addiction to alcohol does not increase the occurrence of family dysfunction. This implication further supports the notion that there is no relationship between addiction and behavior control. Behavior control is one of the dimensions of the FAD and will be discussed in detail in the instrumentation section of chapter 3.

Binion (1982) studied differences in psychosocial aspects of early family experiences in heroin addicted men and women. She examined 170 females and 202 males in methadone treatment centers in Detriot, Los Angeles, and

Miami. The subjects were issued questionnaires which elicited information about psychological states, personal relationships, attitudes, parenting, family and personal background, drug use, and demographic data. They were asked to respond to the instrument, which was developed by the investigator, based upon their perceptions of their family of origin. She reported in her findings that heroin addicts were raised in families that function well with two parents who got along reasonably well. In addition, she reported that gender differences did exist. Females were more likely to seek out an addict peer group due to poor self esteem or an unhappy home situation, while males reported difficulties outside the family associated with school, poverty, and peers. Peer group influence was a more important factor in male initial drug use. Both groups reported more favorable perceptions of their mothers versus their fathers. In conclusion, the author reported that the families of heroin addicts lack any severe pathology in family functioning, but differences did exist in male and female perceptions. Therefore, her study does not support any relationship between the subjects' heroin addiction and family functionality.

While the previous studies do not seem to convey a relationship between family functionality and addiction, much of the literature presents a different point of view. Rees and Wilborn (1983) studied drug abusing adolescents and

their families with nondrug abusing adolescents and their families. They selected 26 adolescents from a private drug treatment hospital and 26 adolescents from similar socieoeconomic and geographical distributions for the purposes of comparing the two groups. The focus of the investigation was on child rearing practices of parents of drug abusing adolescents and those of nondrug abusing adolescents. In addition, a distortion measure between adolescents' and parents' perceptions on parental behavior was assessed as a possible indicator of adequate or inadequate family communication and as indicator of how the adolescent believes the parent acts. The Parent Attitude Survey (PAS) was used to assess child rearing attitudes of parents. The Child's Report of Parental Behavior Inventory-Revised (CRPBI-R) was utilized to assess parental behavior from the viewpoint of the adolescent, and parental behavior as the parent believes the adolescent will report it. Lastly, they used the Self Esteem Inventory (SEI) to assess the adolescent's self esteem. The results showed that nondrug abusing subjects scored significantly higher on the SEI than did the drug abusing subjects. Nondrug abusing subjects had less distortion as measured by the CRPBI-R than did the drug abusing subjects. In addition, the nondrug abusing subjects rated their parents higher on the CRPBI-R than did the drug abusing subjects. Parents of the nondrug abusing subjects also scored higher on the PAS than did the

parents of the drug abusing adolescents. One of the authors' conclusions about these findings is that the families of drug abusing subjects have a lack of open and relevant communication. Thus, their study offers support for a relationship between communication patterns in the family and addiction to drugs.

Barnes (1984) studied adolescent alcoholism among 124 families. She developed a scale which assessed alcohol consumption, alcohol related problems, problem drinking, deviant behaviors, and parental nurturance. One of her hypotheses asserted that parental nurturance and support are negatively associated with adolescent alcoholism. Her findings supported this particular hypothesis and thus, concluded that family dysfunction as it relates to lack of parental nurturance is related to adolescent alcoholism. This lends support to a relationship between affective involvement and responsiveness and adolescent alcohol addiction. However, from her study it is not clear if the alcoholism was a result of the lack of nurturance or if the lack of nurturance resulted from parental frustration over the alcoholism.

Liepman et al. (1989) tested 20 alcoholic male veterans and their steady mates of at least six months on the FAD utilizing a repeated measures analysis. The couples were given two copies of the FAD, one for periods of abstinence, and one for periods of use of alcohol. They found that both

partners perceived family functioning to be healthier in dry periods in contrast to wet periods. Their study indicates a relationship between family functionality and addiction in regards to alcohol as assessed by the FAD.

Kosten et al. (1986) studied eight adult opiate addicts and their families' level of functioning. They assumed that there was dysfunction as a result of the addiction and hypothesized that this would be improved by having the subjects begin treatment with naltrexone, an opiate antagonist, and having the families begin multi family therapy (MFT). The families were rated by clinicians who viewed videos of the MFT sessions on global functioning, problem solving, structure, autonomy and affect. The rating scales were developed by the investigators. They found that the families moved from a chaotic interaction pattern to a more stable family structure possibly as the result of either the abstinence or the MFT or both. Although this study primarily examines treatment methods, it, in an indirect way still illustrates a relationship between family functionality and addiction.

In addition to the research studies presented above, the relationship between family functionality and addiction has been the major subject area of some published books. Bowen (1990) in his book on family therapy devotes a chapter to alcoholism and the family. In this chapter exploring theoretical concepts, clinical patterns, and family and

systems therapy, he offers theoretical support for a relationship between family functionality and alcohol addiction. A circular pattern of escalating anxiety exists in the family associated with the alcoholic's consumption and the family's reaction to that consumption. The author concludes that if the family could control its anxiety then the problem could become manageable and consumption could be dealt with on an effective basis.

Steinglass et al. (1987) in their book on alcoholism and the family cover a wide variety of areas associated with families and alcohol addiction. Among these are family systems and alcoholism, the life history model of the alcoholic; the early, late, and middle phases of development, and treatment. One of the concepts they deal with is problem solving in the family with an alcoholic. They note that problem solving behavior is not exhibited by members unless alcohol is consumed. The same is true of families in that they may not utilize their problem solving skills until the alcoholic begins to drink. Then the family uses its skills to deal with the crisis at hand.

