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I am submitting herewith a dissertation written by Louis Murdock Smith III entitled "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.

Tricia McClam, PhD,
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We have read this dissertation
and recommend its acceptance.

Accepted for the Council:

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and Dean of The Graduate School

# THE NATURE OF RECOVERY:

# A QUALITATIVE STUDY OF CHEMICALLY DEPENDENT MALES

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Louis Murdock Smith III

May 1994

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# DEDICATION

This dissertation is dedicated to my wife, Linda, who continually encouraged me along this journey with its myriad obstacles and stumbling blocks. This work is also dedicated to my children, Nathan, Johanna, and Jessica, who patiently encouraged their father to do his homework while they did theirs.

As I complete this final stage in my journey to the doctorate, I wish to pay homage to my father, Louis Murdock Smith, Jr., PhD, who would have enjoyed the process once removed, and to my mother, Susanne Griswold Leinster Smith, the eternal encourager. Though they have passed through the portals of death into a greater life, their presence during this journey has ultimately brought about healing.

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transcribing the interviews; Diane Kitts for her assistance with the medical records research; and the excellent staff at Inter-Library Loan who have come to know me on a first name basis.

# ABSTRACT

Recovery is the goal of chemical dependence treatment, but little is known empirically about the process from the perspective of those receiving treatment and embracing recovery. Through the use of in-depth interviews, genograms, and medical record analyses, this research investigates the "story" of individual men identified as working a successful recovery program from chemical dependence. These research participants received treatment from either, or both, the inpatient and outpatient programs at the alcohol and drug treatment center at a university medical center. Using these qualitative research methods, their stories emerge from the data. Their stories tell of their recovery process, and the events, people, and insights ("success points") in treatment and recovery that helped them experience a transformation in their lives.

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# CHAPTER I

## INTRODUCTION

### INTRODUCTION

Recovery is a seemingly illusive state, a condition that often evades the person who is chemically dependent. For the person struggling mightily to break free from the hold of chemical dependence, recovery is perhaps a distant state of bliss, health, and wholeness seen as the dim light shining at the end of the long tunnel of treatment. Recovery may be a treasure lost, through the slow slide into relapse or from the momentary drop of the guard against old patterns of behavior. Recovery may be the goal so the judge will look kindly on the repentant and changed man, the probation or parole officer will go easier on the reformed law-breaker, or the wife will see that the marriage and family really can be different this time. Recovery may be one day at a time, one hour at a time, one minute at a time, or even not drinking or using right now. Recovery means many things to many people at different times.

Recovery to the uninformed healthcare provider may be the absence of mood-altering substances in the patient's drug screens. This is often the criterion of successful recovery for the courts, employers, schools, and football

coaches. This is not recovery. The absence of mood-altering substances in the body is sobriety, the first step of recovery. Recovery goes beyond just being alcohol- or drug-free. Recovery is infinitely more than "Just say no."

Recovery is being clean and sober, but it is also a transformation into a new expression of self. The transformation begins with the cessation of drinking and drug use and continues with the struggles of therapy, education, 12-Step meetings, recreation, and anything else that a treatment program (whether institutional or personal) demands. Recovery's transformation continues on with participation in aftercare group therapy or meetings, always more 12-Step meetings, a constant evaluation of residual behaviors and beliefs that need alteration, and an alertness to possible relapse back into the old ways. In the midst of all the demanding work, recovery does become a treasure--the pearl of great value--that has no price.

Recovery from chemical dependence is difficult to grasp, comprehend, or describe. This is true for the person who is chemically dependent, the healthcare professional involved in chemical dependence treatment, or a concerned family member, friend, or citizen. Most persons can recognize someone transformed by recovery, and say, "That's it!" Still there is a struggle to describe recovery beyond the use of either relatively simple phrases or statements of what it is not. Recovery is a concept, a process, an

experience, as well as a moment in time. Recovery can be recognized for what it is and for what it is not. There is one thing that is clear about recovery: it is the goal of those involved with chemical dependence treatment.

A better understanding of the nature of recovery from chemical dependence is needed. The experiences of both provider and patient are the primary sources of this improved understanding. Providers and prophets of chemical dependence treatment have been exceedingly generous in making their thoughts, theories, and research available on the nature of recovery. The same has not been true for those for whom recovery has a most intensely personal meaning. The "Big Book" (aka, Alcoholics Anonymous) is filled with anecdotes of "hitting bottom" and the salvation found in AA, but it is not an empirical study of the nature of recovery from chemical dependence. The present study sought to understand recovery from the perspective of the patient and not the provider. This patient perspective comes from the participants' stories of treatment and recovery, gathered through their interviews, genograms, and medical record analyses.

## SIGNIFICANCE OF THE STUDY

The value of this study was that it provided a new perspective on chemical dependence treatment and recovery.

Little or no research has been done that asks about the nature of recovery from the perspective of those who have been through treatment for chemical dependence. This does not discount the incredible value of existing empirical research, but it recognized that only part of the story has been told. The intent of this study was to provide some understanding of the unexplored part of the story--not unlike exploring the dark side of the moon. Additionally, this research looked at the nature of recovery for chemically dependent males, not from the traditional linear view of cause-and-effect, but from the holistic, inclusive, and comprehensive view of systems theory. The significance of this study was that it provides a perspective not previously available.

## RESEARCH QUESTIONS

The focus of this research is to address and answer the question: "What is the nature of recovery from chemical dependence for males who are identified as successful in their treatment and recovery?" A fundamental assumption in asking this question is that the individual, who is experiencing "successful recovery," is the primary and best source for understanding the nature of recovery from chemical dependence. The individual (or research participant) as a source of data "tells his story" during

the interviews, by the development of the genogram, and with analysis of the medical record (both for additional data and for triangulation of data).

Secondary research questions were concerned with issues developed from the effort to understand the nature of recovery. These four secondary questions focus on gender issues, the role of family of origin in treatment and recovery, medical records/triangulation of data, and success points of recovery.

First, how do gender issues affect the treatment and recovery process? The percentage of males identified as chemically dependent and in treatment is distinctly higher than the percentage of males in the population at large. An investigation of the probable significance of gender issues (especially ones relating to "the making of a man" or initiation/ transformation, fathers and sons, sexuality/spirituality, and gender role socialization) is at the core of this question.

Second, what is the impact of the family of origin on the research participant's recovery? Since people do not emerge fully developed from the head of Zeus, studying the influences of the intergenerational transmission of the beliefs and behaviors, and rules and roles received from the family of origin, is critical. The genogram was the tool used to elicit information, as were the interviews and medical record analysis of family information and treatment

involvement.

Third, do the "stories" presented by the research participants align with the information available in the medical record? Triangulation of data (checking out the "story") is essential not only because of the effects of mood-altering substances on cognitive and memory function, but also address concerns over prevarication and denial consistent with early stages of recovery from chemical dependence. This question is not asked with a sense of judgment or condemnation, but in recognition of the adverse and toxic effects of mood-altering chemicals on the physical, social, emotional, and spiritual state of the chemically dependent person.

Fourth, were there identifiable success points in the treatment and recovery process, and what were they? The purpose or concern of this question was to better understand "success" in treatment and recovery. If, for example, particular persons, events, program components, organizations, or therapeutic tools made a difference, then these success points became valuable information.

## DELIMITATIONS

There were clear parameters defined in this study. This is done principally to provide as much structure as possible when addressing a seemingly unstructured research

question, since the "nature of recovery" which was approached qualitatively rather than quantitatively. Sobriety can be quantified (one is either drug-free or not), but recovery can only be described in a holistic manner from a more subjective view. The delimitations are set to address this concern as much as possible.

All participants were adult males over eighteen years of age, living in Knoxville, Tennessee, or within one hour's drive from Knoxville. Their last treatment for chemical dependence (prior to their participation in this research) was through the same treatment center (Alcohol and Drug Recovery Center, UT Medical Center, Knoxville, Tennessee). The participants had a minimum of six months of recovery after completion of primary treatment, but were no more than twenty-four months post-primary treatment. These were all persons considered by clinical staff to be individuals who were succeeding in continuing recovery. There were no set educational requirements, but some ability to express themselves verbally was considered an asset. Additionally, there were no vocational requirements but all were either employed or attending college full-time. Though they did not necessarily grow up in urban areas, all the participants lived in the metropolitan area of Knoxville. All agreed to participate in this research without any coercive consequences, or anticipation of material gain.

## DEFINITION OF TERMS AND CONCEPTS

Several different terms and concepts used in chemical dependence treatment, family systems theory, and in this dissertation may not be familiar to all readers. The following definitions are offered as one means for the reader to become more familiar with some of the language and ideas of these fields of study.

**Chemical dependence and chemical abuse** are described by many different words or phrases (for example, psychoactive substance use, alcoholism, drug abuse, substance abuse, drug addiction, and chemical dependence). Chemical dependence is used herein to describe the state in which physical, emotional, social, and spiritual alterations have occurred, and continue until sobriety and recovery are embraced. The limited exception to this is in the case studies where specific mood-altering substances are identified. Chemical dependence is the third and final stage following the use and abuse of mood-altering substances.

Chemical dependence and abuse are identified in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition - Revised) (DSM-III-R) as disorders with the essential feature of "a cluster of cognitive, behavioral, and physiological symptoms that indicate that the person has impaired control of psychoactive substance use and continues

use of the substance despite adverse consequences" (DSM-III-R, 1987, p. 166). It is important to note that the symptoms of dependence are the same regardless of the psychoactive substance, even though there is variation in physiological responses. Nine characteristic symptoms are identified in the DSM-III-R, with at least three needed for a diagnosis of dependence [see Appendix E for the list of Diagnostic criteria for Psychoactive Substance Dependence].

Psychoactive Substance Abuse is a diagnostic category usually applied to those who have just started using mood-altering chemicals, or those psychoactive substances that are less likely to result in physiological withdrawal. It is a "Category for noting maladaptive patterns of psychoactive substance use that have never met the criteria for dependence for that particular class of substance" (DSM-III-R, 1987, p. 169). Unchecked abuse usually leads to dependence [see Appendix E for the list of Diagnostic criteria for Psychoactive Substance Abuse].

There are nine classes of psychoactive substances associated with both dependence and abuse: alcohol; amphetamine or similarly acting sympathomimetics; cannabis; cocaine; hallucinogens; inhalants; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; sedatives, hypnotics, or anxiolytics. One psychoactive substance is associated only with dependence and not abuse: nicotine. Other features of psychoactive substance use disorders are:

route of administration; duration of psychoactive effects; associated features; age at onset; complications; impairment; course; predisposing factors; sex ratio; differential diagnosis; nonpathologic psychoactive substance use for recreational or medical purposes; and repeated episodes of Psychoactive Substance-induced Intoxication. The individual psychoactive substance use disorders are listed in Appendix E.

**Family of origin**, a term from family systems theory, refers to the family in which one is born or adopted, and includes an individual, the parents and any siblings. From an intergenerational perspective, a family of origin would include at least three generations, so additional layers of aunts, uncles, cousins, and grandparents, great-aunts, and great-uncles would be added. The information about one's family of origin is not just the biological or genetic data, but also might include information about educational, vocational, cultural, ethnic, social, religious, sexual, and medical histories.

**Level of functioning** refers to the cognitive, behavioral, physical, academic, and emotional abilities of an individual, and that individual's ability to function within a particular context. When considered within the context of chemical dependence treatment and recovery, level of functioning refers to the ability to understand the educational components of treatment, process the

psychotherapeutic encounters appropriately, and attain sufficient intrapsychic insight. This is particularly relevant considering the incidence of dual diagnosis with persons who are chemically dependent.[1] With a lower level of functioning, a patient is usually less able to fully benefit from the treatment and recovery process.

**Mood-altering substances** are any substances external to the body that, regardless of the route of administration, result in an alteration of mood. Mood is "a pervasive and sustained emotion that [has] a major influence on a person's perception of the world" (Thomas, 1985, p. 1066). The alteration of mood may be either manic ("up") or depressive ("down"), depending on the psychopharmacological properties of the substance taken. These mood-altering substances include those listed in the DSM-III-R, but can include any substance that alters the body's neurochemistry (for example, extreme and excessive consumption of water alters the body chemistry and results in a "high").

**Nuclear family** is another family systems theory concept, and is the family we have created for ourselves through marriage, sometimes known as a family of creation. This is a family made up of husband/father, wife/mother, and children/siblings. In less traditional forms, there may not

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[1] Dual diagnosis, or dual disorder, refers to an individual's diagnosis of chemical dependence and, usually, some specific mental illness. See Daley, Moss, and Campbell (1987), and Evans and Sullivan (1990) for more information.

be legal connections or there may be "same-sex parents", but other dynamics remain the same or similar.

**Recovery** is a state of being beyond mere sobriety, or the absence of mood-altering substances, and is subjectively identified as further along the continuum toward restored health and wholeness. Most any person entering chemical dependence treatment can figure out "don't drink" or "don't use"--this is sobriety. Recovery is the stage that follows sobriety, and includes taking whatever additional steps are necessary in self-evaluation, behavioral modifications, and any other changes appropriate so one is no longer under the control, or influence, of the addiction(s). Not everyone attains recovery. Some persons relapse into old behaviors of use. Recovery is not an end, but is a process of transformation into an ever-evolving person.

**Sobriety** may be seen more as a physical state than an emotional, intellectual, or spiritual state of being. Sobriety is the absence of non-therapeutic mood-altering substances from the body. This definition does not preclude the use of psychopharmacological medications, prescribed by a knowledgeable physician aware of the individual's chemical dependence. Attaining sobriety varies according to the "life" of the drugs introduced into the body.

**Spirituality** is an important concept within most chemical dependence treatment and recovery. It is the recognition that there is a dimension, or power, greater

than that of human existence. The treatment and recovery community, particularly as expressed through the efforts of persons associated with Alcoholics Anonymous, makes a distinction between religion/ religiosity and spirituality. The emphasis on spirituality in chemical dependence treatment and recovery is in response to the often present strong narcissistic, ego-centered characteristics of those who are chemically dependent. The folk wisdom of the treatment and recovery community asserts that one must experience a "spiritual awakening" in order to succeed in treatment, and to move on into recovery. Transformation usually includes some component of an active spirituality.

**Success points** are those instances, understandings, events, or changes in the research participant's treatment (primary, secondary, or tertiary) that are identified as making a difference in attaining recovery from chemical dependence. These are the "things that made the difference" in a successful treatment, and facilitated moving into recovery. A success point could be the development of a relationship with one of the clinical staff members. It could also be the educational program, a "spiritual awakening," behavioral change, or intrapsychic insight.

**Transformation** is directly related to both recovery and success points. The difference between the patient who moves from dependence to sobriety, and the patient who moves from dependence through sobriety into recovery is

transformation. Success points are "symptoms" of a transformation experienced by the person who has entered into recovery. Like recovery, it is a subjective description that often arises out of a story of dependence, treatment, or recovery, and represents "a change in character or condition" (Webster's, 1971, p. 940). Transformation and conversion, as understood within a religious context, are similar. Transformation is a holistic experience, with changes in the physical, emotional, and spiritual aspects of the person transformed.

**Treatment** for chemical dependence in the American healthcare system usually follows a medical model because of affiliation with the hospitals, and insurance reimbursement perspectives. There are occasions when a person who is chemically dependent might enter into recovery without medical intervention, but the norm for treatment is within a center affiliated in some manner with a medical facility and under the directorship of a physician. Because of the normative nature of medical treatment for chemical dependence, treatment necessarily must be considered in that context for this research.

There are three stages to treatment (primary, secondary, and tertiary), with each having a distinct place on the time-line of treatment and recovery. Primary treatment takes place during the most active stages of treatment, which include detoxification and treatment center

care. This may take place within a hospital or medical center, at a residential treatment center, with a partial hospitalization or outpatient program, or some combination thereof. Primary treatment may take place every day of the week, five days a week, or three nights a week--each program has different requirements. The patient may be in primary treatment for two weeks to several months, often depending on such matters as economic resources available for treatment costs to licensing board or professional organization requirements for treatment. The level of intensity of treatment is a key to primary treatment.

Secondary treatment refers to that time following a regular discharge from treatment, regardless of what the abovementioned variables may be, into an aftercare or continuing care program. This level of treatment places less of a demand on the patient's time and resources (often there is no direct cost), but asks for a regular commitment of time for continuing recovery support by treatment peers and clinical staff. The norm for secondary care is one year, but it may go beyond that time for professionals such as physicians, nurses, or law enforcement personnel. Tertiary treatment follows discharge from secondary care, and is usually characterized by participation in support groups such as Alcoholics Anonymous or Narcotics Anonymous.

**Twelve Steps** are the foundation of self-help groups that have grown out of Alcoholics Anonymous. The premise

and success of Twelve Step programs come out of the process implicit in these Twelve Steps, with an emphasis on acknowledgement of a problem, helplessness with the problem, and recognition that the problem cannot be handled alone. The Twelve Steps of Alcoholics Anonymous follow but, with slight modification, they can serve most any group in need.

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous, 1976, pp. 59-60)

## ORGANIZATION OF THE DISSERTATION

This dissertation is presented in five chapters and five appendices. An extensive bibliography is also included.

**Chapter One:** The first chapter is the "Introduction" to the study, and includes a statement of the problem, significance of the study, research questions, delimitations, definition of terms and concepts, and organization of the dissertation.

**Chapter Two:** The second chapter, the "Review of Related Literature," includes an introduction, and sections on an introduction to the problem, models of addiction, family systems theory (addressed specifically to intergenerational family theory, genograms, and family systems theory and chemical dependence), gender issues, methodological procedures (case studies, qualitative interviews, and

medical record and document analysis), and a chapter summary.

**Chapter Three:** The third chapter is a presentation of the "Research Methodology" that includes an introduction, a discussion of confidentiality issues that relate to chemical dependence, the process of data gathering (participants, interviews, genograms, and medical records), data analysis (data management, interviews, genograms, medical records, and coalescing of data), methodological concerns (reliability, validity, and credibility), and chapter summary.