Kinney and Leaton (1987) have also published a book dealing with a wide range of issues associated with alcoholism. These include medical, etiology, behavior, family, and treatment issues. The alcoholic is quite frequently emotionally isolated in general. This is true in his own family as well. The family walls off the alcoholic

in order to deal with him. Thus, the alcoholism appears to be related to the family's affective involvement. The authors also note that alcoholic families have masked communication patterns. These are implemented by the family in order to avoid issues which are too painful to address directly.

Johnson (1980) who published a book dealing with alcohol addiction, is in agreement with Kinney and Leaton, with regard to the isolation of alcoholics, thus relating alcoholism to the affective dimension of family functionality.

In summary, the preceding review of literature illustrates two points. First, some of the work does not offer support for a relationship between family functionality and addiction. However, the majority do support this relationship in one way or another. The previous works which are cited here examined various sub-groups for example, adults, adolescents, and different types of substance abuse, i.e. alcohol, heroin, opiates, etc. but they all had one thing in common; discussion of the relationship between family functionality and addiction. This study is inspired by this common theme and yet looks at the relationship in not just one sub-group or one type of addiction, but in all sub-groups and addictions that might be represented by the samples drawn without making any distinctions among them at this point. Lastly, the

literature reviewed here appears to come from various directions in regards to sub-groups and type of addiction. This is due to a lack of extensive research conducted in this area. An exhaustive data base search as well as a review of journals was conducted prior to the beginning of this study. The results of that search were presented here.

CHAPTER III

METHODS AND PROCEDURES

1. Sample

The subjects for this study were divided into two sample groups. The groups were defined as the general population sample, N=304, and the addicted population sample, N=154. The general population sample was produced through random selection from the population of the Memphis metropolitan area. The metropolitan area was defined as the Memphis city limits and the surrounding suburban communities of Bartlett, Germantown, Cordova, and Collierville within the state of Tennessee. Selection of this sample group was accomplished with the assistance of a private research organization. This organization was well recognized and qualified in the area of sample production. They handle various marketing and political survey studies, and thus, routinely and repeatedly produce general population samples

for these surveys. A meeting was set up with officials of the organization and the design of the investigation was discussed. It was agreed that a random sample of the Memphis area could be produced for the study.

The method by which the sample was selected involved dividing the city into regions established by 1990 census tracts. Next, a telephone overlay was utilized to further section off the city according to telephone prefixes. Then a random number generating system produced the four digit suffixes to be dialed in each prefix area. The phone calls wee made and those meeting the criterion of being 18 years of age or older and able to respond to the questions were interviewed. The age of 18 was selected so as not to be entangled with the problems of parental consent.

The general population sample had a limitation in that it was not screened for addiction in order to insure a true random sample. As previously mentioned, the assumption was made that the percentage number of addicted subjects would be no greater than that of the whole population under consideration. Therefore, it is also assumed that their responses would not significantly influence the results. The large number included in the sample gives support for this assumption. Foote (1990) estimates the percentage of the Memphis population which is addicted to be approximately 14%. In addition, there was no means of eliminating subjects who may not have been addicted, but came from a

family touched by addiction in some manner.

The addicted sample was selected from the local chemical dependency facilities, both public and private. Each facility, within the same geographic area used for the selection of the general population sample, was contacted concerning the study. A meeting time with the program directors of each facility was established for the purpose of explaining the study and demonstrating how confidentiality could be maintained. This was very important because of the need for these facilities to guarantee their patients the right to total privacy during treatment. All patients at the participating facilities, at or over the age of 18 (again for eliminating parental consent problems) and willing to take part in the study, were included in this sample. This included inpatients as well as after care patients who had already been through inpatient treatment. Inclusion of all patients was necessary to gain an adequate sample because of the small populations maintained at each facility. It is important to emphasize that all participation by the patients was strictly voluntary. They had the program explained to them and then were allowed to decide to participate or not to participate. This was also an important point in gaining the cooperation of the various facilities.It is important to acknowledge also that participation of the treatment facilities was voluntary. It was previously noted in

chapter 1 that six of fifteen treatment facilities participated in this research. Most of the facilities which did not participate did not refuse to do so. Their lack of participation centered around time constraints for completion of this study. Several of the nonparticipating facilities required anywhere from a month to several months to provide approval for participation thus, it was not possible to include them.

Some of the characteristics of the addicted population limiting the study need to be acknowledged as well. Five of the six facilities participating in this study were private nonprofit facilities. Thus, it may be possible that this particular sample contains a high percentage of subjects from the lower socieoeconomic strata. However, the assumption is made that the large sample size is representative of the addicted treatment population, and that some high socieoeconomic subjects may also be in the sample as well due to stipulations associated with their insurance coverage.

2. Instrumentaion

The instrument used to assess family functionality in this study was the Family Assessment Device (FAD) (appendix A). A review of several related scales was made prior to the beginning of the research. This particular scale was selected based on its refinement over the years as well as the reported reliability and validity scores.

The FAD was developed by Nathan Epstein, Lawrence Baldwin, and Duane Bishop (1983). It was based on the McMaster model of family functioning Walsh (1982). The FAD is made up of seven scales which measure problem solving, communication, roles, affective involvement, affective responsiveness, behavior control, and general functioning.

Problem solving is the family's ability to solve problems at a level that maintains family functioning. This dimension assess two types of problems, instrumental and affective. There also are seven stages in the process of problem solving which are: identification of the problem, communication of the problem to the appropriate person(s), development of action alternatives, decision on one alternative, action, monitoring the action, and evaluation of success. It postulated that this process is most effective when all stages are carried out, and least

effective when the first stage is not accomplished, i.e. the problem is not even identified.

Communication is the exchange of information between family members. The focus is on two dimensions, i.e. whether messages are clear and if members communicate directly about instrumental and affective areas. It is assessed on the basis of combinations of dimensions, i.e. clear/direct versus clear/indirect, and masked/ direct versus masked/indirect. It is postulated that the most effective is clear and direct while the least effective is masked and indirect.