**Chapter Four:** The fourth chapter contains an introduction, analyses, and results of six case studies, each considered independently of each other. These case studies are based on the interview data, medical record data, genogram data, and genogram analyses. Each case study is divided into three parts: a description of the participant (before treatment and during treatment); family systems information (family of origin issues and genogram analysis); and interpretations and implications based on the research questions. The chapter concludes with a summary.

**Chapter Five:** The final chapter includes an introduction, a discussion of the conclusions drawn from all six of the case studies considered together, and the implications of these conclusions for treatment and recovery.

**Appendices**: The five appendices include information on the institutional review board proceedings (Appendix A), the participant information packet (Appendix B), a brief genogram interview outline (Appendix C), a genogram interpretive categories (Appendix D), and psychoactive substance criteria (Appendix E).

# CHAPTER II

# REVIEW OF RELATED LITERATURE

## INTRODUCTION

This research was conducted to obtain an understanding of the nature of recovery from the perspective of chemically dependent males. The purpose of Chapter II is to explore selected literature which is relevant to the development of such an understanding. The relevant areas are an introduction to the problem, models of addiction, family systems theory, gender issues, and methodological procedures.

## INTRODUCTION TO THE PROBLEM

For most people unfamiliar with the dynamics of chemical dependence, drug addiction and alcoholism usually are seen as separate problems. Not only are they inappropriately seen as separate and distinct health issues, but often they are judged differently because of a false distinction made about their "moral content." Drug addiction is characterized as a problem of deviancy, criminal behavior, and inner-city chaos, while alcoholism is treated more kindly as a reflection of its legality and the

general social acceptance of alcohol use. This is not the position taken by mental health professionals active in chemical dependence treatment. Whether the problem is drug addiction, alcoholism, or both, a unity of dysfunction is the predominant view. In the language of treatment and recovery, "a drug is a drug is a drug."

Another reason to see drug addiction and alcoholism under the umbrella of chemical dependence is the changing patterns over the last generation from single substance dependence to multiple substance dependence. Doweiko (1990) states that "Increasingly, one sees not alcoholism or drug addiction but poly-drug use in the same person. The implication is that if addicts find it so easy to switch addictions, perhaps these are not different diseases but different manifestations of a single condition: addiction" (p. 2).

When presented with the question of the prevalence of addiction, considerable problems arise. You can count the number of houses on a block, cars in garages, or people on a street, but how does one count the number of people who are alcoholics or drug addicts when professionals cannot agree on definitions or sources of data? The definitions of alcoholism, drug addiction, substance abuse, or chemical dependence move along a continuum from "no" through "possibly and probably" to "yes." Estimates of addiction vary from 10% of the American population to 40%, while

others postulate that 20% of Americans are addicted to chemicals while an additional 20% are steady users (Doweiko, 1990). The American Psychiatric Association (1985) estimated that 10 million adults and 3 million children and adolescents are alcoholic. This report also included an estimate of 500,000 heroin addicts, and at least 7 million people using prescription drugs without medical supervision. The number of studies making estimates of assorted chemical misuse appear endless, but the abovementioned give a description of the magnitude of the problem. In one way or another, most people are affected by chemical dependence, whether as one who is chemically dependent, as a family member or friend, as an employer or fellow worker, or as an innocent bystander caught in the aftermath of destructive behavior.

Considering the magnitude of the problem, successful treatment and recovery are paramount issues. Whether there are one hundred thousand or one hundred million persons addicted to mood-altering substance, successfully addressing treatment and recovery issues in central to the resolution of the problem. A principal goal is to attain knowledge of the differences between success and failure in treatment and recovery for chemical dependence.

There is considerable conjecture on the effectiveness of different theories or methods for chemical dependence treatment. Ellis, McInerney, DiGiuseppe, and Yeager (1988)

suggest that Ellis' Rational-Emotive Therapy is the best way to treat alcoholics and substance abusers. Monti, Abrams, Kadden, and Cooney (1989) see cognitive-social learning theory as the more effective base for treatment planning and implementation. Kaufman (1985a) and Freeman (1993) propose family systems theory as the appropriate theoretical perspective and clinical response for chemical dependence treatment. Edwards (1990) and Stanton, Todd, and Associates (1982) specifically propose structural/strategic family systems theory as the preferred method of treatment.

The divergence of opinion about chemical dependence continues with Larsen (1985) and Johnson (1980) considering the Twelve Steps of AA to be the approach that is at the core of successful treatment (as do most treatment providers), particularly as set out in Alcoholics Anonymous (1976) and Twelve Steps and Twelve Traditions (1981). In opposition to this position, Peele (1988, 1989) presents a "different vision of alcoholism" and a rejection of the "diseasing" of every human complaint, particularly when applied to chemical dependence treatment. Hester and Miller (1989) propose an "informed eclecticism" for treatment professionals. Cohen (1988) is concerned with the neurochemistry of addiction, Hofman (1983) with the biomedical aspects of addiction, and Frances and Miller (1991), Gallant (1987), and Nace (1987) look at addiction and its treatment from the viewpoint of medicine and

psychiatry.

There are additional suggestions from various sources on how particular professionals should approach chemical dependence issues. Apthorp (1985) and Clinebell (1984) offer counsel to clergy on alcoholism and drug abuse, while Smith (1991) addresses rehabilitation counselors.

As informative and valuable as the abovementioned are in understanding chemical dependence, and implementing effective treatment methods, they are one-sided. The research on chemical dependence treatment and recovery addresses multiple issues from the perspective of the provider, but not the participant. If successful treatment and recovery are to be better understood, then both provider and participant perspectives are needed. Clearly, there is a considerable body of research available[1], the overwhelming majority concerned with provider perspective issues. The same cannot be said about research on the participants' perspectives, since there is a paucity of empirical studies from this untapped perspective.

In this effort to understand treatment and recovery from chemical dependence, the participants' perspectives will be considered from two stances: family systems theory and gender issues. Family systems theory is generally

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[1] A computer search for journal articles (the descriptors were: alcoholism, substance abuse, drug abuse, drug addiction, chemical dependence, and addiction) in PsycLit (1/87-6/93) identified 14,978 articles, ERIC (1/82-6/93) listed 7,171, and Medline (1/89-9/93) listed 21,236.

external to the participant, while gender issues are generally internal. Clearly there is not a dichotomous split between family issues and gender issues with all the crossover points between family and self, but the starting points are different with one internal and the other external. Additionally, family and gender are principal points for definition when telling one's story--so much of who we are, how our lives take shape, and which choices we make are determined by our family and our gender.

There are four principal areas targeted in this review of related literature: models of addiction in chemical dependence, family systems theory, gender issues, and methodological procedures. The review of related literature for family systems theory focuses on three areas: intergenerational family systems theory, genograms, and family systems theory and chemical dependence. Methodological Procedures is divided into three parts (like Gaul): case studies, qualitative interviews, and medical record and document analysis.

## MODELS OF ADDICTION

The disease concept of addiction is the predominant model used in chemical dependence treatment centers, and fundamental to the "teachings" of Alcoholics Anonymous, Narcotics Anonymous, and other Twelve Step programs. Doweiko

(1990) writes that the disease concept or model defines chemical dependence as an illness, even a genetic or metabolic disorder. E. M. Jellinek (1960) first proposed that alcoholism is a disease, with symptoms and a progressive course that results in death if left untreated. Loss of control and a progressive course are the two key elements to Jellinek's understanding of alcoholism. The importance of Jellinek's work is in its departure from the view of alcoholism predominant at that time--alcoholism as a matter of moral weakness and lack of willpower. There can be no doubt that Jellinek's ground breaking work in "de-moralizing" addiction made possible great strides in understanding and treating chemical dependence.

The difficulty with the disease concept of chemical dependence is that it is too limiting. The disease concept easily becomes reductionistic, moving down to the linear cause-and-effect thinking that predominates medicine and the healthcare field. Clearly, chemical dependence is not just the physiological process of addiction--sobriety is not recovery. These are not new criticisms of the disease concept. Corlett (1990), Faulkner, Sandage, and Maguire (1988), Fillmore and Kelso (1988), and Peele (1989) all speak out against the disease concept. Peele (1989) writes:

> What is this new addiction industry meant to accomplish? More and more addictions are being discovered, and new addicts are being identified, until

> all of us will be locked into our own little addictive worlds with the other addicts like ourselves, defined by the special interests of our neuroses. What a repugnant world to imagine, as well as a hopeless one. (p. 4)

The difficulty with the disease concept of addiction is not that it is inherently wrong--disregarding Peele's diatribe--but that it tends to over-simplify, while ignoring the complexities of the addiction. A more comprehensive and inclusive model of addiction is called for when considering chemical dependence treatment and recovery.

The diversity of opinion about chemical dependence comes through some of the recent research about the many variables related to the disorder. Fuhrmann and Washington (1984), and Ward (1985) offer broad-based descriptions of concepts of chemical dependence treatment, while Asch (1984) is concerned with the conceptualizing of disability relative to chemical dependence, Abberley (1987) addresses chemical dependence and a moral point of view, and Hyland (1987) writes about social theory of disability and chemical dependence. Lang (1985) sees an interaction of the social psychology of drinking and sexuality. Galanter (1983) and Rosenstock, Strecher, and Becker (1988) explain chemical dependence using social learning theory. Frawley (1987) suggests a neurobehavioral model of addiction; Wilson (1987a & 1987b) suggests cognition is critical to understanding

alcoholism; Levy (1987) rejects the empirical evidence and suggests that individual psychotherapy might be an appropriate treatment modality for alcoholism; and Bucholz and Robins (1989) view alcoholism from a sociological perspective.

Though a diversity of suggested models of chemical dependence was identified above, there is a model of addiction that is more consistent with family systems theory than the disease concept. Though building on the clinical and empirical knowledge arising from the disease concept of chemical dependence, Wallace (1985), Mechanic (1986), Lewis (1991), and Gallagher, McCann, Jerman, Hughes, Langelier, and Stewart (1990) present a more comprehensive model of addiction by describing different aspects of the biopsychosocial model of health and healthcare treatment. Wallace (1985) defines the biopsychosocial model as "an interactive model, one in which biological, psychological and social factors all enter into the prediction of compulsive drinking" (p. 592). Lewis (1991) writes,

> Although alcoholism and a variety of other diseases can be described by a rigid notion of disease, few diseases fit the model of being purely biological, discrete entities with steadily progressive courses and that show no evidence of volitional influence in their etiology or manifestations. . . . A far more satisfactory way to understand medical disease is the

> biopsychosocial model which proposes that etiologies are best understood by the interaction of biological, psychological, and sociocultural risk factors. (p. 262)

The biopsychosocial model of addiction addresses the diversity of disease, with multiple layers and directions of influence. This model is also consistent with family systems theory, while the disease concept tends not to be. One of the great dyssynchronous characteristics of chemical dependence treatment is its dependence upon the disease concept of addiction, while declaring addictions to be "family diseases" and using family systems theory ideas and techniques. The biopsychosocial model does much to redress this imbalance when it stands in place of the disease model of addiction. The biopsychosocial model is far more consistent with and responsive to family systems theory than the disease model of chemical dependence. Unfamiliar to many, family systems theory offers a more balanced view of human interaction and of chemical dependence. The following sections address the concern of unfamiliarity with family systems theory.

## FAMILY SYTEMS THEORY

To over-simplify the complexity of human existence, there are two ways of seeing people: either as individuals

standing by themselves and apart from others, or as part of an interactive and interrelated system (for example, family, work, church, or social club). The view taken herein is that there is an active and complex interweaving of the multiple threads of existence. This means that every person is part of many systems and subsystems.

Perhaps one of the most significant distinctions made between these two views of existence is linear causality versus circular causality. Linear causality can also be described as "cause-and-effect" because of the sequential nature of its thinking--"b" happened because "a" happened. Circular causality (spherical causality is a more accurate description because of the multi-dimensionality of systems interaction, rather than just the two dimensions of a circle) maintains that any change at any given point will affect many others, which in turn will affect the original point of change. Adopting this circular causality frame of reference, fundamental to family systems theory and understanding family dynamics, is the suggestion made by Goldenberg and Goldenberg (1991).

> A family is more than a collection of individuals sharing a specific physical and psychological space. A family is a natural social system, with properties all its own, one that evolved a set of rules, is replete with assigned and ascribed roles for its members, has an organized power structure, has developed intricate

> overt and covert forms of communication, and has elaborated ways of negotiating and problem solving that permit various tasks to be performed effectively. The relationship between members of this microculture is deep and multilayered, and is based largely on a shared history, shared internalized perceptions and assumptions about the world, and a shared sense of purpose. Within such a system, individuals are tied to one another by powerful, durable, reciprocal emotional attachments and loyalties that may fluctuate in intensity over time but nevertheless persist over the lifetime of the family. (p. 3)

Steinglass (1984) maintains that family systems theory is more like a "conceptual model built around a set of core concepts" (p. 582). Three concepts have particular importance in the context of the present study: the family as a system; the concept of control; and the concept of systemic growth. Steinglass (1984) maintains that the family is a system not only because it "is comprised of a set of units or elements (individuals) standing in some consistent relationship or interactional stance with one another, but further that the behavior of the family system is best understood as a product of its organizational characteristics" (p. 582). This concept is both the

keystone of family systems theory[2], because it asks that the world and human interaction be seen in a different light. The implications of this for healthcare, especially for chemical dependence treatment, are profound. According to Steinglass (1984), "This radically different way of defining pathology has directed our thinking away from a reductionistic attempt at uncovering 'underlying' psychopathology, and redirected our attention instead toward a description of the organizational characteristics of the family as a system" (p. 583).

The second concept, control, reflects the patterns and predictability of family responses. Any family system will develop a sense of balance (whether it be healthy or not), and become resistant to changing the system, described as either homeostasis or cybernetic regulation. Steinglass (1984) writes that "Both terms describe the capacity of living systems to maintain the constancy of their internal environments in the face of external change" (p. 583). The adage is "known craziness is safer than unknown health" when faced with making fundamental changes, thus describing one of the primary problems in the psychotherapeutic process. A family system will maintain its existence through control of

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[2]The inclusive phrase "family systems theory" is the one commonly used in this dissertation, but also has "family systems therapy" as part of its definition. Therapy is theory in action, and "family systems therapy" is used when specifically applicable.

family responses, that is how the system is maintained. Control can be either a positive or a negative factor in a family system's functioning.

The third concept is about systemic growth (morphogenesis), which maintains that there is a natural tendency for growth within a system to greater organizational complexity. As uncertainty is reduced, patterned behavior is increased, information levels are increased, and the system will grow. Two elements are essential to this growth, effective family communications and clarity of family boundaries. Steinglass (1984) writes,

> The nature of family communication patterns and family boundaries are therefore major determinants of the pace and direction of family growth. The better the communication patterns, the more functional the nature of family boundaries, the more effective is information exchange within the family. High quality information permits the development of sophisticated and complex organizational characteristics, and more highly patterned and integrated interactional behavior within the family. The key here is the notion of patterned growth. (p. 584)

Broderick (1993) discusses the basics of family systems theory. He provides an excellent structure for understanding family systems theory in his chapter, "Family Process Theory" (Sprey, 1990), when listing five identifying

characteristics. Because understanding family systems theory is fundamental in this research, these characteristics are listed below.

**I. The family is a . . . system.**

When looking at a family, one looks for its core characteristics in the qualities of the system as a whole, rather than on the qualities of the individual. The systems approach is focused primarily on process rather than structure. The assumptions of linear causality that undergird traditional social science perspectives are rejected, and a model of circular, reflexive causality is embraced.

**II. The family is a . . . social system.**

The family is a social system with its members' interactions consisting of a series of communicative events or messages. These communicative interactive events constitute social encounters as well as subject-matter exchanges. Each may be evaluated as a relationship-defining event as well as an information-sharing event. The subject-matter component of the exchange is called the **message** and the relational component, the **metamessage**. Communication theory states that it is impossible for two people to be aware of each other's presence and not communicate.

**III. The family is an . . . open, social system.**

**IV. The family is an ongoing, open, social system.**

Because a systems approach focuses upon process, it

focuses primarily on events that are observable in clock-time (i.e., seconds, minutes, and hours). Because it is also an ongoing system, there is a secondary focus on patterns of exchange that endure over calendar-time (days, months, years, and generations). The set of ongoing processes that define a system are framed by recurring, repetitive patterns that may be observed over time. From these recurring and repetitive patterns, the rules that govern the system can be identified.

**V. Every system necessarily operates within constraints imposed upon it.**

Family process is limited by the particular subsystems attributes which give it composition. Family process is constrained by its own size and structural composition. This same family's process is also limited by the larger suprasystem or ecosystem of which it is part (Adapted from Broderick in Sprey, 1990, pp. 178-197).

The importance of family systems theory to understanding the nature of recovery from chemical dependence comes from its contextual role. All the varieties, vagaries, variations, and venues of chemical dependence do not happen in isolation. Chemical dependence is not just a physiological process that can be addressed by first identifying the cause and then implementing the effective cure. Chemical dependence affects the person on physical, emotional, social, and spiritual levels. Only

family systems theory and therapy adequately responds to the onion-like layers of addiction and its behavioral effects.

## Intergenerational Family Systems Theory

Several different types of family systems theory have developed since its beginnings in the 1950s. Nichols (1984) identifies eight types: psychoanalytic family therapy, group family therapy, experiential family therapy, behavioral family therapy, extended family systems therapy, communications family therapy, strategic family therapy, and structural family therapy. Goldenberg and Goldenberg (1991) have reduced the number to six: psychodynamic, experiential/ humanistic, Bowen, structural, communication/strategic, and behavioral approaches to family theory and practice.

Though each of these different approaches to family systems theory have something to offer to the treatment of chemical dependence, one approach does stand out as more appropriate to the question of the nature of recovery. Known by several different names (family of origin therapy, extended family systems therapy, intergenerational family therapy, transgenerational therapy, natural systems theory, or Bowen family systems therapy), one of the primary contributors is Murray Bowen (Bowen, 1985, & Kerr and Bowen, 1988). The strength of this approach, when relating to treatment and recovery from chemical dependence, derives

from its recognition of the significance of one's family in the development of emotional and behavioral patterns, the centrality of the development of self, and the ability to alter dysfunctional or destructive patterns from one's family of origin. Bowen, like other family systems theorists, "recognized that people are the products of their context" (Nichols, 1984, p. 345), but he went beyond the nuclear family to the social networks of one's extended family. Where chemical dependence is present, families often are chaotic, with poor relationship boundaries, and are "ruled" by dysfunctional beliefs, behaviors, rules, and roles. Bowen Family Systems Theory offers a way to understand the chaos, its impact on family members, and the responses that will disrupt the destructive patterns, thus setting the identified patient free to address the consequences of familial and individual behavior relative to chemical dependence.

In an article first published in 1975, Bowen (1985) lists six theoretical concepts of family systems therapy: differentiation of self scale, triangles, nuclear family emotional system, family projection process, multiple generation transmission process, and sibling position. Nichols (1984) states that Bowen identifies six interlocking concepts for his approach to family systems theory: emotional triangles, differentiation of self, nuclear family emotional system, family projection process,

multigenerational projection system, and influence of sibling position. Bowen later added two more concepts to the list, so Goldenberg and Goldenberg (1991) identify the following as the eight interlocking concepts of Bowen Theory: differentiation of self, triangles, nuclear family emotional system, family projection process, emotional cutoff, multigenerational transmission process, sibling position, and societal regression.

Understanding chemical dependence treatment and recovery from the perspective of Bowen Theory does require some understanding of these concepts. These concepts are used in the case studies to describe and analyze family systems issues. Using the Goldenberg and Goldenberg (1991) glossary (pp. 319-332), brief definitions of these concepts are below.

**Differentiation of self:** The separation of one's intellectual and emotional functioning; the greater the distinction, the better one is able to resist being overwhelmed by the emotional reactivity of his or her family, and is thus less prone to dysfunction.

**Emotional cutoff:** The flight from unresolved emotional ties to one's family, typically manifested by withdrawing or running away from the family, or denying its current importance in one's life.

**Family projection process:** The mechanism by which parental conflicts and immaturities are transmitted,

through the process of projection, to one or more of the children.

**Multigenerational transmission process:** The process, occurring over several generations, in which poorly differentiated persons marry similarly differentiated mates, ultimately resulting in offspring suffering from schizophrenia or other severe mental disorders.

**Nuclear family emotional system:** An unstable, fused family's way of coping with stress, typically resulting in marital conflict, dysfunction in a spouse, or psychological impairment of a child; their pattern is likely to mimic the patterns of past generations and to be repeated in future generations.

**Sibling position:** The birth order of children in a family, which influences their personalities as well as their interactions with future spouses.

**Societal regression:** The notion that society responds emotionally in periods of stress and anxiety, offering short-term "band-aid" solutions, rather than seeking more rational solutions that lead to greater individuation.

**Triangles:** A three-person system, the smallest stable emotional system; a two-person emotional system, under stress, will recruit a third person into the system to lower the intensity and anxiety and gain stability.

Understanding these concepts is important to understand that

portion of the case studies that address family systems issues.

Bowen (1985) addresses chemical dependence, and his view of its impact on family systems, in an article first published in 1974 ("Alcoholism and the Family"),

> How does alcoholism fit into systems concepts? From a systems' viewpoint, alcoholism is one of the common human dysfunctions. As a dysfunction, it exists in the context of an imbalance in functioning in the total family system. From a theoretical viewpoint, every important family member plays a part in the dysfunction of the dysfunctional member. (p. 262)

Bowen states later that persons who become alcoholic fall along a continuum (differentiation of self scale). At one end is the person who handles attachment to parents by denying that there is attachment, and taking on a super-independent posture that declares that he does not need anyone, and that he can do it himself. Bowen writes,

> This person's life is burdened by his high self-expectations and unrealistic sense of responsibility. His Achilles' heel is the denial of his need for others, and his super-independent posture, which is in turn reinforced by his spouse and children. The harder he works, the more he becomes emotionally isolated. When he feels most burdened and the isolation is most intense, he often finds relief from alcohol, thus

> initiating a well known drinking pattern. (1985, p. 264)

At the other end of the continuum is the person who is so attached to parents, that he is never able to develop a productive life. In Bowen's words, "The mechanism of denial permits him to keep his distance from the realization of his need for his mother [and father] and from all subsequent such relationships in which need would have to be acknowledged" (1985, p. 265). Most who are chemically dependent fall somewhere between these two ends of the continuum.

Bowen wisely concedes that alcoholism [read chemical dependence] is one of the most difficult emotional dysfunctions to treat, and that family systems therapy offers no magic solution. The issue is not how much or what someone is abusing but, as Bowen states, "The basic strength or level of differentiation of self, rather than the intensity of the alcoholism, is a rather good predictor of the outcome of any effort at therapy" (1985, p. 267). Success in therapy can also be gauged by the level of anxiety within a family, with the principal task to discover the means of stopping the anxiety spiral. Bowen (1985) also states,

> The more the family is threatened, the more anxious they get, the more they become critical, the greater the emotional isolation, the more the alcoholic drinks,

> the higher the anxiety, the greater the criticism and emotional distance, the more the drinking, et cetera, in an emotional escalation that makes the problem worse and both sides more rigidly self-righteous. Anything that can interrupt the spiraling anxiety will be helpful. (p. 267)

Generally speaking, the chemically dependent person operates between two tightly-sprung boundaries of too much closeness and too much emotional isolation. "When he is drinking, he is emotionally isolated" according to Bowen (1985, p. 268).

Family systems theory presents a very particular view of the dynamics of family interaction, stating that the individual units of a family do not act in isolation but are profoundly influenced and defined by their family of origin. Bowen Theory takes this systems perspective one step further with the introduction of the intergenerational dimension of family influences. Additionally, Bowen has a well-developed structure for understanding his particular theoretical expression of family systems theory.

## Genograms

Use of genograms (another Bowen innovation) is fairly common within the clinical setting of chemical dependence treatment centers, though there is sparse use of genograms in empirical research. Most genogram use is tied to

analysis of family histories of alcoholism or addiction, or of dysfunctional family rules, roles, beliefs, and behaviors as they have an impact on treatment. Obviously, genogram use is much more prevalent within those treatment centers that declare family systems theory as their guiding principle. Genograms, also known as family diagrams, are an essential tool within intergenerational family systems theory. Though not universally used in treatment settings, they are a tool familiar to most clinical staff members. The applicability and use of genograms in an empirical setting is a relatively new concept.

This section covers four areas relative to genograms: definitions, primary use, secondary use, and research use. Genograms are an unfamiliar concept to most persons, but their use within intergenerational family systems theory is critical. Understanding genograms ideally means clarity relative to transgenerational transmission processes, clinical assessment, and interfamilial dynamics. Genograms can be used in different ways beyond primary clinical assessments, particularly for secondary assessments of specific populations, or of specific problems or issues.

The simplest definition of a genogram is: "A schematic diagram of the family relationships based on the genetic tree, usually involving several generations" (Sauber, L'Abate, Weeks, & Buchanan, 1993, p. 184). The more complete McGoldrick and Gerson (1985) definition is:

> A genogram is a format for drawing a family tree that records information about family members and their relationships over at least three generations. Genograms display family information graphically in a way that provides a quick gestalt of complex family patterns and a rich source of hypotheses about how a clinical problem may be connected to the family context and the evolution of both problem and context over time. (p. 1)

Marlin (1989) says that a genogram is a family tree that talks. Carter (Walters, Carter, Papp, & Silverstein, 1988) writes that "A genogram (family diagram) is a map that provides a graphic picture of family structure and emotional process over time" (p. 96). Nichols and Everett (1986) consider the genogram to be an invaluable resource for assessment, identifying its origins in anthropological and genealogical studies, and arguing that it "provides diagramatically the position and location of family members, their births, death, marriages and divorces, over several generations" (p. 184).

Family dynamics are consistently identified clinically as major factors in the development and treatment of, and recovery from chemical dependence. Not only do family dynamics play a role in behaviors that may result in chemical dependence, they are principal concerns in successful treatment and recovery. Family dynamics often

are most effectively assessed through the use of a genogram. Silverstein (Walters, Carter, Papp, & Silverstein, 1988) identifies a genogram as "a family diagram, commonly of three generations, linking the two sides of a family and tracing the emotional patterns through the generations. Such a device identifies the family process as intergenerational and contextual" (p. 133).

Kerr and Bowen (1988) state that "The diagram [read genogram] reflects the ebb and flow of emotional process through the generations. It defines the vicissitudes of a living organism, the multigenerational family" (p. 306). This transgenerational understanding addresses the "diseasing of America" concerns of such persons as Peele (1989)--for example, the person who blames parents for present-day problems because of parental deficiencies must assume responsibility for their own recovery. Peele (1989) writes,

> The basic viewpoint is 'My family is the cause of the problems in my life.' An alternative to this viewpoint is that every family member, including one's parents, is embedded in a multigenerational emotional process and everyone, including oneself, has a responsibility to grow up as much as possible within that process. . . . Learning enough about the multigenerational emotional history of one's family to change the way one thinks about the family and about oneself probably

> contributes more to the effort to 'grow up' than anything else a person can do. (p. 309)

With intergenerational family system theory, this is the primary use of genograms. Wynn (1981) asserts,

> The genogram covers not only the family's current history, but also reaches back through previous generations--at least to the grandparents of adults. . . . This device can be used to discover details about health, religious and ethnic background, deaths, divorces, relationships, moves, transgenerational patterns, broken relationships, scandals, strengths, traditions, and family ghosts. (p. 127)

Broderick (1993) asserts that all intergenerationally oriented therapists use the genogram as a device for eliciting a family's core story. Framo (1992), Goldenberg and Goldenberg (1991), Hoffman (1982), McGoldrick and Gerson (1985), Nichols (1988), Piercy, Sprenkle and Associates (1986), and Wachtel (1982) identify the assessment, diagnostic, and therapeutic value of genograms in understanding intergenerational family systems.

Apart from the aforementioned primary use in clinical assessment, secondary uses of the genogram investigate different aspects of human interaction. Wynn (1981) states that a genogram is a standard device for organizing a family's history, used not as a simple, mechanical tool but to identify numerous topics and feelings--somewhat of a

hybrid between Bowen's intergenerational and Minuchin's structural/strategic family systems theory.

Some specific uses of genograms to assess and describe family systems characterized by chemical dependence do appear in the literature, though they are few in number. Carter (Walters, Carter, Papp, & Silverstein, 1988) demonstrates the effectiveness of a genogram in describing alcoholic family systems (pp. 181ff and pp. 314ff), through a precise description of family dynamics using word and picture. Synol (1984) addresses the alcoholic marital dyad and the use of family mapping (Minuchin's modified version of a genogram), with similar precision as Carter. Both use the genogram effectively in identifying relational patterns common to families with chemical dependence.

Other secondary uses includes Baird and Doherty's (Karpel, 1986) discussion of the use of a genogram in coping with serious illnesses, recognizing that "Sometimes the graphic clarity of a genogram will provide diagnostic insight into the current patient's medical problem" (p. 375). Erlanger (1990) and Ingersoll-Dayton and Arndt (1990) discuss the use of genograms in assessing older clients. However, Nichols (1984) warns that

> Filling out the genogram is not an end in itself, nor is it a simple matter. The genogram is only a skeleton which must be fleshed out with important information about the family. In order to put meat on the

> skeleton's bones, it is necessary to know what to look for. Dates, relationships, and localities are the framework for exploring emotional boundaries, fusion, cutoffs, critical conflicts, amount of openness, and the number of current and potential relationships in the family. (p. 376)

The value and use of genograms in cross-cultural family therapy is discussed in McGoldrick, Pearce, and Giordano (1982). McGoldrick and Gerson (Carter & McGoldrick, 1988) discuss the use of genograms in studying families over the life cycle. Okiishi (1987) sees genograms as an effective tool in career counseling, while Bahr (1990) uses genograms and family chronologies in family science classes as a means for students to better understand themselves. Howe (1990) uses biographies and genograms in a "Psychology of Women" course so daughters might learn more about their mothers.

In trying to understand successful therapeutic intervention when most assessment tools indicated sure failure, Kanner (1984) uses a genogram to discuss "cures of unknown origin." Lewis (1989) proposes the use of color-coded family conflicts and characteristics in putting a genogram together. Hof and Berman (1986) consider a sexual genogram as an effective assessment and therapeutic tool when working with marital sexual dysfunction. Salgado de Bernal and Alvarez-Schwarz (1990) discuss their use of genograms in family therapy concerned with promoting

personal growth, or formation.

Beck (1987) describes a different perspective in the use of genograms which varies some from the usual family of origin approach. Differing from the usual position of gathering data without considering the effects of the data gathering process, Beck maintains that the emotional component of the process is important to address in the development of the therapeutic alliance. Beck 1987) states "This paper examines the tendency to construct genograms in an affective vacuum--a phenomenon consistent with Bowen theory, yet potentially problematic in the ongoing process of treatment" (p. 343).

Though there are a variety of secondary uses for genograms, as seen above, the link between clinical uses and research use is faint at best. A difficulty with literature on genograms is the emphasis solely on a clinical context, without consideration to the use of genograms as a research tool. McGoldrick and Gerson (1985) address the "non-empirical" nature of genogram use within the clinical setting:

> The genogram has been used by clinicians as a format for collecting, organizing, and interpreting data, rather than as a standardized measurement technique. Hence, family clinicians have not been particularly concerned with the psychometric characteristics of the genogram, or even with reliability and validity in the

usual sense of those terms. (p. 147)

Even this concern expressed by McGoldrick and Gerson (1985) references the genogram back to the clinical setting, and its use in clinical practice rather than as a distinct research tool. The genogram, because of its holistic approach to seeing the multiple layers of a person's history and life, is an effective clinical tool. It is an excellent research tool for the same reasons, with the ability to draw the disparate pieces into a unitary expression of a system's story. This is true whether that system is a family, a couple, or an individual. The customary use for genograms is in the clinical setting. The use of genograms as a research methodological procedure is a new usage, but one that can reveal a wealth of data.

## Family Systems Therapy and Chemical Dependence

As indicated in the introduction to this chapter and the discussion of related literature on chemical dependence, there is considerable divergence of thought on the topic. The treatment community defines chemical dependence as a family disease, because all family members are affected by the addicted person's behavior to some degree, some even to the point of significant injury. When one views chemical dependence from the perspective of family systems therapy, the interplay and interaction of each part on the other, and

on the whole of the system, become increasingly apparent. As Nace (1987) writes,

> Alcoholism is commonly referred to as a 'family disease,' meaning that family members living with an alcoholic are affected by the alcoholism. They may be anxious, depressed, irritable, withdrawn; somatic symptoms may develop; acting-out behaviors or co-addiction may occur. Family disease also refers to the possibility that a family member's behavior may perpetuate (enable) the drinking of the alcoholic. (1987, p. 175)

The literature on family systems theory addresses either the impact of chemical dependence on the family, the role of family therapy in chemical dependence treatment, or a proposed understanding of chemical dependence dynamics from the perspective of family systems theory.

The role of family systems therapy in chemical dependence treatment is discussed in a number of sources with each presenting similar views on family systems theory and chemical dependence.[3] Exemplifying this literature on

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[3] see Alonso-Fernandez (1987), Bennun (1985), Bessey & Borduin (1986), Clinebell (1985), Cottone, Handelsman, & Walters (1986), Doweiko (1990), Frawley (Peele, 1988), Gallant (1987), Greif & Schwartz (1987), Guinan (1990), Heath & Stanton (Frances & Miller, 1991), Kaufman (1985b), Kaufman & Kaufman (1977), Kerr & Bowen (1988), Larsen (1985), Levine (1985), McGoldrick, Pearce, & Giordano (1982), Monti, Abrams, Kadden, & Cooney (1989), W. Nichols (1988), O'Farrell (1989), O'Farrell & Cowles (Hester & Miller, 1989), Peele (1989), Sauer (1984), Singer (1984), Stanton (1979a, 1979b), Stanton et al. (1978), Todd &

family systems therapy and chemical dependence treatment, Nace (1987) is concerned with the impact of chemical dependence on the family and also the role of family systems therapy in the treatment setting. In the discussion on the family treatment, Nace (1987) identifies a continuum of family functioning that families exhibit, "The continuum of family functioning ranges from the well-functioning (competent family) to the dysfunctional (dominant-submissive family or chronically conflicted family), to the severely dysfunctional family (chaotic family)" (p. 178).

Viewing chemical dependence from a family systems perspective is somewhat in opposition to the customary perspectives of the treatment community. This perspective begins with the linear nature of the disease concept of chemical dependence, which has its roots firmly implanted in the medical model of healthcare. The medical model looks for "cause and effect" in all problems put before it. This is contrary to the fundamental definitions of family systems theory. Kaufman (1985a) writes,

> Experimental observations of family systems show that alcohol use in a family is not just an individual matter. The use of alcohol and the consequential behavior of drinking is dynamically related to events in the family system. Thus, the use of alcohol is

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Selekman (1989), Schwartzman (1988) Usher, Jay & Glass (1982), Vaillant (1983), Vanicelli (1987), Wermuth & Scheidt (1986), & Wynn (1991).