"Roles" refers to an established set of behaviors for maintaining the family such as provision of resources, support, adult sexual gratification, personal growth, etc. In addition, the "roles" dimension also assesses if tasks are clearly and equitably assigned to family members and accountability is handled for them. There are two functions assessed by the roles dimension, 1) necessary and 2) other. Further, there are two areas of family functions, instrumental which includes provision of resources, and affective which includes nurturance and support as well as adult sexual gratification. Mixed areas include life skills development and systems management. It is postulated that this dimension is most effectively handled when roles are clearly allocated to appropriate individuals and accountability is built in. It is least effective when

these functions are not addressed and/or allocation and accountability is not built in.

Affective responsiveness assesses how well the family can experience appropriate affect over a variety of stimuli. There are two groupings, 1) welfare emotions and 2) emergency emotions. It is postulated that this dimension is most effectively handled when a full range of responses is appropriate in amount and quality to stimulus. It is least effective when the range of affects is narrow and/or amount and quality is distorted.

Affective involvement focuses on how much family members are interested in, and place value on, each other. Six styles of involvement are identified:1) absence of involvement, 2) involvement devoid of feelings, 3) narcissistic involvement, 4) empathic involvement, 5) overinvolvement, and 6) symbiotic involvement. It is postulated that the most effective is empathic involvement, while the least effective is symbiotic involvement and absence of involvement.

Behavior control centers on how standards of behavior are maintained over a variety of situations, including dangerous situations, psychobiological needs and drives; e.g. eating, sleeping, eliminating, sex, and aggression; and socialization inside and outside the family.

General functioning assesses the overall health and pathology of the family along with all of these six

dimensions. It is a composite entity.

Miller et al.(1985) reported test-retest reliability on each of the seven scales of the FAD as follows: problem solving (.66), communication (.72), roles (.75), affective responsiveness (.76), affective involvement (.67), behavior control (.73), and general functioning (.71). Concurrent validity was established by administering the FAD, and FACES II to the same subjects. Faces II is a scale based on the Olsen Circumplex Model of Family functioning (Olsen, Sprinkle, and Russell, 1979), and has been reported to have a high level of internal consistency (.80-.91). The overall correlations between these two scales were close to the predictions made and offer good evidence for the concurrent validity of the FAD.

The FAD is a sixty item anchored, self report scale. The respondents read a statement then check if they strongly disagree, disagree, agree, or strongly agree to the item. The scores produced on each scale range from 1.00 (healthy) to 4.00 (unhealthy). The terms "healthy" and "unhealthy" are used by the scale developers. Completion takes about twenty minutes.

3. Data Collection

Both the addicted and general population samples were asked to respond to the FAD statements based on their families of origin. The general population sample subjects were administered the scale through a phone survey. Prior to the beginning of this phase of the study the researcher met with the team of interviewers from the previously mentioned private research organization to explain what was expected from them and to answer questions. The interview team was employed by the research organization and all were trained in this line of work. The interview team was not informed of the purpose of the study prior to the data collection. This insured that they would not bias the subjects in any way during the course of the interview. Subjects were assured of remaining completely confidential. When they answered their phones, the interviewer identified himself and explained the purpose of his call. Then the potential subject was asked if he was at least 18 years of age. If so, he then told the subject that he did not need to know his name and asked for the subject's permission to proceed with the interview.

The addicted sample's data were obtained by having a staff member in each chemical dependency facility administer

the scale to the patients 18 years of age or older. During the initial meeting with the program directors, the number of patients was determined and the appropriate numbers of scales were left with them. As with the general population sample, the patients were not informed about the purpose of the study prior to responding to the scale. As previously mentioned, this insured that their responses would not be biased. Thus both samples remained blind to the study's objectives. In addition, the patients were given a consent letter to sign prior to beginning their participation (please see appendix C). This letter informed them that their participation was strictly voluntary and they would not be jeopardized for their lack of participation. They then signed this letter and dated it, then a staff member witnessed the signature with his own and the letter was placed in the patient's chart. This procedure protected the researcher and the hospital from any future legal repercussions. By having the letter placed in the chart, confidentiality of the patient was maintained in that the researcher had no identifying information about the subject when the scales were picked up from the hospital.

In addition to the FAD, demographic data were obtained from both groups. This information included age, education, income, marital status, race, and gender. For each subject a score, ranging from 1.00 (healthy) to 4.00 (unhealthy), was produced for each of the seven subscales, i.e. the lower

the score the healthier the subject perceived his family of origin on the dimension of concern. The term healthy corresponds to the terminology of the scale. These scores are the basis to the statistical analysis.

After the data were collected, the information on both sample groups was entered into a computer system for the purpose of scoring the FAD and statistical analysis. Two identical sets of programs were set up to handle the data from both groups (please see appendix B). The first program accepted the sixty six columns of data produced on each subject. The first six columns represented coded demographic data in the order of age, education, income, marital status, race, and gender. The next sixty columns were the responses to the FAD. The program stored the columns into a file to be used in calculating the scores for each of the seven subscales. Once all the subjects were entered, a second program read the data and produced the scores which were entered along with the demographic data into another file. This procedure was repeated for both sample groups producing two separate files. In both files the layout (fields) of the data were as follows: one column identification code for sample of addicted or general population, three columns for subject number, and one column each for age code, education code, income code, marital status code, gender code, and race code, followed by three columns each for problem solving score, communication score,

roles score, affective responsiveness score, affective involvement score, behavior control score, and general functioning score.

After the preceding procedure, both files were combined for the purpose of statistical analysis. The BMDP statistical software package was used to run a two tailed t test for independent samples. An independent samples test was used for the reason that the two sample groups could be considered as coming from two independent populations. Furthermore, a two-tailed non directional t-test was employed since there was no clear theoretical support for directional testing. The probability (p) level of 0.05 was apriori set as the level of significance to reject the null hypotheses.

CHAPTER IV

RESULTS

This study utilized a total of 458 subjects. The the addicted population sample had 154 subjects and the the general population had 304 subjects. The demographic data are summarized in tables 1-4. Table 1 lists the age characteristics of the addicted sample, the general population sample, and both samples together. Table 2 lists the education characteristics of the addicted sample, the general population sample, and both samples together. Table 3 lists the income characteristics of the addicted sample, the general population sample, and both samples together. Table 4 summarizes the marital status, race, and gender of the addicted sample, the general population sample, and both samples together.

The data in table 1 show that in the addicted sample ages are concentrated in the lower age brackets (over 92%), while the general population sample has a lower concentration in these brackets with a more even distribution in the upper brackets. Table 2 reveals that

the general population sample has a higher concentration of subjects in the upper two education brackets (27%), while the addicted sample has a lower number of subjects in the same brackets (10.4%). Likewise, table 3 illustrates the same results for income characteristics. The addicted sample has less subjects in the upper two income brackets (7.8%), compared to the general population sample which has considerably more subjects in the same two brackets (44.1%). Table 4 shows that the addicted sample has a lower incidence of marriage as well as a higher number of blacks and males in contrast to the general population sample.

TABLE 1
AGE DISTRIBUTION FOR THE ADDICTED SAMPLE
THE GENERAL POPULATION SAMPLE
AND ALL SUBJECTS

AGE	ADDICTED	GENERAL	ALL
18 - 34	99 (64.3%)	97 (31.9%)	196 (42.8%)
35 - 44	43 (27.9%)	80 (26.3%)	123 (26.9%)
45 - 54	9 (05.8%)	49 (16.1%)	58 (12.7%)
55 - 64	3 (01.9%)	33 (10.9%)	36 (07.9%)
65 - up	0 (00.0%)	45 (14.8%)	45 (09.8%)

TABLE 2
EDUCATION DISTRIBUTION FOR THE ADDICTED SAMPLE THE GENERAL POPULATION SAMPLE AND ALL SUBJECTS

EDUCATION	ADDICTED	GENERAL	ALL
Less Than High School	34 (22.1%)	32 (10.5%)	66 (14.4%)
High School Graduate	49 (31.8%)	87 (28.6%)	136 (29.7%)
Some College	55 (35.7%)	103 (33.9%)	158 (34.5%)
College Graduate	12 (07.8%)	56 (18.4%)	68 (14.8%)
Post Graduate	4 (02.6%)	26 (08.6%)	30 (06.6%)

TABLE 3
INCOME DISTRIBUTION FOR THE ADDICTED SAMPLE THE GENERAL POPULATION SAMPLE AND ALL SUBJECTS

INCOME	ADDICTED	GENERAL	ALL
$0-$9,999	75 (48.7%)	62 (20.4%)	137 (29.9%)
$10,000-$19,999	40 (26.0%)	51 (16.8%)	91 (19.9%)
$20,000-$29,999	27 (17.5%)	57 (18.8%)	84 (18.3%)
$30,000-$49,999	8 (05.2%)	77 (25.3%)	85 (18.6%)
$50,000-up	4 (02.6%)	57 (18.8%)	61 (13.3%)

TABLE 4
MARITAL STATUS, RACE, AND GENDER DISTRIBUTION FOR THE ADDICTED SAMPLE THE GENERAL POPULATION SAMPLE AND ALL SUBJECTS

MARITAL STATUS RACE/GENDER	ADDICTED	GENERAL	ALL
Marital Status			
Married	55 (35.7%)	178 (58.6%)	233 (50.9%)
Not Married	99 (64.3%)	126 (41.4%)	225 (49.1%)
Race			
White	65 (42.4%)	194 (63.8%)	259 (56.6%)
Black	87 (56.5%)	105 (34.5%)	192 (41.9%)
Other	2 (01.3%)	5 (01.6%)	7 (01.5%)
Gender			
Male	93 (60.4%)	85 (28.0%)	178 (38.9%)
Female	61 (39.6%)	218 (71.7%)	279 (61.1%)

Hypothesis 1 stated that the subjects from the general population would rate their families healthier on the dimension of family problem solving, in relation to their families of origin, than subjects from the addicted population. The t-test used to test this hypothesis indicated a statistically significant difference, thus rejecting the null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family problem solving ($t = -5.85$, $df = 456$, $p \leq 0.0000$).

Hypothesis 2 stated that subjects from the general population would rate their families healthier on the dimension of communication patterns, in relation to their families of origin, than subjects from the addicted

population. The t-test used to test this hypothesis showed a statistically significant difference, thus rejecting the null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family communication patterns ($t = -8.80$, $df = 456$, $p \leq 0.0000$).

Hypothesis 3 stated that the subjects from the general population would rate their families healthier on the dimension of family role behavior, in relation to their families of origin, than subjects from the addicted population. The t-test used to test this hypothesis indicated a statistically significant difference, thus rejecting the null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family role behavior ($t = -4.53$, $df = 456$, $p \leq 0.0000$).

Hypothesis 4 stated that the general population would rate their families healthier on the dimension of family affective responsiveness, in relation to their families of origin, than subjects from the addicted population. The t-test used to test this hypothesis indicated a statistically significant difference, thus rejecting the null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family affective responsiveness ($t = -5.74$, $df = 456$, $p \leq 0.0000$).

Hypothesis 5 stated that the general population would rate their families healthier on the dimension of family affective involvement, in relation to their families of origin, than subjects from the addicted population. The t-test used to test this hypothesis indicated a statistically significant difference, thus rejecting the null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family affective involvement ($t = -7.10$, $df = 456$, $p \leq 0.0000$).