> purposeful, adaptive, homeostatic, and meaningful. The problem of alcoholism is not just the consequences of drinking per se, but more importantly, the system functions that are filled by drinking in the dynamics of the family system. (p. 35)

Kaufman (1985a) asserts that alcoholism [read chemical dependence] is a "systems-maintaining and systems-maintained device" (p. 37), like any other family dysfunction. Lewis, Dana, and Blevins (1988) take this argument a step further, and state that "A family-systems counselor views the alcoholic or addict simply as the identified symptom-bearer in the family, rather than as the primary focus of attention, and wants to know what function the drinking behaviors perform in the family unit" (p. 172). Edwards (1990) continues this developing understanding of family systems theory and chemical dependence, particularly when making the following assertions:

> The systems approach to therapy assumes that all behavior doesn't originate from within the individual, but is triggered and maintained by the patterns--the repetitious interactions--between and among the members of the family. The total of the family system is greater than the sum of its individual elements. . . . A chemically dependent person uses alcohol or other drugs because of his or her craving for the drug, not because he or she is a member of a dysfunctional

> family. However, being a member of a dysfunctional family can contribute to the alcohol or other drug use by making it more urgent for one or more members to seek escape, relief from tension, and medication for various negative feelings. And most important, the family dysfunction, although not directly causing the CD [chemical dependence], can contribute quite directly to preventing recovery. (p. 22)

There are numerous other writings on chemical dependence and family therapy[4] that take a similar approach to family systems therapy and chemical dependence as Kaufman (1985a), Lewis, Dana, and Blevins (1988), and Edwards (1990). Krestan and Bepko (Carter & McGoldrick, 1988) do not avoid the debate over the nature of chemical dependence, while presenting a similar definition of chemical dependence as those listed above as they concern themselves with chemical dependence over the changing family life cycle. Krestan and Bepko (Carter & McGoldrick, 1988) state,

> Considerable controversy exists regarding the

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[4] see Anderson (1987), Annis (1974), Babst, Deren, Schneider, Lipton, & Dembo (1978), Bennun (1988), Coleman (1982, 1987), Coleman & Davis (1978), Coleman & Colgan (1986), Davis (1977-78), Eldred, Brown & Mahabir (1974), DeForest, Roberts & Hobbs (1974), Friedman, Utada & Morrissey (1987), Gfroerer (1987), Googins & Casey (1987), Hoopes (1987), Huberty & Huberty (1986), Jurich, Polson, Jurich & Bates (1985), Kaufman (1986a, 1986b), Klagsbrun & Davis (1977), Lupetz, Larosa, Klagsbrun & Davis (1977), Murphy (1984), Noone & Reddig (1976), Protinsky & Cross (1990), Root (1986), Singer (1984), Stanton (1979), & Starr (1989).

> classification of alcoholism as a disease. Our operating premise is that alcoholism is a systemic process that affects and is affected by interaction that occurs between the drinker and the alcohol, the drinker and himself or herself, and the drinker and others. The effects of drinking result in adaptive changes at all systemic levels, and because it is ultimately highly destructive to all these levels, as well as potentially life threatening, alcoholism is most efficiently referred to as a disease. (p. 484)

Melvin (1984) and Glynn (1982-83) are interested in family systems and chemical dependence out of life-span research about families and drugs, as were Kreskan and Bepko (Carter & McGoldrick, 1988).

Systems theory and family systems theory require a different view of the world and human interaction, one that calls for circles, spheres, and wholeness rather than lines, sequences, and units. Family systems theory necessiates a more comprehensive view of chemical dependence than other models that might be used. The challenge for the non-systems thinker is to see the world in a different way, one that speaks of connection and not isolation.

## GENDER ISSUES

The issues associated with gender probably began when the first steps were taken to divide labor according to sex, but for our culture, it was codified with the writing of Genesis and the two stories of the creation of man and woman. One story related the origin and dependence of woman on man, while the other spoke to the essential equality of both. Thus began the struggle to understand what it means to be a man, and to be a woman--an eternal struggle. Baber (1992) addresses this struggle in Naked at Gender Gap when he writes,

> **Gender Gap:** The territory where we all live in a naked and vulnerable condition. The male and the female of the species are situated on separate sides of Gender Gap, each man and each woman yearning to close the distance between the sexes.
>
> None of us is sure of how to do that.
>
> Life at Gender Gap is hard for men and hard for women.
>
> As much as we might wish for it, there is no escape.
>
> Its landscape stretches to infinity. (p. xii)

This gender struggle characterizes the processes of human interaction, and it characterizes the redefinition processes current within contemporary American society. The gender struggle is very applicable to the search for identity exemplified by the six men whose stories are told in this

report.

Gilmore (1990), as a cultural anthropologist, studied a variety of cultures seeking to understand the meaning of manhood. He writes,

> The cultural hypostasis of the male image, which I believe exists to a degree in many societies, led me to believe that the manhood ideal is not purely psychogenetic in origin but is also a culturally imposed ideal to which men must conform whether or not they find it psychologically congenial. That is, it is not simply a reflection of individual psychology but a part of public culture, a collective representation. (pp. 4-5)

Through Gilmore's (1990) ethnographic studies of various cultures, three male imperatives emerge as defining characteristics of manhood, "To be a man in most of the societies we have looked at, one must impregnate women, protect dependents from danger, and provision kith and kin" (p. 223). Though considered an expendable commodity in many cultures, a "real man" is expected to be Impregnator, Protector, and Provider.

What comes through clearly in Gilmore's work is the idea that manhood is made, as opposed to the definitive transition to womanhood with menarche. From this develops the importance of male grouping, being taught how to be a man or mentoring, the presence of father or father-

surrogate, and initiation. Van Gennep (1960 [originally published in 1909]) was the first to address this issue and the centrality of rites of passage throughout human existence, whether they are dealing with individual and groups, pregnancy and childbirth, initiation, betrothal and marriage, or funerals. Henderson (1967) addresses initiation from a Jungian perspective of archetypes, while Raphael (1988) is concerned with rites of passage within American culture, and writes,

> Why are men so nervous about their own masculinity? Male insecurity used to be a well-kept secret, known only to our perceptive female companions who happened to stumble upon it. But now the cat is out of the bag. First came the guilt-ridden reaction to feminism, with hypersensitive men apologizing profusely and confessing their insecurities aloud for all the world to hear. Now we have the Rambo-styled backlash to the hypersensitive male--but this time we're not easily fooled by false bravado. . . . We all can see, on some level, that even Rambo must have had a mother--and for all we know he might be scared to death of women. (p. ix)

Raphael (1988) addresses similar issues as Gilmore (1990), Van Gennep (1960), and Henderson (1967) when discussing rites of passage, male validation, combat and contests, competition, and unmanly behavior and guilt; and he writes,

> Perhaps the primitives, after all, were too

> mechanistic. 'Manhood' is not necessarily a definable state of being which is achieved once through a rite of passage and then in some sense owned. To become a man is a never-ending task which inevitably involves more than the completion of prescribed ritual. (p. 191)

From these perspectives, manhood is seen as a state of being that is attained through both "doing" (e.g., rites of passage, initiation), and "accepting" the responsibilities assigned by cultural definitions of being a man. This is true in both modern, industrial societies and in non-industrial, "primitive" cultures--manhood is made.

Much research has been done on gender, gender identity, and gender roles over the last generation, particularly through the work of feminist scholars. Concerned with evaluating and redressing culture-based gender inequities, these scholars have done fundamental work in the redefinition process. This is not the place to address these issues, other than to reference some of significance. As with most questions concerning human interaction, there is always the "nature/nurture" debate and gender issues are no different. Fausto-Sterling (1985) enters into the debate concerning biological theories of gender, giving a clear presentation on developmental physiology. Basow (1986) presents a balanced discussion of gender stereotyping, and suggested responses to correct the present-day imbalances.

Seemingly without exception, writers interested in

gender issues acknowledge the cultural basis of definitions of gender, gender identity, and gender role. Lorber and Farrell (1991) present a series of essays addressing the social construction of gender:

> The reason for gender categories and the constant construction and reconstruction of differences between them is that gender is an integral part of any social group's structure of domination and subordination and division of labor in the family and the economy. As a major social status (if not the major social status), gender shapes the individual's opportunities for education, work, family, sexuality, reproduction, authority, and the chance to make an impact on the production of culture and knowledge. (pp. 1-2)

Boone and Cadden (1990) present a series of edited essays, written by men, on rethinking male cultural position as the result of feminist thinking. Eisler (1988) writes of social evolution and changing gender relations from a New Age perspective. Filene (1986), Dinnerstein (1976), Hearn and Morgan (1990), and Chesler (1978) write about sex roles from the perspectives of contemporary history, social psychology, sociology, and Freud. Sociolinguist Tannen (1990, 1986) writes of the differences in communication between men and women.

From a different perspective than the above, there are those who address gender issues in relationship to

spirituality and masculinity. Using biblical images and stories, Rohr and Martos (1992) address male spirituality from a Franciscan perspective, while Arnold (1991) writes as a Jesuit Old Testament scholar. Culbertson (1992), an Episcopal priest and pastoral theologian, seeks redefinition of male spirituality as the new Adam, while Dalbey (1988), a United Church of Christ minister, calls for the healing of the masculine soul. Heller (1990) describes spirituality while using his experience as a clinical psychologist to address male misperceptions of God (God as the Senior Executive, Mighty Hulk, or Divine Referee). J. Moore (1980) and Nelson (1988) both write of the inseparability of sexuality and spirituality, and the need to consider both when exploring intimacy with God and self.

A predominant theme with many authors is the struggle with changing definitions and expectations regarding manhood, from both internal and external sources. Gerzon (1982), Pasick (1992), Kupers (1993), Abbott (1987, 1990), Stoltenberg (1989), Staudacher (1991), and Thompson (1991) address the search for new meanings by facing changing definitions of power, intimacy, grief, sex, justice, consciousness, and self. Easthope (1990), Pittman (1985), and Taffel (1986) investigate the masculine myth in the popular culture and its destructive characteristics, while Peck (1981) critiques male role research over the last fifty years and declares it to be a distortion of the data.

Ornstein (1991), Pittman (1993), Osherson (1986, 1992), and Lee (1987, 1991a, 1991b) are concerned with the centrality of fathers in the development of positive definitions and experiences of manhood.

While some address the angst of changing definitions and expectations, others offer distinct perspectives on masculinity and manhood. Bly (1988, 1990) uses poetry and myth to redefine men, Keen (1991) uses self-actualization and spiritually-grounded masculinity for his redefinition, while Gingold (1991) makes fun of the men's movements through some on-target satire. Pederson (1993) uses the Myers-Brigg Type Inventory to understand masculine personality types, and Pearson (1989, 1991) offers six or twelve archetypes for self-discovery. R. Moore and Gillette (1990, 1991, 1992, 1993) also use Jungian archetypes to describe masculine behavior as king, warrior, magician, or lover. Sanford and Lough (1988), Johnson (1989, 1991), and Monick (1987) also use Jungian psychology to define male behavior.

There is an increasing tendency in psychotherapy to be more alert to gender dynamics within the therapeutic setting, both for men and for women. This is a recognition that in some settings "one size does not fit all." Johnson and Brock (1988) compare male and female responses in discussing gender-specific therapy. D. Moore and Leafgren (1990), Meth and Pasick (1990), Druck (1985), Farrell

(1986), Fossum (1989), and Barnett, Biener, and Baruch (1987) describe the unique and not-so-unique experiences of men in therapy. An entire issue of the Journal of Mental Health Counseling (Kelly & Hall, 1992), and a major portion of the Fall 1990 issue of Psychotherapy (1990, 27(3)) are devoted to men in therapy.

Perhaps the clearest message to come out of these diverse readings is the state of flux concerning gender, particularly in understanding the changing nature and definition of masculinity and manhood. This state is understandable considering the changing nature of American society, but that does not make it any easier for the individual who is trying to figure what is going on in his life. Though most men are not aware of the questions being asked by feminists and masculinists and the answers they offer, the issues identified remain ones that affect all men in varying degree. The fundamental question remains, "What does it mean to be a man?"

The answers to this question are as diverse as the positions and perspectives of those referenced above. The "answers" that stand out, though, address the issue of "the making of a man" or initiation/transformation, fathers and sons, sexuality/spirituality, and roles (especially Gilmore's three-fold male imperatives of impregnator, provider, and protector). With the usual characteristic of developmental delay for persons who are chemically

dependent, many of these primary issues become distorted, ignored, or never addressed. Part of the recovery process will necessarily address these issues, particularly when approached from a family systems perspective.

## METHODOLOGICAL PROCEDURES

The methodological process in this dissertation may be described as an accumulation of data from different sources, building one upon another, and moving toward a common ground of understanding the nature of treatment and recovery from chemical dependence. The framework of this process are the case studies. To this case study framework is added the content of the interviews, medical records, and genograms. This discussion of related literature about case studies, qualitative interviews, and medical record and document analysis is offered primarily for a more precise understanding of these topics. Genograms are considered above within the Family Systems Theory section. This also is done to provide clearer understanding of the components of the methodological process.

### Case Studies

Case studies are the framework for this research. They are as modular units that are self-contained, but when they

are merged with other units, they combine to create a greater structure. Each case study herein concerns itself with a single story, for that is what a case study does best. There is also a need to understand the "robustness" that arises from combining case studies.

Marshall and Rossman (1989) state that there are several purposes to case study research: to chronicle events; to render, depict, or characterize; to instruct; and to try out, prove, or test. Goetz and LeCompte (1984) identify clinical case studies as the central qualitative research design in psychology. They also recognize that case studies in this setting are comprehensive, and write,

> Although the clinical interview constitutes the core of data collection in this tradition, it is supplemented by painstaking observation, by interviews with others significant to the client subjects, by projective devices and other psychometric instruments, by interpretive examination of public and private documents, and by introspective analysis of the therapist researcher's own responses and experiences. (Goetz & LeCompte, 1984, p. 24)

Goetz and LeCompte (1984) assert that case study research and analysis is a preferred design for "intensive, in-depth examination of one or a few instances of some phenomena" (p. 46). Crabtree and Miller (1992) state that a case study examines "most or all the potential aspects of a particular

distinctly bounded unit or case (or series of cases. A case may be an individual, a family, a community health center, a nursing home, or an organization" (p. 5).

Patton (1990) maintains that case studies are useful where the researcher needs understanding of "some special people, particular problem, or unique situation in great depth, and where one can identify cases rich in information" (p. 54). He states,

> Case studies are particularly valuable when the evaluation aims to capture individual differences or unique variations from one program setting to another, or from one program experience to another. A case can be a person, an event, a program, an organization, a time period, a critical incident, or a community. Regardless of the unit of analysis, a qualitative case study seeks to describe that unit in depth and detail, in context, and holistically. (p. 54)

Yin, in Case Study Research (1989), defines a case study as "an empirical inquiry that: investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used" (p. 23).

In the same book, Yin (1989) discusses the four basic types of designs for case studies using a 2 x 2 matrix. This matrix is built around the choice of single-case designs or multiple-case designs against holistic (single)

or embedded (multiple) unit(s) of analysis. The four types of designs are: (1) single-case (holistic) designs; (2) single-case (embedded) designs; (3) multiple-case (holistic) designs; and (4) multiple-case (embedded) designs. The value of multiple-case over single-case design begins with the ability to do "comparative" studies. According to Yin, "The evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust" (1989, p. 52). The choice of either embedded or holistic reflects the unit(s) of analysis, with neither being more substantive than the other.

Yin (1989) also recognizes that replication logic rather than sampling logic is fundamental to the use of multiple-case design, as the researcher looks for repetition of patterns, results, or responses. He writes that replication "either (a) predicts similar results (a literal replication) or (b) produces contrary results but for predictable reasons (a theoretical replication)" (1989, p. 53).

Yin's case study research analysis, presentation of design models, and discussion of protocols for implementation present a complete understanding of case studies. The current case study research literature constantly references back to Yin as the source of knowledge. Considering the clarity of Yin's thought on case study research, the model presented is the preferred one at

this time.

The research for this dissertation flows from a holistic multiple-case design. Holistic because of the single unit of analysis (the research participant), and multiple-case because of the six-fold repetition of data gathering and analysis. Taken individually, the case studies of these six males in recovery from chemical dependence present six different stories. Taken collectively, the replication (literal) gives answer to the question of experiential commonality in recovery from chemical dependence.

## Qualitative Interviews

Webster's (1971) defines an interview as "a formal consultation usually to evaluate the aptitude, training, or progress of a student or prospective employee; [or] a meeting at which a reporter obtains information from a person; a report or reproduction of information so obtained" (p. 443). Babbie (1989) states that an "interview is an alternative method of collecting survey data. Rather than asking respondents to read questionnaires and enter their own answers, researchers send interviewers to ask the questions orally and record respondents' answers" (p. 244).

Lofland and Lofland (1984) write that "Intensive interviewing, also known as 'unstructured interviewing,' is

a guided conversation whose goal is to elicit from the interviewee rich, detailed materials that can be used in qualitative analysis" (p. 12). Marshall and Rossman (1989) see qualitative interviews more like Kahn and Cannell's "conversation with a purpose" than formal, structured interviews; and write, "An interview is a method of data collection that may be described as an interaction involving the interviewer and the interviewee, the purpose of which is to obtain valid and reliable information" (p. 82). McCracken (1988) declares that an interview is the most effective tool in qualitative research.

Goetz and LeCompte (1984) present Denzin's three forms of interviews (the scheduled standardized interview, the non-scheduled standardized interview, and the non-standardized interview), while Patton (1990) identifies three approaches to qualitative interviewing (the informal conversational interview, the general interview guide approach, and the standardized open-ended interview). Yin (1989) writes that case-study interviews fall into one of three different categories: open-ended interviews; focused interviews; and structured or survey interviews.

Open-ended interviews are as they are named, with a seemingly unlimited ability to move back and forth from one subject to another, or from the interviewer to the interviewee and then back to the interviewer. Focused interviews retain much of the openness of the open-ended

interviews, but the interviewer is concerned with a particular topic and has questions that are aimed at eliciting data about that topic. Survey interviews are used to respond to a research strategy that calls for strict uniformity of process rather than adaptability.

Taylor and Bogdan (1984) define the in-depth interview as "repeated face-to-face encounters between the researcher and informants directed toward understanding informants' perspectives on their lives, experiences, or situations as expressed in their own words" (p. 77). They also maintain that the interviewer, not the interview protocol or guide, is the research tool. Snyder (Gilgul, Daly & Handel, 1992) suggests that in-depth interviewing is best considered along a continuum from highly structured, survey interviews to unstructured, open-ended interviews.