Hypothesis 6 stated that the subjects from the general population would rate their families healthier on the dimension of family behavior control, in relation to their families of origin, than subjects from the addicted population. The t-test used to test this hypothesis indicated a statistically significant difference, thus rejecting the null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family behavior control ($t = -2.55$, $df = 456$, $p \leq 0.0111$).

Hypothesis 7 stated that the subjects from the general population would rate their families healthier on the dimension of family general functioning, in relation to their families of origin, than subjects from the addicted population. The t-test used to test this hypothesis indicated a statistically significant difference, thus

rejecting null hypothesis of no difference between the means of the two groups, with the general population scoring healthier on the dimension of family general functioning ($t = -7.03$, $df = 456$, $p \leq 0.0000$).

Table 5 lists the mean, standard deviation, t values, degrees of freedom, and p-values for each of the tests used in the statistical analysis.

TABLE 5
t-TESTS OF STATISTICAL SIGNIFICANCE FOR THE DIMENSIONS OF FAMILY FUNCTIONALITY BETWEEN GENERAL POPULATION AND ADDICTED GROUPS

DIMENSIONS	MEAN		STD.DEV.		t	df	p
	G.P.*	A**	G.P.*	A**			
Problem Solving	2.10	2.39	0.45	0.55	-5.85	456	0.0000
Commun-ication	2.15	2.53	0.40	0.49	-8.80	456	0.0000
Roles	2.25	2.42	0.34	0.45	-4.53	456	0.0000
Affective Response	2.24	2.54	0.47	0.62	-5.74	456	0.0000
Affective Involve.	2.22	2.55	0.43	0.55	-7.10	456	0.0000
Behavior Control	1.92	2.02	0.36	0.43	-2.55	456	0.0111
General Function	2.04	2.38	0.45	0.57	-7.03	456	0.0000

*G.P.-General Population ** A-Addicted

CHAPTER V

DISCUSSION OF RESULTS

Descriptive analysis of the demographic data appears to suggest several indications. The data on the distribution of age indicates that addicted subjects are young and middle aged. Over 92% of the addicted sample are between eighteen and forty four years of age, while 7.7% are between forty five and sixty four, with none over the age of sixty five. Kinney and Leaton (1987) point out that viewing addicted people as younger may be an erroneous assumption and the age distribution in this study may not be indicative of national age distributions. They reported that over 20% of the elderly also have a significant alcohol problem. Furthermore, the authors point out that the elderly may not receive treatment because the concerns on the elderly are ignored in our society. Because they are older, we show less concern for their substance abuse problems, assuming they have nothing left to live for anyway, but no one would hesitate to agree that a young man ought to receive treatment even though he may die tomorrow

in an accident. Thus the age distribution in this study may not reflect national trends with regards to who is affected by addiction, but seems to be indicative of national trends in relation to who are in the chemical dependency facilities.

In the education distribution over 50% of the addicted subjects had only a high school education or less while only 10.4% had a college degree or better. In contrast, only 39.1% of the general population subjects had a high school education or less while 27% had a college degree or higher. In addition, the income distribution shows similar trends. Among the addicted subjects 74.7% made less than $20,000 per year compared to 37.2% of the general population subjects. Furthermore, only 7.8% of the addicted subjects made more than $30,000 per year while 43.1% of the general population subjects were in the top two income brackets. Therefore, the data on education and income appear to be related. Johnson (1980) points out that as addiction progresses there is a marked deterioration in the individual's personality as well his functioning. Thus, depending on the age of onset for addiction, an individual's ability to complete educational goals or hold a job appears to be jeopardized which is reflected in the demographic data.

Examination of the marital status, race, and gender distribution data suggests addicted individuals are less

likely to be married, more likely to be black, and are likely to be male. It appears that these data are indicative of the subjects in this study only, and not supportive of national trends of addicted individuals. There are no conclusive statistics which show addiction is higher among nonmarried individuals, blacks, or males. In fact, available information indicates that addiction is equally prevalent among either marital state, race or gender (Johnson 1980).

As previously mentioned, the FAD assesses seven areas of family functioning. The data reveal a significant difference in all of the seven areas between the mean scores for the addicted population and the general population, with the latter having significantly healthier scores than the former. This does not in any way indicate or imply that a dysfunctional family of origin caused anyone of the addicted subjects to turn to substance abuse in their adult life. What it does explicitly indicate is that there is a statistically strong relationship between family functionality and addiction. The exact nature of that relationship is unclear from the findings in this research, however; analysis of these results reveals some possibilities that may lead to a clearer conceptualization. Therefore, discussion of each of the seven scales and what they assess is warranted.

The problem solving dimension refers to the family's

ability to resolve conflicts which may threaten the overall functioning of the family. Effective resolution of these conflicts assists the family unit in maintaining efficient family functioning. Thus, from the results it seems evident that families touched by addiction in some manner are less adept at dealing with problem resolution. This finding appears to be in line with what Steinglass et al. (1987) report in their text. Families dealing with addiction are normally quite skillful at crisis problem solving since the addict can produce many situations which require immediate "band aid" solutions. However, they are only dealing with symptoms and not the real problems. Therefore, they may never get the opportunity to develop real problem solving capabilities but merely exist from crisis to crisis, thwarting growth in the family as a whole and in the individual members as well. The family has come to organize its regulatory behavior to accommodate the addicted individual, a view which is supported by Steinglass et al. (1987).

Examining the relationship from another direction reveals an additional point of view. An individual could come from a family which is dysfunctional because of some other cause, for example mental illness. It may be possible that a member of this family does not learn effective problem solving techniques while growing up. Without this skill he could become frustrated in his efforts to solve his

own adult problems and turn to substances to relieve his discomfort.

The second dimension of the FAD, communication, assesses the exchange of information among family members. The focus is on whether verbal content is clear and if it is directed at the person for whom it was intended or to someone else. It is found that the addicted population perceived their families' of origin communication as significantly less healthy than the general population. These findings are consistent with Rees and Wilborn (1983) who had also reported similar findings in that the families of drug abusing subjects lack open and clear communication. Thus, it is not unreasonable to state that communication in the addicted population's families of origin may be characterized as possessing content which is unclear and/or not directed at the appropriate family member. These findings also seem to support Kinny and Leaton (1987) who suggest that communication in addicted families is beset with avoidance transactions. This is communication which is used to avoid the real issues facing the family. In fact, they may be unable to speak the unspeakable since families with addicted members frequently have various issues and skeletons in the closet which are not to be confronted directly.

The dimension of family roles as measured by the FAD focuses on the established patterns of behavior for handling

a set of family functions which include provisions of resources, providing nurturance and support, supporting personal development, maintaining the family systems, and providing adult sexual gratification. In addition, it assesses if tasks were assigned equitably and carried out responsibly. This study found that the addicted population perceived their families of origin as doing poorly in this dimension compared to the general population. In addition, these individuals were less likely to have had tasks assigned efficiently or carried out responsibility in their families of origin. This implies that the addicted population came from homes that were poorly managed in the necessities that provide for a stable environment and nurturing atmosphere. Especially in relation to parental nurturance, Barnes' (1984) study yielded similar results.

Affective Responsiveness assesses the extent to which families are able to experience appropriate affect over a range of stimuli. Typically, addicted individuals are emotionally isolated and distant from others. The findings of this study indicate that addicted individuals perceive their families of origin as lacking in the expression of warmth and emotional closeness, thus restricting the range of affective expression within the family. This finding is supported by Johnson (1980) who discussed the emotional isolation alcoholics experience as well as their families. Therefore the members are unable to respond to emotional

stimuli with a full spectrum of feelings.

Affective Involvement assesses the extent to which family members are interested in each other's activities and concerns. The finding of this study is that the addicted population again perceived their families of origin as less functional than the did the general population. This means that as a family members became too involved in each other's problems or not involved at all. In addition, they may have only become involved in other's affairs when it was something of interest and thus were overly self centered. Kinney and Leaton (1987) support this finding by their discussion of isolation in the alcoholic family. Due to this isolation family members may have a lack of involvement with each other.

Behavior Control assesses the way in which a family expresses and maintains standards for the behavior of its members and if this control was flexible or rigid. However, the addicted population still perceived their families of origin as less functional than the general population. This indicates that their families were less likely to know what to do in emergencies, could get away with breaking rules easily, or had unclear expectations about psychobiological needs and drives. This finding is in disagreement with Pollock et al. (1990) who found no relationship between aggression and alcoholism.

The last scale assessed the overall family functioning

of the family. The addicted population perceived an overall lower functioning in their families of origin, as compared with the general population. It is felt that this lends support for the findings on the other six scales. Had this particular scale not yielded statistically significant data, then the other results would appear to be in conflict, because the general functioning scale assesses the same areas as the other six scales combined.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

This study attempted to contribute new knowledge to the existing body of information concerning the relationship between family functionality and addiction. There have been several studies that have dealt with this problem in one manner or another. However, there are conflicting findings in these studies. In addition, the methods used to assess the relationship have varied. Some used indirect methods while others employed more direct procedures. This study used a direct method to examine how addicted and general population subjects perceived their families of origin in terms of family functionality, without intending to establish a direction in the relationship. Based on the findings, it can be stated that a family dealing with an addicted individual may be quite dysfunctional.

Therefore, this research concludes that a relationship exists between family functionality and addiction. It further concludes that more research is needed to clarify the nature of the relationship. Of the areas examined with

regards to family functionality, which intricate aspects of these may have a more direct impact in understanding family functionality and addiction? More investigations are needed to establish direction in this relationship as well. A valuable contribution to this field would be in establishing if certain types of dysfunctional families produce addictive behavior in adulthood. Therefore, clinicians could intervene with potential addicts before they begin using addictive substances. However, it appears that there is not any one definitive answer to the relationship under examination here. Family functionality and addiction are highly complex issues with complex and difficult solutions. Further exploration into this area should reveal that the relationship is most likely a two way street, revealing that in some cases addiction is responsible for family dysfunction, and in others family dysfunction is responsible for addictive behavior. In either case, if more is understood about this relationship then clinicians could begin to focus their attention more on prevention rather than treatment. Lastly, attention should also be directed in future studies on how other variables such as race, gender, income, education, age and marital status effect or does not effect the relationship under consideration in this study. Examination of these variables may yield a still greater understanding and depth of information about working with families and their addicted members.

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APPENDIXES

APPENDIX A



Version 3

Nathan B. Epstein, M.D.
Lawrence M. Baldwin, Ph.D.
Duane S. Bishop, M.D.

The Brown University/Butler Hospital Family Research Program
Butler Hospital
345 Blackstone Boulevard
Providence, Rhode Island 02906

Date of Administration: _____

Family Role: _____

Identification Number or Family Name: _____

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FAMILY ASSESSMENT DEVICE
Brown/Butler Family Research Program