Key-informant interviewing, career or life histories, and surveys are three specialized forms, identified by Goetz and LeCompte (1984), that apply to all interview forms. They assert that key-informant interviews elicit data from "individuals who possess special knowledge, status, or communicative skills and who are willing to share that knowledge and skill with the researcher" (Goetz & LeCompte, 1984, p. 119). Tomm (1987a & 1987b) addresses some of the impact of interviews as an intervention, particularly relevant when considering key-informant interviewing. Heller (1987) discusses the importance of the first

interview in gathering participant information. Gilchrist (Crabtree & Miller, 1992) presents key-informant interviewing along similar lines as Spradley (1979), recognizing the importance of a "good" source. Gilchrist makes an additional comment that "clinicians are generally good interviewers" (Crabtree & Miller, 1992, p. 80) which is relevant to this research because its clinical linkages.

Career or life-history interviews elicit data from the "narratives of participants, which then are used to formulate questions or inferences about the culture of a people" (Goetz & LeCompte, 1984, p. 120). Marshall and Rossman (1989) state that life histories give "an insider's view of a culture. . . .[and] as a deliberate attempt to define the growth of a person in a cultural milieu and to make theoretical sense of it" (p. 96). Frank (1984) uses life history to describe adaptation to disability. In an interesting twist, Agar and Hobbs (1983) suggest the use of artificial intelligence in ethnographic interview analysis.

Lofland and Lofland (1984) suggest that an interview guide is the instrument for logging the data from the interview, and "is considerably less formal or structured than the questionnaire or interview schedule used in survey research or opinion polling" (p. 53) but no less important. Goetz and LeCompte (1984) write, "Some researchers refer to the non-standardized interview as an interview guide, in which general questions to be addressed and specific

information desired by the researcher are anticipated, but may be addressed during the interview informally in whatever order or context they happen to arise" (p. 119).

Though there are appropriate opportunities for their use in survey research, interviews reach greatest potential research effectiveness when used in the qualitative paradigm. There are few persons who could not give a simple definition of an interview, pedestrian though it may be, but the literature indicates that there is both depth and richness to qualitative interviews. The distinctions made in the models presented by Goetz and LeCompte (1984), Patton (1990), or Yin (1989) are not great, for these authors follow similar patterns.

The process most appropriate to this research setting is exemplified in a "nonstandardized interview" (Goetz & LeCompte (1984), the "general interview guide approach" (Patton, 1990), and an "open-ended interview" (Yin, 1989). Additionally, the identification or "key-informants" to tell their stories (perhaps modified or limited life histories) is integral to refining the types of interviews to be done.

## Medical Records and Document Analysis

Acknowledging the paucity of literature on the use of medical records in qualitative research is unavoidable. The few articles referencing medical records were concerned with

pharmacological or medical procedure effects. The principal writings most closely related to this research area are concerned with document analysis, from either an historical perspective or for program content evaluation. There is some similarity with Rank's (Gilgul, Daly, & Handel, 1992) use of case records for data gathering.

Miller and Crabtree (Crabtree & Miller, 1992) state that a focus on artifacts is the common denominator in documentary-historical style of experimental research. They maintain that "The researcher using this style gazes at an artifact through the camera and filter most appropriate for the intent. The artifacts can be archives, literature, medical records, instruments, art, clothes, or data tapes from someone else's research" (p. 5). Goetz and LeCompte (1984) describe four activities that are part of the collection and examination of artifacts: "locating artifacts, identifying the material, analyzing it, and evaluating it" (p. 155). Apart from getting the proper signed releases and having the appropriate identification number, these are relatively easy tasks when dealing with medical records.

Though speaking from the perspective of historical rather than specifically of document analysis, Bedolla (Crabtree & Miller, 1992) writes,

> historical knowledge is about the manner in which humans in the past have constructed their unique

> reality; it is about historical facts and their intelligible connections. Historical method is thus not only appropriate for questions about the past, but also for questions about what was happening then and about the manner in which humans constructed their reality. These are questions about historical facts or about their intelligible relations. (p. 163)

Yin (1989) maintains that there are six sources of evidence for case studies: documents, archives, interviews, direct observations, participant-observation, and physical artifacts. He states that, "For case studies, the most important use of documents is to corroborate and augment evidence from other sources" (Yin, 1989, p. 86). Yin also addresses the value of multiple sources of evidence, stating that it is a major strength of case study data collection and that there is greater opportunity to use multiple sources in case studies than with other research methods.

Patton (1990) writes that there are three kinds of qualitative data collection: in-depth open-ended interviews, direct observation, and written documents. Patton writes, "Document analysis in qualitative inquiry yields excerpts, quotations, or entire passages from organizational, clinical, or program records; memoranda and correspondence; official publications and reports; personal diaries; and open-ended written responses to questionnaires and surveys" (1990, p. 10).

Patton (1990) also asserts that documents are a rich source of information, particularly in this age of "paper trails" on most any subject or experience within an institutional setting. According to Patton, "Program records and documents serve a dual purpose: (1) they are a basic source of information about program decisions and background, or activities and processes, and (2) they can give the evaluator ideas about important questions to pursue through more direct observations and interviewing" (1990, p. 233).

When using client records, such as medical records, as a source of information the issue of confidentiality is a principal concern. While Patton (1990) states that confidentiality must be respected, this seems to be a weak statement compared to the potential harm if confidentiality is breached. This is particularly true when working with research participants involved in recovery from chemical dependence.

The issue of modification of document content is addressed when Patton (1990) writes,

> The extent to which an evaluator will include actual references to and quotations from program records and documents in a final report needs to be negotiated on the basis of which documents ought to be considered part of the public record of the program being studied and, therefore, possible to be publicized without

breach of confidentiality. (pp. 233-234)

On this subject, Patton (1990) appears to be taking a somewhat naive approach to protection of confidentiality relative to medical records. Clearly there are situations in which documents and client records are in the "public domain" and are accessible to most any one interested. When considering documents such as medical records, personnel files, and psychotherapy files, there is a different understanding concerning access to these records and confidentiality relative to their content. Patton's position is not substantive enough regarding research into issues of chemical dependence and protection of confidentiality, because of the extreme importance of the maintenance of confidentiality to those who are chemically dependent.

## CHAPTER SUMMARY

This chapter reviewed related literature to the question of the nature of recovery for chemically dependent males, addressing the issue from multiple perspectives. Consideration was given to literature on models of addiction, family systems theory (particularly intergenerational/Bowen family systems theory, genograms, and family systems theory and chemical dependence), gender issues, and methodological procedures (case studies,

qualitative interviews, and medical record and document analysis). The next chapter presents the research methodology.

# CHAPTER III

# RESEARCH METHODOLOGY

## INTRODUCTION

This chapter presents a description of the research methods and procedures used in the collection and analysis of the data gathered. After a review of the problem, the main body of the chapter addresses confidentiality, data gathering (participants, interviews, genograms, and medical records), data analysis (data management, interviews, genograms, medical records, and coalescing of data), methodological concerns, and a chapter summary.

## REVIEW OF THE PROBLEM

The goal of this research is to better understand the nature of recovery from chemical dependence. This understanding comes from the perspective of the person who has received treatment, and continues in recovery from chemical dependence. This is accomplished by each research participant "telling his story" relating to drug use, treatment, and recovery. These "stories" are created from the data found in the interviews, genograms, and medical records. The themes, or success points, for each

participant are identified in each case study; these, in turn, are coalesced into a unitary discussion of the success points of recovery. There are six research participants, one from a pilot study and five from the principal study. The research participants are limited to one gender (male) because of the possibility of gender role socialization issues in recovery.

Patton (1990) asserts that case studies are particularly useful when interested in understanding special people, particular problems, or unique situations in depth. Patton writes,

> Case studies are particularly valuable when the evaluation aims to capture individual differences or unique variations from one program setting to another, or from one program experience to another. A case can be a person, an event, a program, an organization, a time period, a critical incident, or a community. Regardless of the unit of analysis, a qualitative case study seeks to describe that unit in depth and detail, in context, and holistically. (p. 54)

As this is a study pursuing an in-depth understanding of "special people", the organization of this research is built around six case studies. Each participant's story is a unique expression of the nature of his recovery from chemical dependence and case study method is an effective way of structuring the research process.

The over-arching framework in this study is the holistic multiple-case design set out by Yin (1989). The unit of analysis (thus holistic rather than embedded) is the individual participant in each case study; and multiple-case design with the multiple participants of the study. Yin states that "The evidence from multiple cases is often considered more compelling, and the overall study is therefore regarded as being more robust" (p. 52).

The key to this "robustness" is replication. Again from Yin, "The logic underlying the use of multiple-case studies is the same. Each case must be carefully selected so that it either (a) predicts similar results (a literal replication) or (b) produces contrary results but for predictable reasons (a theoretical replication)" (p. 53). Within the limits of human behavior and institutions, each of these case studies is a literal replication of the other.

The goal of this research is to answer the question, "What is the nature of recovery for a chemically dependent male?" The answers to the research question emerge out of the "story" of each participant. Each participant's story is given substance and form by the data from interviews, genogram, and medical record analysis.

The "source" for research participants is the Alcohol and Drug Recovery Center (ADRC), The University of Tennessee Medical Center at Knoxville, Knoxville, Tennessee. The U.T. Medical Center at Knoxville is a large regional referral

center, teaching hospital, and research center. It is a financially self-supporting institution that receives little funding from the State of Tennessee. The limited State funding is tied with its teaching function as a training site for health care professionals. The Alcohol and Drug Treatment Center is a sixteen-bed inpatient unit in the medical center complex (a closed-door hall in one wing); and an outpatient unit in a remodelled house on the University of Tennessee campus. The outpatient unit is across the Tennessee River, approximately a ten minute drive from the medical center.

The treatment approach at ADRC is similar to most other chemical dependence treatment centers, following the medical model and the disease concept of chemical dependence. There is an underlying commitment and involvement in the Twelve Step processes of such self-help support groups as Alcoholics Anonymous and Narcotics Anonymous. The inpatient unit houses the medical detoxification program, inpatient treatment patient beds, and administrative offices. Rather than the traditional 28-day treatment sequence, the inpatient treatment protocol is based on a program of variable length of stay. This results in patients transferring to the least restrictive environment (usually outpatient treatment) as soon as clinically appropriate, and in keeping with restrictions determined by method of payment for services received.

The outpatient unit has three tracks for chemical dependence treatment: one evening program and two day programs. The evening program involves treatment three nights a week, for a duration averaging eight to ten weeks. Patients in the evening program tend to be those persons who are higher functioning and have regular employment. The day programs offer more intensive treatment, with patients in treatment five days a week for four to six weeks, and are similar to partial hospitalization programs. The two daytime tracks make a distinction on level of psychosocial functioning, with higher functioning patients in track one and lower functioning in track two. A number of the track two patients are characterized by a dual diagnosis of chemical dependence and other mental disorders.

A board certified psychiatrist/addictionologist is medical director of the treatment center, with registered nurses and "psych techs" providing medical care. The clinical staff is made up of a clinical psychologist, a counseling psychologist (part-time), a licensed clinical social worker, a certified social worker, master's level nurse clinician, and several bachelor's level counselors. All the clinical staff have state or national counselor certification in chemical dependence, addiction, or similar fields. About one-half of the treatment center's staff are in recovery from chemical dependence. Both the inpatient and outpatient units have administrative support personnel.

This researcher served as an intern (600 hours) on the inpatient unit, meeting degree requirements for a Master of Science in Rehabilitation Counseling and eligibility requirements leading to Certification as a Rehabilitation Counselor. The internship developed into a half-time position as a counselor/case manager with the outpatient unit for twenty months. The research participants were not in inpatient treatment while the researcher was an intern, or in the outpatient treatment while he was employed with ADRC. Through this experience with ADRC, the researcher possessed a familiarity with the center's treatment philosophy, processes, and personnel. This research developed from observations made while he was a healthcare provider at the treatment center.

## CONFIDENTIALITY

Critical to the entire research process is the issue of confidentiality. This is not only a concern for the researcher and the Institutional Review Board (IRB), but a major one for the research participants. Without a sense of some assurance that their identities would remain confidential, the participants would not have felt secure enough to be open with disclosure regarding treatment. Confidentiality is a foundational issue in effectiveness with psychotherapy in general, and with chemical dependence

treatment in particular. This researcher's experience as a chemical dependence treatment provider gave consistent emphasis to concerns for confidentiality.

Federal regulations address particular concerns in chemical dependence treatment, and access to chemical dependence treatment medical records. Stamped on each page of an out-of-state treatment center discharge summary, made available for medical record analysis by one participant, was the following statement:

> Disclosure of this Material is prohibited by Federal Law. "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibits [sic] you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

An "Authorization for Release of Medical Information Concerning Alcohol and Drug Treatment" form specific to this research study was developed in response to the above (see Appendix A), in keeping with UT Medical Center policy.

The University of Tennessee Medical Center at Knoxville Institutional Review Board's principal concern in its evaluation process was confidentiality, beginning with the

recruitment process through the analysis of the data. The particulars of the Board's evaluation process may be found in Appendix A, and the final requirements are presented below in the Data Gathering section of this chapter.

The research participants were very willing to be a part of the research, particularly with the knowledge that "telling their story" not only benefitted themselves but also others. Even with this willingness to participate, they still sought reassurances that their identities would not be revealed. This is an understandable concern considering the predominant societal response to chemical dependence, even when someone has stopped using mood-altering substances, gone through treatment, and continues in recovery.

It is important to distinguish between anonymity and confidentiality, particularly with the importance of Twelve-Step "Anonymous" programs (for example, Alcoholics Anonymous and Narcotics Anonymous) in chemical dependence treatment and recovery. Webster's (1971) defines anonymity as "the quality or state of being anonymous; one that is anonymous," and anonymous as "having or giving no name; of unknown or unnamed source or origin; lacking marked individuality or personality" (p. 37). Webster's defines confidential as "private, secret; showing or indicative of intimacy; entrusted with confidences" (p. 174).

A certain level of anonymity is maintained through

alteration of names and other identifying information. Every effort was made to maximize anonymity. The greatest assurance of confidentiality arises out of making the research data as anonymous as possible, and taking measures to sever identifying items from the data (such as erasing the interview tapes, filing the authorization for release of medical information form in the medical record, and destroying the "Consent to be Contacted" forms). Assurances of absolute anonymity and confidentiality are not possible, and the participants were informed of these limitations. The participants and those who know them probably will recognize the individual participants in the case studies and the analyses.

## DATA GATHERING

### Participants

The research participants were recruited from those persons who had completed treatment for chemical dependence at ADRC. The selection criteria for possible participants included successful completion of treatment (receiving a "Regular Discharge" from the treatment facility), maintenance of sobriety (not ingesting in any fashion any mood-altering substances), continuing participation in Twelve Step programs (as set out in a patient's Continuing

Care plan), and recommendation of their counselor/case manager. Additionally, the participant must be at least six months but no more than twenty-four months post-primary treatment. Primary treatment is defined as that time when the participant was a patient in either the inpatient or outpatient treatment unit. Secondary treatment is when the patient has successfully completed primary treatment, received a regular discharge, and participated in a weekly Continuing Care program.

The participant recruitment process was initiated at a meeting with ADRC clinical staff members. During this meeting, the plan for the research was described, questions answered, and samples of the participant information packets distributed. Most of the questions from clinical staff members related to understanding the type of person desired for recruitment as a research participant. The Continuing Care Coordinator was designated as the contact person during the recruitment process.

Based on closed discussions among clinical staff members after the abovementioned meeting, a list of potential participants was developed. The Continuing Care Coordinator spoke to a potential participant and, if he expressed a willingness to proceed, was given an information packet. Only one potential participant was contacted at a time. This meant that the number of persons contacted did not exceed the number of research participants desired.

Also, this spaced out researcher and participant contact over a manageable time-frame. Approximately eight months passed between contact with the first participant and the final contact with the last participant. There was equitable representation from those who received primary treatment in inpatient unit, outpatient unit, or both, and secondary treatment in the inpatient and outpatient continuing care programs. Demographic particulars are found in each case study.

In the participant information packet was a "Consent to be Contacted" form. The potential participant who decided to proceed in the research process completed and mailed the form, in a pre-addressed stamped envelope included in the packet, to the researcher. From the information on this form, the potential participant was contacted by the telephone. The telephone conversation included a brief description of the program, responses to any questions, reassurance of confidentiality, and the scheduling of the first interview. All who agreed to be contacted agreed to participate in the research.

## Interviews

The interviews took place in a number of different settings: in the Psychological Services Director's office at the inpatient unit; in the living room at a participant's

home; in a university classroom; and in therapists' offices at a local private counseling center. The individual interviews lasted between approximately fifty minutes and two and one-half hours. The location, date, and time of the interviews were scheduled, first, for the convenience of the research participant and, second, for the convenience of the researcher.

The interviews were taped using a regular-size cassette tape recorder and external microphone. An interview guide was used (see Appendix A) consistent with Patton's (1990) general interview guide approach, and he writes,

> An interview guide is a list of questions or issues that are to be explored in the course of an interview. An interview guide is prepared in order to make sure that basically the same information is obtained from a number of people by covering the same material. The interview guide provides topics or subject areas within which the interviewer is free to explore, probe, and ask questions that will elucidate and illuminate that particular subject. Thus the interviewer remains free to build a conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style--but with the focus on a particular subject that has been predetermined. (p. 283)

The principal areas listed on the interview guide are drug

use history, family history, education and employment history, treatment experiences, post-treatment experiences, sex/gender developmental history, and life cycle developmental history.

Interviews for five of the six participants involved two separate sessions, while one participant was interviewed during a single session. The length of interviews was related to the varying levels of intellectual and verbal functioning of the different participants. If there were two interviews, then the first session focused on drug use history, family history, developmental history, education and employment history, and completion of the genogram. The participants were asked to tell their story up to the point of last entering treatment for chemical dependence at ADRC.

During the first interview, a second interview was scheduled, the authorization for release of medical information form was completed, and questions that the participant had about the research were answered. The participants received a small, pocket-size spiral notebook, with the instructions to use it as a place to write down any thoughts or memories they had between interviews related to telling their story. None of the participants wrote anything down, but some did report thinking about the issue under consideration. The participant with the single interview was the last person interviewed. Because of cognitive functioning limitations, all interview information

was gathered from him during one session without a need to meet for a second interview. The participants were asked not to discuss details of the interview and research process with other persons during the interview process. There were no reports of discussion between participants about the research.

The second interview focused on the participant telling about his experience in treatment at ADRC, both primary and secondary. Each participant was asked to reflect upon those parts or areas of treatment (for example, lectures, therapy groups, counselors, meetings, or videos) that stood out as particularly helpful. The participants were asked to identify the events during their treatment and recovery that they would describe as significant, transitional, or transformational. The identification of success points was also part of this interview. The researcher asked for and received permission to contact the participant if further information was needed. This did not prove to be necessary. Additionally, the genograms were reviewed and revised, if necessary, during the second interview.

The taped interviews were transcribed by the outpatient unit secretary, an individual familiar with the language of chemical dependence and concern for confidentiality. The transcriptionist was compensated by the researcher for the work done. The interviews were entered into a computer word-processing program by the transcriptionist, and copied

onto computer disk. On receipt of the disk, the transcribed interviews were checked for spelling errors, revised to remove any specific identifying information, and read for accuracy and clarity. The accuracy of the transcriptions was checked by the researcher by listening to the taped interview while comparing it to the computer screen text of the interview. After this step and in keeping with the process approved by the UT Medical Center IRB, the tapes were erased.

Using the word-processing program, the text was formatted and converted to a DOS Text and copied into a data-management program, The Ethnograph (Seidel, Kjolseth, & Seymour, 1988). Using the data-management program, the interview text lines were numbered and printed. Hard copies of the interview texts were used during the data analysis.

## Genograms

Though principally used in a clinical setting rather than for research purposes, the genogram is "a rich source of hypotheses about how a clinical problem may be connected to the family context and the evolution of both problem and context over time" (McGoldrick & Gerson, 1985, p. 1). The data were gathered during the first interview, and the genogram's initial construction was done by hand during this interview. The data were later transferred to a computer

program, Relativity (Zalman-Miller, 1990), for additional refinement and copies were printed. The conventions used in the construction of the genogram were those set out by McGoldrick and Gerson (1985).

Construction of a genogram followed a three-stage process. First, the basic data concerning three-generations of family members were gathered, including name, sex, age, relationship, birth order, and cause of death, if applicable. Second, information relating to employment, education, ethnicity, and health, especially chronic conditions such as chemical dependence, mental illness, or disability, was gathered. Third, descriptions of individuals were collected, particularly the quality and characteristic of relationships and other family dynamics issues. McGoldrick and Gerson's (1985) "Outline for a Brief Genogram Interview" was used as a guide for the interviews. It includes questions about the index person, children and spouses, family of origin, mother's family, father's family, ethnicity, major moves, significant others, problem areas for all listed, and relationship dynamics with all listed (pp. 157-158). See Appendix C for a detailed description of this interview guide.

The genograms were shown to the participants at the second interviews to check the accuracy of the instrument. The genogram for the participant who could say it all in one setting was checked during that single interview.

## Medical Records

The inclusion of medical record information in a person's "story" about recovery from chemical dependence was for triangulation of data. Additionally, the medical records presented a different perspective on the participant and process of his recovery. This is particularly relevant with this population because of possible problems of chemically induced memory loss, and patterned problems with veracity (more by omission than commission).

With the assistance of the Medical Records Department staff at UT Medical Center, the participant files relating to chemical dependence treatment were made available for review. Note that the Medical Records Department requirements and processes were clarified as part of the information submitted to the IRB. This resulted in congenial and cooperative interaction with the Medical Records Department staff.

Because of active involvement with either an impaired professionals group or continuing care programming, two participants' medical records were studied at the outpatient unit. In one case, a treatment summary from an out-of-state treatment center was reviewed. In each case, the signed authorization for access to medical information concerning chemical dependence treatment was filed in the medical record at the UT Medical Center.

There was considerable difference among the content and detail of each medical record, principally along the division between inpatient treatment versus outpatient. The medical records for those persons who went through inpatient treatment closely followed a medical or hospital approach, while the outpatient medical records were more in line with the type of recordkeeping generally used by psychotherapists. An example of the differences may be found with note-taking. The inpatient unit had "Nurses' Notes" with very brief notations, while the outpatient unit had more comprehensive "Progress Notes." Also, progress notes were kept for outpatient continuing care but were not kept for inpatient continuing care.

The review of the medical records produced a "narrative chronology" of the primary treatment process at a minimum. With some participants, this chronology also included information about their experience in secondary care, from the providers' perspectives. Beginning with the first dated notation through the last, either summary or verbatim notes were taken of "events" in treatment. These events were such items as notes from therapy sessions, physician and nurses' notes, treatment plans, diagnostic and discharge summaries, correspondence, and any other related information.

The medical record reviews for the first two participants involved the notes being taken by hand. The notes then were typed into a computer word-processing

program. A notebook computer was used for the subsequent four participants' medical record reviews as a labor saving move.

The narrative chronology was entered into a computer word-processing program, checked for spelling errors, revised to remove any specific identifying information, and read by the researcher for accuracy and clarity. Using the word-processing program, the text was formatted and converted to a DOS Text and copied into a data-management program. Using the data-management program, the narrative chronology text lines were numbered and printed. This hard copy of the narrative chronology text was used during the data analysis.

## DATA ANALYSIS

### Data Management

Once the transcripts from the interviews and medical record reviews were produced in hard copies, the process of active data analysis began. In a parallel process, the analysis on the genograms began with the production of the final computer-generated figures. Using three-ring binders, the several texts and genograms were assembled into sections that were interview text(s), medical record review text, and genogram for each participant. Computer disk copies of the

texts were placed in a bank safety deposit box. Within human limitations, no intentional inter-analysis or intra-analysis of participant data was done until the material for each case study was evaluated.

## Interviews

Prior to data analysis there had been two "exposures" to the data. The first exposure to the data was the actual interview itself, while the second was during review of the text for accuracy before the hard copies were produced. The third exposure to the texts was a simple but careful reading of the interviews, with no markings or notations made. During the fourth reading of the texts, a marker highlighted those words, phrases, and sentences that stood out as relevant to the issue of recovery and chemical dependence. The fifth reading added any notes or comments about the texts, highlighted or not, that related to the research topic. The sixth formal encounter with the interview texts involved another reading of the texts by the researcher, highlighting of relevant words, phrases, or sentences, and addition of notes or comments.

On a basic level, the information garnered from the texts was the participant's story--all the assorted bits and pieces that are added up to complete the picture of any person's life. With each reading of the texts, the use of

particular words, phrases, expressions, or other patterned descriptions emerged. These varied with each participant according to his life experiences, influenced by factors such as education, economics, race, ethnicity, and sexual orientation. The "results" of these readings fell into one of two groups: the overall narrative that tells of a participant's particular life; and the participant's interpretation and expression of the nature of their recovery from chemical dependence.

## Genograms

The skill and knowledge to analyze genograms arises principally from clinical experience rather than from the field of family research. Good analysis of genograms includes not only the data that are provided but also an awareness of what is not provided. For example, with the first participant, Thomas Adams, the ideal genogram that includes the participant's generation and at least the two that preceded it was not possible. His minimal information about his parents' generation and lack of knowledge about his grandparents' generation is informative when evaluating intergenerational family dynamics, particularly when interpreting family of origin influences on chemical dependence behaviors and recovery.

Analysis of the genograms generally follows McGoldrick

and Gerson's (1985) Genogram Interpretive Categories (pp. 159-160), which are based on the outline that they provide for the genogram interview. These categories are family structure, life cycle fit, pattern repetition across generations, life events and family functioning, relational patterns and triangles, and family balance and imbalance. See Appendix D for a detailed description of these interpretive categories.

## Medical Records

The analysis of the medical records followed a similar process as the interviews. The first encounter with the data was the original opportunity to take summary or verbatim notes. The second encounter was the accuracy check prior to the text's conversion to DOS text, and transfer to the data management program. The third encounter was a simple but careful reading of the text, while the fourth included marking words, phrases, and sentences relevant to the inquiry into the nature of chemical dependence treatment and recovery. The fifth reading included marginal notations, and the sixth reading was a final review of the text for relevant information.

While the interview was the primary source of data for the participant's story, the medical record data were the primary source for triangulation of data. The medical

record presented the healthcare providers' view of the treatment and recovery process, as opposed to the participant's view. This proved to be an effective tool for verification of information given in the interviews. This is not a question of doubting the veracity of the participants, rather it comes from the knowledge that mood-altering substances can affect memory well into the treatment process.

## Coalescing of Data

Coalescing something involves taking different items and bringing them together into a cogent whole. Each of the three data sources offers a different perspective on the question of the nature of recovery from chemical dependence. The interviews provide the participant an opportunity to present his perspective or story. The genogram presents the context of intergenerational influences on an individual's responses to the vagaries of life. The medical record is both a source of provider interpretations and for information verification. In the individual analyses of interviews, genograms, and medical records and in the interweaving of the data from these three sources, the goal was to both present a case study of an individual's experience and to identify the success points in recovery. The synthesis was fundamentally an inductive process. The

data from the interviews, genogram, and medical record were coalesced into a single "story" of the participant's experience with treatment and recovery.

Patton (1990) writes that "Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis" (p. 390). He identifies two ways that patterns may emerge from the data. The first is called "Indigenous Concepts," or the analyst uses "the categories developed and articulated by the people studied to organize presentation of particular themes" (Patton, 1990, p. 390). The second is "Sensitizing Concepts," or "the analyst may also become aware of categories or patterns for which the people studied did not have labels or terms, and the analyst develops terms to describe these inductively generated categories" (Patton, 1990, p. 390). The coalescing of data is related to the second way of pattern emergence, which Patton (1990) describes in the following way:

> In contrast to indigenous concepts, sensitizing concepts are concepts that the analyst brings to the data. These sensitizing concepts have their origins in social science theory, the research literature, or evaluation issues identified at the beginning of the study. Sensitizing concepts give the analyst "a general sense of reference" and provide "directions

> along which to look" (Blumer, 1969:148). The inductive application of sensitizing concepts is to examine how the concept is manifest in a particular setting or among a particular group of people. (p. 391)

The sensitizing concepts used in this analysis relate to chemical dependence treatment and recovery and family systems theory.

## METHODOLOGICAL CONCERNS

Qualitative researchers no longer offer an apology for their methodology in reaction to once predominant positivist views. This change comes out of an understanding that quantitative and qualitative research operate out of different paradigms. Though this research follows the qualitative paradigm, there are many in the chemical dependence treatment field who are not familiar with qualitative processes. This section is aimed at answering their methodological concerns.

Kirk and Miller (1986) state that "Qualitative research is socially concerned, cosmopolitan, and, above all, objective" (p. 10). They further state,

> A commitment to objectivity does not imply a desire to "objectify" the subject matter by "overmeasurement" (Etzioni, 1964), or to facilitate authoritarian social relationships by treating human beings as though they

were certain features they may happen to have. It does not presuppose any radically positivist view of the world; it emphatically eschews the search for final, absolute "truth," preferring to leave such an enterprise to philosophers and theologians. (p. 11)

The two reference points of research objectivity are reliability and validity. Kirk and Miller (1986) define reliability as "The extent to which the same observational procedure in the same context yields the same information; . . . [and validity as] The quality of fit between observation and the basis on which it is made" (p. 80). Patton (1990) asserts that "The validity and reliability of qualitative data depend to a great extent on the methodological skill, sensitivity, and integrity of the researcher" (p. 11).

## Reliability

Goetz and LeCompte (1984) write, in reference to ethnographic research, that "Reliability refers to the extent to which studies can be replicated. It requires that a researcher using the same methods can obtain the same results as those of a prior study. This poses a herculean problem for researchers concerned with naturalistic behavior or unique phenomena" (p. 211). Reliability means it can be done again. They write,

External reliability addresses the issue of whether

> independent researchers would discover the same phenomena or generate the same constructs in the same or similar settings. Internal reliability refers to the degree to which other researchers, given a set of previously generated constructs, would match them with data in the same way as did the original researcher. (Goetz & LeCompte, 1984, p. 210)

Goetz and LeCompte (1984) maintain that no study achieves perfect external reliability, but the problems of this type of research make this more difficult. They maintain that researchers "enhance the external reliability of their data by recognizing and handling five major problems: researcher status position, informant choices, social situations and conditions, analytic constructs and premises, and methods of data collection and analysis" (Goetz & LeCompte, 1984, p. 214). Each of these five problem areas is applicable and is addressed in this research.

In Goetz and LeCompte's (1984) view, research status position is the extent to which "researchers [are] members of the groups being studied and what positions. . .they hold" (p. 214). The difficulties that arise with replication principally relate to the social context and relationship that the researcher has with the participants. This problem is addressed through detailed description of the researcher's role and status with regard to the

institutional source of participants, and to the participants themselves.

Informant choices is a similar problem but the focus is on participant uniqueness rather than the researcher. Each participant has very particular and personal information to reveal in his story, and cannot give a universal picture of chemical dependence. The criteria for selection as a potential participant are detailed in the "Selection of Participants" and in this chapter. Because of the particular interest in individual stories of the nature of their recovery from chemical dependence, and the ultimate description in a case study, there will always be a certain level of idiosyncracy. This is kept to a minimum by the selection criteria, which can be replicated.

Social situations and conditions refers to the context in which the data are gathered. Goetz and LeCompte (1984) state, "What informants feel to be appropriate to reveal in some contexts and circumstances may be inappropriate under other conditions" (p. 215). This is an especially significant area with persons who are chemically dependent, with the major concerns for confidentiality and anonymity beyond the researcher/ participant boundary. This is addressed by privacy of interview settings, modification of all texts to remove identifying information, erasure of tapes, and placement of releases in medical records.

Analytic constructs and premises replication, according

to Goetz and LeCompte (1984), require that "the constructs, definitions, or units of analysis that informed the original research are [not] idiosyncratic or poorly delineated" (p. 215). This means that there must be explicit identification of the assumptions and metatheories that are foundational to terminology and methods of analysis used. They also write that, "Definitions for concepts should be clear and sufficiently lacking in idiosyncracy so as to be intelligible to other researchers and, where appropriate, to the participants being investigated" (Goetz & LeCompte, 1984, p. 216). A wheel is invented only when existing definitions, concepts, guidelines, processes, or methods do not offer an adequate response to the issue under consideration. Existing concepts and processes are used as often as possible to minimize this threat.

The problem of methods of data collection and analysis is addressed when researchers "strive to present their methods so clearly that other researchers can use the original report as an operating manual by which to replicate the study" (Goetz and LeCompte, 1984, p. 216). This is simply addressed by the underlying presumption in the construction of this chapter, that it be sufficiently detailed to permit another researcher to replicate the study--within the limitations of human behavior and institutions.

Internal reliability is concerned with agreement or

consistency across the research process, that there is congruency of data gathering among the several research participants by the researcher(s). Though more of a problem with multiple researchers, it is still an issue with the holistic multiple case design used in this research. Goetz and LeCompte (1984) identify five strategies to reduce threats to internal reliability: low-inference descriptors, multiple researchers, participant researchers, peer examination, and mechanically recorded data.

Low-inference descriptors refer to "Verbatim accounts of participant conversations, descriptions phrased as concretely and precisely as possible from field notes or recordings of observations, and such other raw data as direct quotations from documents" (Goetz & LeCompte, 1984, p. 218). The movement from interviews, genograms, and medical record through analysis, to identification of success points, and ultimately to stating conclusions and implications of the research data has few filters that would alter the appearance of the data.

Multiple researchers are described by Goetz and LeCompte (1984) as "The optimum guard against threats to internal reliability in ethnographic studies" (p. 219). When multiple researchers are not possible, especially because of funding or human resource restraints, then sources that can offer corroborating or confirming information are also sought. The use of medical record

information and genograms offers the corroborating and confirming information. Though idiosyncracies on some level will always enter in, a single researcher has positive response to internal reliability concerns when using pre-determined criteria, guidelines, and procedures.

Participant research assistants and peer examination are both applicable as strategies to reduce threats to internal reliability in ethnographic research. The first involves using others, who qualify as participants, to confirm the accuracy of data gathering. The second is a similar process but involves the researcher's peers in the confirmation process. Neither are applicable in this research setting.

Mechanically recorded data are subject to the whim of electronic failure but, when it does work properly, the result are data in a reasonably pure form. These data are useless unless analysis follows, and researcher idiosyncracies can enter into the process with data analysis. Transcripts from interviews, genograms, and texts of summary and verbatim notes from medical records all provide a level playing field for analysis.

## Validity

As Goetz and LeCompte (1984) point out, "reliability is concerned with replication of scientific findings, validity

is concerned with the accuracy of scientific findings" (p. 210). Kirk and Miller (1986) state that "To focus on the validity of an observation or an instrument is to care about whether measurements have currency (what do the observations buy?), and about whether phenomena are properly labeled (what are the right names for variables?)" (p. 21). Goetz and LeCompte (1984) assert that "Establishing validity necessitates demonstration that the propositions generated, refined, or tested match the causal conditions that [are] obtain[ed] in human life" (p. 220). Simply stated: is it real?

Goetz and LeCompte (1984) further state that "Internal validity refers to the extent to which scientific observations and measurements are authentic representations of some reality; external validity refers to the degree to which such representations can be compared legitimately across groups" (p. 210). The identified threats to internal validity are history and maturation, observer effects, selection and regression, mortality, and spurious conclusions.

History refers to the changes that occur as society progresses, while maturation refers to the changes that take place in an individual. This research is like a cross-sectional study, because much of the data come from a freeze-frame of each participant's understanding and expression of the nature of his recovery. Even the medical

record analysis loosely falls into a cross-sectional study because it is bounded by the clear time-frame of admission and discharge from treatment. There is some influence of maturation issues regarding the separation of the first and second interviews.