ID _____ _____ _____

1. Planning family activities is difficult because we misunderstand each other.

   _____ SA _____ A _____ D _____ SD _____

2. We resolve most everyday problems around the house.

   _____ SA _____ A _____ D _____ SD _____

3. When someone is upset the others know why.

   _____ SA _____ A _____ D _____ SD _____

4. When you ask someone to do something, you have to check that they did it.

   _____ SA _____ A _____ D _____ SD _____

5. If someone is in trouble, the others become too involved.

   _____ SA _____ A _____ D _____ SD _____

6. In times of crisis we can turn to each other for support.

   _____ SA _____ A _____ D _____ SD _____

7. We don't know what to do when an emergency comes up.

   _____ SA _____ A _____ D _____ SD _____

8. We sometimes run out of things that we need.

   _____ SA _____ A _____ D _____ SD _____

9. We are reluctant to show our affection for each other.

   _____ SA _____ A _____ D _____ SD _____

10. We make sure members meet their family responsibilities.

    _____ SA _____ A _____ D _____ SD _____

11. We cannot talk to each other about the sadness we feel.

    _____ SA _____ A _____ D _____ SD _____

12. We usually act on our decisions regarding problems.

    _____ SA _____ A _____ D _____ SD _____

13. You only get the interest of others when something is important to them.

_____ SA _____ A _____ D _____ SD _____

14. You can't tell how a person is feeling from what they are saying.

_____ SA _____ A _____ D _____ SD _____

15. Family tasks don't get spread around enough.

_____ SA _____ A _____ D _____ SD _____

16. Individuals are accepted for what they are.

_____ SA _____ A _____ D _____ SD _____

17. You can easily get away with breaking the rules.

_____ SA _____ A _____ D _____ SD _____

18. People come right out and say things instead of hinting at them.

_____ SA _____ A _____ D _____ SD _____

19. Some of us just don't respond emotionally.

_____ SA _____ A _____ D _____ SD _____

20. We know what to do in an emergency.

_____ SA _____ A _____ D _____ SD _____

21. We avoid discussing our fears and concerns.

_____ SA _____ A _____ D _____ SD _____

22. It is difficult to talk to each other about tender feelings.

_____ SA _____ A _____ D _____ SD _____

23. We have trouble meeting our bills.

_____ SA _____ A _____ D _____ SD _____

24. After our family tries to solve a problem, we usually discuss whether it worked or not.

_____ SA _____ A _____ D _____ SD _____

25. We are too self-centered.

_____ SA _____ A _____ D _____ SD _____

26. We can express feelings to each other.

_____ SA _____ A _____ D _____ SD _____

27. We have no clear expectations about toilet habits.

_____ SA _____ A _____ D _____ SD _____

28. We do not show our love for each other.

_____ SA _____ A _____ D _____ SD _____

29. We talk to people directly rather than through go-betweens.

_____ SA _____ A _____ D _____ SD _____

30. Each of us has particular duties and responsibilities.

_____ SA _____ A _____ D _____ SD _____

31. There are lots of bad feelings in the family.

_____ SA _____ A _____ D _____ SD _____

32. We have rules about hitting people.

_____ SA _____ A _____ D _____ SD _____

33. We get involved with each other only when something interests us.

_____ SA _____ A _____ D _____ SD _____

34. There's little time to explore personal interests.

_____ SA _____ A _____ D _____ SD _____

35. We often don't say what we mean.

_____ SA _____ A _____ D _____ SD _____

36. We feel accepted for what we are.

_____ SA _____ A _____ D _____ SD _____

37. We show interest in each other when we can get something out of it personally.

_____ SA _____ A _____ D _____ SD _____

38. We resolve most emotional upsets that come up.

_____ SA _____ A _____ D _____ SD _____

39. Tenderness takes second place to other things in our family.

_____ SA _____ A _____ D _____ SD _____

40. We discuss who is to do household jobs.

_____ SA _____ A _____ D _____ SD _____

41. Making decisions is a problem for our family.

_____ SA _____ A _____ D _____ SD _____

42. Our family shows interest in each other only when they can get something out of it.

_____ SA _____ A _____ D _____ SD _____

43. We are frank with each other.

_____ SA _____ A _____ D _____ SD _____

44. We don't hold to any rules or standards.

_____ SA _____ A _____ D _____ SD _____

45. If people are asked to do something, they need reminding.

_____ SA _____ A _____ D _____ SD _____

46. We are able to make decisions about how to solve problems.

_____ SA _____ A _____ D _____ SD _____

47. If the rules are broken, we don't know what to expect.

_____ SA _____ A _____ D _____ SD _____

48. Anything goes in our family.

_____ SA _____ A _____ D _____ SD _____

49. We express tenderness.

_____ SA _____ A _____ D _____ SD _____

50. We confront problems involving feelings.

_____ SA _____ A _____ D _____ SD _____

51. We don't get along well together.

_____ SA _____ A _____ D _____ SD _____

52. We don't talk to each other when we are angry.

_____ SA _____ A _____ D _____ SD _____

53. We are generally dissatisfied with the family duties assigned to us.

_____ SA _____ A _____ D _____ SD _____

54. Even though we mean well, we intrude too much into each others lives.

_____ SA _____ A _____ D _____ SD _____

55. There are rules about dangerous situations.

_____ SA _____ A _____ D _____ SD _____

56. We confide in each other.

_____ SA _____ A _____ D _____ SD _____

57. We cry openly.

_____ SA _____ A _____ D _____ SD _____

58. We don't have reasonable transport.

_____ SA _____ A _____ D _____ SD _____

59. When we don't like what someone has done, we tell them.

_____ SA _____ A _____ D _____ SD _____

60. We try to think of different ways to solve problems.

_____ SA _____ A _____ D _____ SD _____

The authors use the term healthy and unhealthy to describe certain items. The unhealthy items are numbers: 1,4,5,7,8,9,11,13,14,15,17,19,21,22,23,25,27,28,31,33,34,35, 37,39,41,42,44,45,47,51,52,53,54, and 58. The items which pertain to each dimension are as follows: Problem Solving, 2,12,24,38,50, and 60; Communication, 3,14,18,22,29,35,43, 52, and 59; Roles, 4,8,10,15,23,30,34,40,45,53, and 58; Affective Responsiveness, 9,19,28,39,49, and 57; Affective Involvement, 5,13,25,33,37,42, and 54; Behavior Control, 7, 17,20,27,32,44,47,48, and 55; General Functioning, 1,6,11, 16,21,26,31,36,41,46,51, and 56.