Observer effects are not only behaviors that participants might exhibit in hope of either pleasing the researcher or maintaining a barrier, but also the relational effects arising for researcher and participant encounters. Though these are unavoidable in a research process such as this, the participants are very familiar with telling their stories because of the emphasis on self-disclosure in treatment and with Twelve Step programs. Selection and regression, and mortality are not relevant issues in this research. Time and evaluation will tell on spurious conclusions that were hopefully absent.

Goetz and LeCompte (1984) believe that "threats to external validity of ethnographic findings consist of those effects that obstruct or reduce a study's comparability and translatability" (p. 228). They describe comparability as

> the degree to which the components of the study--including the units of analysis, concepts generated, population characteristics, and setting--are sufficiently well described and defined that other researchers can use the results of the study as a basis for comparison with other studies addressing related

> issues. . . . Translatability is related, but distinct; it refers to the degree to which the researcher uses theoretical frames, definitions, and research techniques that are accessible to or understood by other researchers in the same or related disciplines. (Goetz & LeCompte, 1984, p. 228)

The four threats to external validity are selection effects, setting effects, history effects, and construct effects.

The threat of selection effects is concerned with "the degree of match between categories and the reality of the group, culture, or setting under investigation" (p. 229) from Goetz and LeCompte's (1984) perspective. The categories or themes that emerge from participants rather than researchers have a positive impact, and Goetz and LeCompte (1984) write that "awareness of the participant derivation of the constructs may function as a control for threats to validity" (p. 229). The categories or themes must be identified from the participants' stories, and not from an external, "before the fact" researcher's list of categories or themes imposed on the data. This is principally addressed by the diversity of the participants, within the constraints of the study, and the use of their stories as the principal data source.

Setting effects, simply put, are reflections of the researcher's impact on research context. This impact takes place whether the researcher is an outside observer

diligently working to remain anonymous, or was an involved insider who was known to the research participants. Like selection effects, the possibility for modification of responses in reaction to the researcher does exist. The most significant way that this threat is addressed is knowing that telling one's story is a familiar process. Participants are familiar with telling their story through treatment and in 12 Step groups.

History effects reflect the knowledge that changes in such factors as locale, time, or people often mean a high probability of different results. This is not to say that there must be an absolute match, for such is impossible, but that the researcher must address the issue of history effects. Knowledge of the processes followed by this researcher work to reduce this threat, and this knowledge is part of the description above.

Construct effects relate to construct validity, or "the extent to which abstract terms, generalizations, or meanings are shared across times, settings, and populations" (p. 231) according to Goetz and LeCompte (1984). Many of these effects may also be threats to construct validity. Goetz and LeCompte (1984) also write, "Because a major outcome of ethnographic research is the generation and refinement--through cross-group applications--of constructs, ethnographers must consider issues of construct validity as critical to the credibility of their results" (p. 232). The

pilot study evaluated the effectiveness of the research plan, thus addressing concerns regarding construct validity.

## Credibility

An issue in any research, credibility is particularly important in qualitative research. Webster's defines credibility as "the quality or state of being credible" (p. 195). And credible is defined as "capable of being believed" (p. 195). Patton (1990) states,

> The credibility issue for qualitative inquiry depends on three distinct but related inquiry elements:
>
> (1) rigorous techniques and methods for gathering high-quality data that is carefully analyzed, with attention to issues of validity, reliability, and triangulation;
>
> (2) the credibility of the researcher, which is dependent on training, experience, track record, status, and presentation of self; and
>
> (3) philosophical belief in the phenomenological paradigm, that is, a fundamental appreciation of naturalistic inquiry, qualitative methods, inductive analysis, and holistic thinking. (p. 461)

It is believed that this research and researcher have appropriately addressed each of these three elements as described below.

The first element of rigorous data gathering and analysis is addressed by clearly defined parameters, whether it be in the interviews, developing the genograms, or reviewing the medical records. The use of the pilot study to codify the process reflects this concern for rigorous data gathering. In a similar way, the data were analyzed in a consistent manner across all the case studies, using the processes and patterns developed in the pilot study. The use of medical records was principally for triangulation, while concerns for validity and reliability are addressed above.

The credibility of the researcher (the second element) is based on both clinical experience and academic training in the fields of chemical dependence, family systems theory, healthcare, counseling, and qualitative research methodology. This researcher, like any other pursuing this type of research methodology, clearly holds "a fundamental appreciation" for this particular paradigm, described in the third element as a "philosophical belief in the phenomenological paradigm."

## CHAPTER SUMMARY

This chapter described the methodology used in gathering and analyzing the data obtained from six chemically dependent males, identified as in recovery from

addiction to mood-altering substances. The data were gathered through the use of in-depth interviews, genograms, and medical record analysis, and analyzed from the perspective of family systems theory with particular attention paid to gender issues. The next chapter contains case studies developed from the six research participants, with each case study providing a description of the participant, discussion of family of origin issues, and interpretations and implications based on the research questions.

# CHAPTER IV

## CASE STUDIES: ANALYSES AND RESULTS

### INTRODUCTION

At the core of this research are the "stories" of the six men who told of their experiences with chemical dependence. These stories emerged from the data found in the interviews, the genograms, and the medical records. By weaving the several strands of different sources into single cloths, the descriptions of participants' experiences in chemical dependence treatment and recovery are given form. These stories are presented as six separate case studies.

Each case study has three parts: first, a description of the participant's history of alcohol and drug use and chemical dependence treatment and recovery is presented; second, family systems information from the participant's family of origin and nuclear family and genogram are set out; and, third, the interpretations and implications of the case study material are offered. The six case studies are listed in the order that the initial interviews took place. The pseudonyms of the participants and family members have no significance apart from the researcher's need for a logical sequencing system and from whimsy.

# CASE ONE: THOMAS ADAMS

## Description of First Participant

The first participant, Thomas Adams, was a 61 year old African-American male, employed as a materials clerk at a large government facility operated by a private contractor. He was admitted to the inpatient unit of the alcohol and drug treatment program of a university medical center for primary treatment, with an initial diagnosis of Alcohol Dependence (303.91) on 17 September 1991. On admission, Mr. Adams registered 0.20 on the breathalyzer test (in Tennessee, 0.10 and above meets the legal definition of intoxication), remaining in primary treatment for twenty-eight days[1]. He was discharged on 15 October 1991 to the inpatient continuing care program for another twelve months in secondary treatment, retaining the diagnosis of Alcohol Dependence. His interviews were on 11 November 1992 and 25 November 1992, and the medical record was reviewed on 14 January 1993. Both interviews took place in an office at the treatment unit, as a convenience for the participant. The genogram was developed from interview data, and checked against the medical record and with the participant for accuracy.

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[1] Most treatment centers' programs are built around a four week or twenty-eight day cycle. It is hard to know whether that time restriction came before or after insurance reimbursement limitations. Length of treatment is a hotly debated issue in the field of chemical dependence treatment.

his wife, though medical record notes indicated that Sara has been and continued to be angry with him about his drinking and its related behavior (e.g., "running with women"). Two of his daughters live in the same community as this participant, while the other two children live out-of-state. He reported a good relationship with his children, and this appeared to true based on the medical record notes, which cited frequent contact with his children during treatment.

Mr. Adams entered the armed services after graduating from high school, and spent about 18 months in Korea. He entered a small college (racially segregated) in a nearby town, but dropped out after two years because he got married. He reported that he sold insurance for a brief time, then worked at a large linen cleaning and supply service for several years. Around 1965, Mr. Adams and his wife moved to New York City so she could complete educational and training requirements to upgrade from an LPN to a RN. The children remained with relatives. The parents returned home in 1968, and Mr. Adams started work at the large government facility in 1969. He has been with the same employer for about twenty-four years. Mr. Adams reported during interviews that his drinking had never interfered with his work, and that "he felt that his continued drinking was going to jeopardize his job performance and his continued employment." This was not

substantiated in the medical record, which stated that his security clearance was pulled because of intoxication on the job. Mr. Adams' employer was willing to work with him and the treatment unit in coordinating post-hospitalization care.

Mr. Adams indicated that he first had a drink as a child, when he and other children would sneak a drink from moonshine caches in the woods. His drinking continued intermittently through high school, until Mr. Adams entered the service. He described constant drinking while stationed in Korea, particularly as he and his fellow soldiers lived in tents with little to do. His drinking continued after leaving the service, with gin as the drink of choice. Mr. Adams described a pattern of going to local bars or illegal drinking establishments. He reported that he tried drugs briefly but did not like the effect.

Mr. Adams entered treatment because of job-related problems with drinking--he came to work with alcohol on his breath. There had been past charges of driving under the influence (DUI) and public drunkenness (PD), including what appeared to be an alcohol-related accusation of assault. Though able to express some concern about possible loss of job because of alcohol, "he feels with some treatment he will be free of his problems at work." The Nursing Assessment done at admission states that Mr. Adams "evidences difficulty with memory recall, especially of

specific dates/procedures." Both are strong indicators of the level of denial at the time of his admission for chemical dependence treatment, and probable adverse effects of chronic alcohol abuse.

Mr. Adams' treatment experience was relatively uneventful, apart from dealing with insurance benefits running out and having to assume the remaining costs of hospitalization. The medical record notes indicate that he was generally cooperative throughout the treatment process, and participated fully in all activities. The principal issue identified by the clinical staff was the participant's denial of his past alcohol abuse and present alcohol dependence. Only with another patient's relapse while in treatment did Mr. Adams' denial begin to abate. He experienced first hand the cost of relapse, when this "treatment friend" renewed use of mood-altering substances. Remnants of his denial still remained during the interviews, such as his minimization of the impact of his drinking on employment (his employer was the catalyst for him entering treatment), or on his marriage (characterized by many years of separation).

The history of alcohol use, abuse, and dependence presented by Mr. Adams is an increasingly unique one because of the current prevalence of polysubstance use with those who are chemically dependent. Few persons remain single drug users today. His experience is similar to Paul

Francis, the final participant, which probably reflects parallels in age more than anything else (they are within ten years of the same age of each other).

## Family Systems Information

Mr. Adams was reared in his mother's hometown, but he knew little of her family other than she had two brothers and "lots of sisters." His mother, Marie, was a homemaker. His father was a cook, often travelling to find work and living away from home to support his family. Stan, Mr. Adams' father, was from Georgia. Mr. Adams reported that his father had some siblings (unknown number or gender), and he never saw his paternal grandparents. Third-generation family information was clearly absent on the genogram (see Figure 1).

Mr. Adams grew up in a small town in a rural county of East Tennessee. He is the sixth child (fourth son) of eleven children, eight of whom are still living. The oldest, Meg, died in 1988 at age 66 from cancer; Jon, the third child and oldest son, murdered his wife on the suspicion that she was having an affair, and then committed suicide in 1969 at age 43; and the youngest sibling, Mike, died in a motor vehicle accident in 1966 at age 24. His five older siblings and closest younger brother completed the eighth grade, while the four younger siblings finished

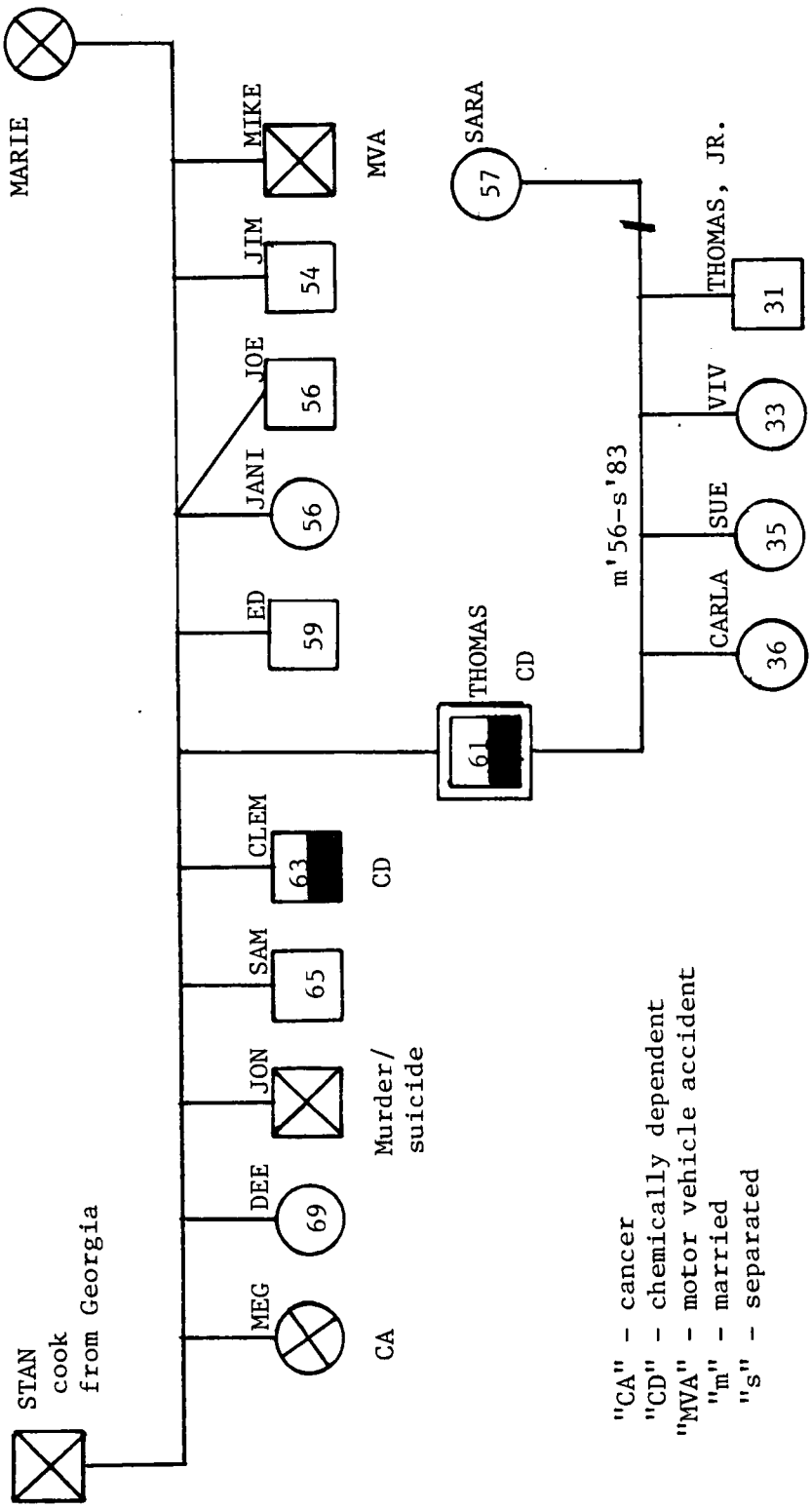



Figure 1 - Thomas Adams (11Nov92)

high school. These educational limitations arose principally from the segregated schools, the absence of adequate educational opportunities for African-Americans in the rural South at that time, and the limitations imposed on almost all residents of Appalachia.

Mr. Adams identified only his brother, Clem, as an alcoholic. It is relevant to note that another brother, Jon, died because of a domestic violence (murder/suicide) incident, and Mike died as result of a motor vehicle accident. Both situations have a high incidence of alcohol and/or drug involvement. Because of the absence of information about third-generation family members, it is not known about other possible familial problems with alcohol or drugs.

The cutoff by Mr. Adams' father from his father may be an indicator of distancing oneself from a dysfunctional family of origin. It also may be a reflection of economic, cultural, and racial patterns of that time. The participant described a distant relationship with his father, and a distant relationship with his wife. There is a high probability that this distancing behavior between father and son, and husband and wife, is a replication of intergenerational transmission of behaviors. This is particularly relevant when considering Mr. Adams' increased emotional isolation as alcohol abuse and dependence increased.

It is difficult to analyze the Bowen Family Systems concepts in relation to Mr. Adams because of the lack of family of origin information. Though his inability to provide information is a clear indicator of emotional cutoff, as discussed above, it also means that analysis of multigenerational dynamics would be conjecture. His ten-year separation from his wife is probably indicative of problems with differentiation of self, seemingly consistent with his difficulty with interpersonal relationships. This separation is also indicative of the nuclear family system.

Much of what emerges from a family systems evaluation, both from the interviews and the genogram, of Mr. Adams can be characterized as a pattern of isolation and difficulty in connecting with other persons. When considering these dynamics in relation to his alcohol use, Mr. Adams' statements about the impact of his "treatment friend's" relapse and the AA meetings on his recovery gain significance. Much of his life reflected isolation (family of origin, nuclear family, and friends) from primary relationships with others. Recovery from alcoholism began with a reversal of this pattern while in treatment.

## Interpretation and Implications

It is difficult to access the importance of gender issues for someone like Mr. Adams. First, generational

differences make gender issues less of an important concern to him. Second, the realities of survival parameters for an African-American male growing up in the United States (and the South in particular) over the last few generations make this a problematic concern. To ask questions that come from Gilmore's (1990) three-fold definition of manhood would likely result in confused responses. Gender issues, especially those that relate to "what it means to be a man," tend to be generationally focused. Mr. Adams would be less concerned for his roles as protector, provider, and impregnator (all of which he has done), than how to both survive and to move ahead in a generally hostile culture.

There was a distinct advantage in working with Mr. Adams' medical record, because of his limited tendency to speak of unpleasant events or issues. Perhaps this was truly from forgetfulness or a desire to provide "good answers" to the researcher, but probably was more a disease-related pattern of prevarication. Rather than acknowledge that he entered treatment because of employer pressure, he stated that drinking never interfered with work. This was not supported by medical record evidence. Family issues concerning the marital relationship were first identified in the medical record. In this case study, there was clear value in triangulation of data.

Four success points emerged from Mr. Adams story: an understanding of chemical dependence; non-isolating

behavior; breaking down of denial (intermittent but still present); and a "spiritual awakening" leading to an increased importance of a spiritual dimension to his life. It is relevant to note that there is always the possibility of bias arising from those issues emphasized by the clinical staff, or by the researcher.