APPENDIX B

This program is a data input program to enter subject data for the Family Assessment Device (FAD).
First an external file named INX.DAT is opened to find out what is the current ID number. Then the ID number is written out to an external file called NUMBERS.DAT. This file holds the raw FAD data which is then processed by a program DO_CALC.PAS. The program then prompts for the demographic data and writes it out as it goes. Then the program prompts for the 60 subject responses and writes them out as well.

After the 60th response, a bell rings and you may enter another client by pressing return or end data entry by pressing Ctl Z. If you choose to exit, the current ID is written out to IDX.DAT and the program ends.

Written: April, 1991 By Bonnie Tyndall

```
Program Input_Data (Input, Output, Idx, Data);
Const
        Bell = 7;
Var
        Idx:   text;
        Data:  text;
        Id,
        Age,
        Educ,
        Inc,
        Marital,
        Race,
        Gender,
        I,
        Pesp:  Integer;

Begin
             (*Get last ID used*)

  Open (File_Variable := Idx,
        File_name := Idx.dat,
        History := Old);
  Reset (Idx);
  Read  (Idx, Id)
  Close (Idx);

             (*Open data file*)

  Open (File_variable := Data,
        File_name := Idx.Dat,
        History := Old);
  Extend (Data);
  Writeln ('Press Return to begin');
```

```
While Not EOF (Input) Do
Begin

          (*Increment ID number and write it out*)

ID := ID + 1;

If ID - 10 THEN
  WRITE (Data, '00':2, ID;1);

If (ID = 10) AND (ID - 100) THEN
  WRITE (Data,'0':1, ID:2);

IF ID = 100 THEN
  WRITE (Data,ID:3);

          (*Get demographic data*)

  WRITE ('Enter client age ':17);
  READLN (Age);
  WRITELN;
  WRITE (Data, Age:1);

  WRITE ('Enter client education ':23);
  READLN (Educ);
  WRITELN:
  WRITE (Data,Inc:1);

  WRITE ('Enter client income ':20);
  READLN (Inc);
  WRITELN;
  WRITE (Data,Inc:1);

  WRITE ('Enter client marital ':21);
  READLN (Marital);
  WRITELN;
  WRITE (Data,Marital:1);

  WRITE ('Enter client race ':18);
  READLN (Race);
  WRITELN;
  WRITE (Data, Race:1);

  WRITE ('Enter client gender ':20);
  READLN (Gender);
  WRITELN;
  WRITE (Data,Gender:1);

  WRITE (Data,' ':1);

          (*Get client's 60 responses*)
```

```
    FOR I := 1 to 60 DO
    BEGIN
     WRITE ('Enter response ':15.I:2,'  ':3);
     READLN (Resp);
     WRITELN;

     WRITE (Data,Resp:1);
     WRITE (Data, ' ':1);
    END;

    WRITELN (Data);

             (*Another Client*)

    WRITELN (Chr(Bell),'Press Return to enter another client
             or Ctl Z to exit);

 END;

 Close (Data);

             (*Write current Id number out for next time*)

 OPEN (File_Variable := Idx,
 File_Name := 'Idx.Dat',
 History := Old);
 IF Id = 10 THEN
   WRITELN (Idx, Id:1);
 IF (Id = 10) AND (Id - 100) THEN
   WRITELN (Idx, Id:2);
 IF Id = 100 THEN
   WRITELN (Idx, Id:3);

 CLOSE (Idx);

END;
```

This program reads raw FAD data from an external file. It then processes the data in the following manner:
1 - It checks to see if the response is an unhealthy response. If it is, it subtracts the response from 5 thereby inverting the response scale.
2 - It then assigns the item to the proper scale.
3 - Averages each scale appropriately.
4 - Writes the scores out to an external file.

```
Program Do_Calc (Input, Output, Data, Scores);
Var

      I,
      J:  Integer;
      Resp: Array [1..1000, 1..60] of integer;
      Set
      Prob_set
      Comm_set
      Roles_set
      Resp_set
      Involv_set
      Control_set
      Func_set,
                  Set of 1..60;
      Prob
      Comm
      Roles
      Response
      Involv
      Control
      Func:   Real;

              (*Main Program*)
Begin

      WRITELN ('Reading raw data in ..please wait..');

              (*Open Files*)

      OPEN (File_Variable := Data,
            File_Name := .Dat,
            History := Old);
      RESET (Data);
      OPEN  (File_Variable := Scores,
            File_Name := Scores.Dat);
      REWRITE (Scores);
      I := 0;

              (*Read in Data*)

      WHILE NOT EOF (DATA) DO
      BEGIN

        I := I + 1;
        READ (Data, Demo[I]);
        FOR J := 1 TO 60 DO
        Begin
          READ (Data, Resp[I,J]);
        END;
        READLN (Data);
    END;
    NUM_CLIENTS := I;
```

APPENDIX C

CONSENT FORM

I do hereby agree to participate in the study being conducted by Frank W. White through the University of Tennessee. I understand that I will be reporting on the behaviors of my family of origin. I understand that all information will be kept confidential and will be available only to Mr. White and his advisor, Dr. Cetingok.

I understand that I am participating voluntarily and can withdraw at any time with no penalties or loss of treatment from this facility. I also had the project explained to me orally by Mr. White and understand the procedures involved.

I further understand that if I have any questions or difficulties, I may contact Mr. White at 377-6275 at any time.

Signature_____

Witness_____

Date_____

VITA

Frank W. White was born in Fort Worth, Texas on September 23, 1953. He attended schools in various cities and graduated from Mandeville High School in Mandeville, LA. in May 1971. The following September he entered Louisiana State University and in May 1977 received a Bachelor of Arts in Psychology.

After several years in the field of business management he entered Graduate School at the University of Tennessee, Knoxville, and attended the College of Social Work, Memphis Branch. He received a Master of Science in Social Work degree in August of 1991.

The author is a member of the National Association of Social Workers. Mr. White will be employed as a Social Worker in a clinical setting following graduation.