The first success point was Mr. Adams' new ability to understand chemical dependence in a manner that supported his recovery. Mr. Adams stated,

> I never really considered myself to be an alcoholic when I was, 'cause I always had a fairly good job and didn't mistreat my family to any extent. . . . I didn't even know what a alcoholic was and I didn't consider myself one because I was a good worker.

His lack of knowledge about chemical dependence was not particularly different than most. Many persons hold the view that an alcoholic is synonymous with a skid-row bum (approximately five percent of those who are chemically dependent). Mr. Adams reported, "I didn't even know what Alcoholics Anonymous was. I didn't know it was a place to help you. I thought it was a place where people would go to drink or whatever or learn to drink." Mr. Adams was not able to identify any particular method, such as lectures or videos, that were more helpful than others. Most of the knowledge about chemical dependence appeared to be received through absorption when in contact with other persons in

recovery. This is not an invalidation of the educational programs, rather that the educational program content appears to need "validation" by other recovering persons.

The second success point relates to a behavioral change from isolating to non-isolating behavior. Mr. Adams had an ever-increasing pattern of isolating himself from others, particularly with regard to family and work. His interpersonal activities increasingly revolved around drinking and those who drank. A change to less isolating behaviors began developing during both primary and secondary treatment, particularly when he started to attend and then become involved with 12 Step meetings. The principal benefit of AA, identified by Mr. Adams, was the interaction with other persons in recovery that helped him to put his alcohol dependence in better perspective. He stated that "The AA meetings is the main thing. I've heard so much in the meetings, you know, that I can look back and say, 'Well, I wasn't half as bad off as some of these people, you know.'" His interaction with other recovering alcoholics represented a change from the isolating and distancing patterns in his family of origin and his nuclear family.

The third success point was somewhat intermittent, but there were indicators of a breaking down of Mr. Adams' denial about the impact of alcohol on his life, particularly regarding work, marriage, and family. The on-and-off again response to denial is related to the level of on-going

minimization. It also appeared to be related to cognitive functioning, because of the varying clarity of thought expressed by him during the interviews. It appeared as if Mr. Adams knew that he needed to stop denying the major impact of alcohol on his life, and he would respond appropriately often. There were also times that he would forget this, and slip back into old patterns of thought that were reminiscent of a "dry drunk." The AA slogan, "progress not perfection," seems appropriate to this situation.

The final success point is an almost universal component to successful and continuing chemical dependence recovery. The development of a spiritual foundation to life for the recovering person is usually a central change. The 12 Step process, a core component of most treatment centers, is described as a spiritual program. It is not surprising to hear Mr. Adams speak of experiencing an awakening to the multidimensionality of life, "An awakening for me. I guess I had been to sleep for so long that it just woke me up." He had grown up in a religious home but had distanced himself from church over the years, and his introduction to spirituality was eye-opening. He went on to say,

> Well, through the treatment this I'd never really heard of a spiritual thing as they said in here. This one Father +++++++ [a local Roman Catholic priest who does lectures on spirituality at a number of treatment centers in the area]. He really woke me up to the

difference between religion and having a spiritual life.

Mr. Adams' developing spirituality assisted in clarifying issues around denial, isolation, and the nature of recovery. The importance of this spiritual awakening to the participant cannot be minimized. It was a recurring theme throughout the interviews.

The implications of this case study stress the importance of combatting the interpersonal isolation that is characteristic of chemical dependence. Additionally, the importance of the reorientation or transformation of one's life, expressed in the language of a "spiritual awakening," is a central point to understanding the nature of recovery from chemical dependence. Finally, the interplay of family systems dynamics in perpetuating dysfunctional behavior is another important issue to recovery.

## CASE TWO: MATTHEW BAKER

### Description of Second Participant

The second participant, Matthew Baker, was a 26 year old single, white male, presently a full-time student at a local community college. He was admitted to the outpatient unit of the treatment program on 18 June 1991, with an admitting diagnosis of Alcohol Dependence (303.90). Though the inpatient unit was the preferred treatment setting, the limited wheelchair accessibility resulted in referral to the outpatient unit because of its less handicapping building. Mr. Baker was under an order for evaluation by his Federal probation officer in December 1990, but did not schedule the evaluation until June 1991. This was his third treatment for chemical dependence, with previous efforts in 1985 at a local private treatment center (followed by halfway house placement and participation in an extended post-treatment program in Atlanta), and in 1989 at the local United Way outpatient treatment program. Mr. Baker was given a regular discharge on 5 August 1991, with an initial referral to a weekly outpatient continuing care program that subsequently was discontinued, resulting in his referral to the inpatient continuing care program. His discharge diagnosis was Polysubstance Dependence (304.90). The initial interview was on 26 January 1993, the medical record was reviewed on

19 February 1993, and the second interview was later in the day on 19 February 1993. The genogram was developed from interview data, and was checked against the medical record and with the participant for accuracy.

Mr. Baker was pleasant and cooperative throughout both interviews, and appeared interested in the subject of recovery from chemical dependence. He had a dry wit, with a sardonic approach to his situation, and a tendency to be clear and direct in his communication. As result of a 1984 motor vehicle accident in which he was a passenger, Mr. Baker has T9 and below paraplegia resulting in use of a wheelchair. There was some occasional cognitive dissonance that may be the result of the motor vehicle accident, though Mr. Baker stated that it was the result of drug abuse. The initial interview was held in an office at a local counseling center that proved to possess significant accessibility barriers, so the second interview was held in an wheelchair accessible classroom at the local university. Mr. Baker did not seem disturbed by the problems at the initial setting. He expressed surprise that he had not said anything about his wheelchair during the telephone conversation, when the first interview was arranged. Considering his usual pattern of addressing this particular issue directly during initial contact, it did seem like an unusual oversight.

Mr. Baker reported that he started drinking in high

school, and that "I remember my first drunk anyway in my sophomore year." He also reported that he first smoked marijuana during that same period of time. Initially, it was under controlled conditions resulting in periodic drinking, but his drinking and drugging were out of control by his senior year of high school. Mr. Baker reported that he "stood to graduate like fifth in my class out of 800 students" but did not graduate on time. He stated that he stopped going to classes because they "got in the way of my drinking and partying."

During the same time that Mr. Baker was becoming chemically dependent, he also became sexually active and stated "I do remember that I lost my virginity my junior year in high school and that sex became an addiction for me." This particular relationship continued midway through his senior year in high school. He reported that the relationship ended because the girl had an abortion. He stated that his drinking and smoking marijuana increased dramatically as he struggled with the breakup of the relationship. This pattern of difficulty with relationships was repeated because of personality deficits, arising from both family of origin issues and developmental delay arising from the chemical dependence. Mr. Baker stated that his increased use arose from his desire "to anesthetize the pain I guess about the abortion and that relationship being over." By the time Mr. Baker completed high school, he

clearly was abusing alcohol and drugs and probably had made the transition into dependence. By his self-description, he had also developed a parallel addiction to sex.

Even with his use-related academic difficulties and delayed graduation, Mr. Baker entered an out-of-state regional university. He reported that he did well during the first semester, relating his academic success to practicing some moderation in drinking and using. Mr. Baker also was a varsity swimmer during this time. He reported that his drinking increased and his academic performance decreased during his second semester. About one month before a major swim meet, he tried unsuccessfully to stop drinking. Mr. Baker stated,

> I broke down after two weeks and got drunk one night and developed some sort of, I think it was tonsillitis or something, got really sick and so I was sick for about ten days and it finally cleared up a few days before the meet but it still had an effect on my performance at that swim meet. I just remember I got sick the day after I got drunk so I was disappointed in myself for allowing that to happen.

His destructive drinking and drugging behavior was very noticeable to his teammates and his coach. He stopped going to classes, "After I failed all my classes that semester I quit going to classes". During the summer Mr. Baker worked diligently to convince his coach that things would be

different, and the coach was willing to give him another chance on the team if he re-established eligibility. Returning to the university for a third semester, Mr. Baker stated that "within a week I was so heavy into it by then I quit going to classes right away." He continued to work out with the team, delayed speaking with his professors (another repeating behavior when faced with major problems), and, with disastrous mid-term grades, he was removed from the team. Mr. Baker stated that he remained at the university for the remainder of the semester rather than return home to Knoxville because he did not want to tell his parents. He did return home, and found a job working in a night club in West Knoxville in February 1984 at age nineteen. Mr. Baker reported that he started experimenting with cocaine during this time.

At about 5:00 AM on 22 June 1984, Mr. Baker was involved in a motor vehicle accident that resulted in his back being broken (T9 and below). While a passenger in a friend's car, the driver fell asleep and ran into the rear of a tractor-trailer rig stopped on the interstate shoulder. The driver was not charged with DUI, but Mr. Baker reported that both of them were heavy users so there probably was some chemical influence on judgment and reflexes. In addition to his broken back, all of his ribs were broken, he was knocked unconscious, and had bone damage to his face. After a six week hospitalization, he was transferred to the

Patricia Neal Rehabilitation Center for a six week program to learn living skills. Mr. Baker said, "I didn't know that [learning living skills] was what I was going there for. I thought they were going to try to do some experimental procedures or something to get me to walk again. That was not what it was all about." Even while first in the hospital and then in the rehabilitation center, Mr. Baker had friends smuggle illicit drugs to him, or "was conning the nurses into giving me drugs, pain killers." By his report, psychotherapy to address the emotional dimension of his paraplegia was not provided during either of his hospitalizations. In describing the months after his discharge, while undergoing personality changes because of cocaine abuse, he stated "I mean I was already bitter anyway and pretty crazy because I wasn't dealing with the emotions from the paralysis. I was strong-willed and decided I was going to take care of any emotional imbalance on my own." His "taking care" was a significant increase in use of alcohol, marijuana, and cocaine.

By January 1985, Mr. Baker had deteriorated because of drug abuse to the point that he was confronted by his parents, particularly his mother. Expressing concern for his drinking and suspected drug use, his parents suggested that he seek help for his problems. He recounted that,

> I said 'no way' and that's when my mom said that she had seen me just 30 minutes prior to the car accident.

> . . . She said that she was willing to testify against me in my lawsuit so I was willing to oblige at that point. I wasn't really happy about it though. I was pissed off.

This was his first treatment for chemical dependence (at a local private psychiatric hospital). It began on 11 February 1985 and continued for forty-five days. He then entered an Atlanta halfway house program and continued with an outpatient treatment program (there were no wheelchair accessible halfway houses in Knoxville).

Mr. Baker was able to maintain his sobriety for about twenty-two months before relapse. While in Atlanta, he received a small lump sum payment in partial settlement of his lawsuit, which he spent compulsively on clothes, an expensive apartment, and eating out. After quickly running through his money, he returned to Knoxville. He reported that he stopped attending AA meetings after about fifteen months, "strong armed alcohol and drugs for another six months," and started drinking about a month after the break up of a "fairly serious" relationship. Mr. Baker said, "So now we are into '87. This is the blur for about the next three years." He reported that he was using mostly marijuana, but that he went on a cocaine binge during that late summer or early fall of 1988 when he received a second lump sum payment. He stated, "I went through about a $10-12,000 cocaine binge. I went through that in about a

month." Mr. Baker stated that he overdosed twice during this cocaine binge, with cocaine induced tachycardia.

By the Fall of 1988, Mr. Baker was living on his own in South Knoxville. His parents recognized his relapse and would not permit him to live in their home. He reported that the drinking and using resulted in him becoming "real violent a lot of times."

**Mr. Baker:** I'm not exactly sure what happened. I know that I would just get physically and violent with people and apparently it didn't matter if you were my best friend or a total stranger. It was usually primarily the same thing. A lot of times it was jealously. I got into a real sick relationship with this young lady who was abusive. I abused her physically and emotionally and maybe some of it came back to me too. I don't really want to say what part she played in it. I know that I was cruel, very cruel. I experienced jail, I experienced a lot of things I hadn't experienced before I went into the program the first time.

**Researcher:** What were you in jail for?

**Mr. Baker:** The first time was in 1989 when I went on a camping trip to the Big South Fork and got up there and lasted about three hours before I got in jail. I punched a Park Ranger.

Originally charged with felonious assault on a Federal

officer (the wheelchair was identified as a weapon), the charges were reduced to a misdemeanor. He was placed on probation for one year and instructed to seek treatment at the United Way supported community treatment program, but failed to complete this second effort. During one week in the eleventh month of his probation, Mr. Baker was first arrested for public drunkenness and then for assault. A student at a local state university at that time, he was given an indefinite suspension from the university because of the assault that took place on university property.

Mr. Baker's probation was revoked and then reinstated in December 1990, with the provision that he have an evaluation for chemical dependence. Mr. Baker avoided facing this problem for about six months, though his probation officer was telling him to get the evaluation and required frequent drug screens. He started finding ways to avoid going in for screens or using alcohol as a palliative in place of marijuana or cocaine. Ultimately, the probation officer held him accountable for his actions, and Mr. Baker stated,

> So finally he got tough with me and around May or June he told me that if I didn't go pick up my assessment and start working with him then he was going to revoke my probation and I would have to serve time at a Federal penitentiary for six months. So that was enough incentive for me to go pick it up and I went and

did that.

Disliking the assessment from ADRC, he sought one from another treatment program in the area and was given an even more demanding plan of treatment. In an effort to convince his probation officer that he had done all that he could, he took his parents along with him to the meeting. Mr. Baker said,

> My mom practiced some really pretty serious stuff right there in the probation office. I was hysterical by the time I left. I lived over near Ft. Sanders, and his office was downtown, and I just rolled back from his office to my apartment and I was crying all the way home.

Mr. Baker went to the local university medical center seeking admission to the inpatient treatment unit but, for reasons that are unclear, was told that they could not accommodate his wheelchair and was referred to the outpatient unit. Told that "the deal was, was that I was not to screw around at all or I was going to be back over at the hospital. They would find a way to accommodate me." He was admitted on 16 June 1991 for his third treatment for chemical dependence. Mr. Baker stated that "I was just going to go through the program to satisfy my probation officer and start using again. I just didn't think that I had deceived myself into thinking that sobriety wasn't worthwhile. I forgot how good it was."

Mr. Baker denied his use of marijuana on his initial assessment for this third treatment, saying that it was over a year since he had smoked. He described his attitude toward entering treatment when he said,

> I went into treatment with the idea of just getting off probation and I was just going to work the system until I pleased the people I needed to please and then I was going to go about my own business. Or so I thought until I got busted with a drug screen for smoking marijuana.

This was said even in the face of a positive drug screen--denial is a powerful force. "Anyway they were going to bust me with that so I had to get honest with that. Sharon [the outpatient unit director] threatened to ship me off to another treatment center." This confrontation became a critical point in Mr. Baker's transition from sobriety to recovery. He stated that

> I was at the point of tears. I was in tears. And I was upset and she told me that I was either going to need to get honest and start working and get off my pity pot or else I was going to have to try something else because the program wouldn't work for me otherwise.

He reported that in the following weeks he just started to feel better, "I guess I saw some hope and I received a lot of encouragement as far as I was concerned."

Once past that confrontation for continuing marijuana

use, Mr. Baker reported that treatment started to fall into place for him. Much of what he was hearing in the treatment program this time was similar to the education programs from previous treatments. He reported that this time he was able to absorb and process what was going on, whether it was lectures on relapse prevention or hearing Earnie Larsen (1985) ask "Who's driving your bus?"

There was a recurring pattern of being late, first seen in his difficulty in getting the evaluation, then missing several appointments, and, finally, getting to the treatment unit on time. [He was late also for both interviews for this research.] Mr. Baker attributed this to a need to change sleeping patterns, and having to "push my wheelchair" about two miles over flat and hilly ground. It was also pointed out to him that,

> through my tendencies to be impulsive, that maybe I would try to do something else real quick before I proceeded onto my next destination, and inevitably not leave myself enough time. I would get distracted just long enough to take up enough time to make myself late and that is the way it still happens today.

Considering that there was sufficient head trauma during the accident that Mr. Baker was rendered unconscious, and that there were examples of cognitive dissonance during the interviews, there may have been neurological damage from the accident that exacerbated existing impulsiveness.

The pattern of procrastination and resistance to direction reappeared when Mr. Baker was called upon to contact halfway houses, and make arrangements for him to relocate into such an environment. "I was looking for a loophole. Actually, I was hoping, they gave me a list [of halfway houses] and I went all the way down the list and I was calling them all to see if they could accommodate a wheelchair." His hopes of failure were dashed when the last listing, Barnabas House, was willing to modify their building for a wheelchair. It is interesting to note that this is the same halfway house where his older brother stayed after his chemical dependence treatment. After several months in the halfway house, Mr. Baker was able to negotiate an arrangement to stay in a part of his parents' home (an apartment modified from the garage).

There were a few instances during the remainder of primary treatment when Mr. Baker exhibited behavior patterns that had certain narcissitic traits (e.g., insisting that taking a break from treatment to visit his brother in Texas would not interfere with recovery, or his resistance to a halfway house placement). Generally, this third primary treatment experience was uneventful. Medical record Progress Notes indicated an engagement with the treatment process, and a general willingness to struggle with his addiction and its behavioral sequelae. On receiving a regular discharge, Mr. Baker started secondary treatment at

the outpatient unit but, when the group was discontinued, transferred to an inpatient continuing care program. He did state that the outpatient continuing care program was more helpful to him because of its greater intensity and clarity of purpose. He was living in the converted garage apartment at his parents' home, and was a student at a local community college with hopes of readmission to the university at the time of the interviews.

## Family Systems Information

By his description, Mr. Baker's mother was often the parent who took the initiative and stood the ground when confrontation was needed. It was his mother who stated that she would not back him up in his lawsuit about the motor vehicle accident unless he got into chemical dependence treatment.

**Mr. Baker:** With my parents it was I never really had a close relationship with them even after I got into the adolescent years, past the age of ten.

**Researcher:** Now has that changed since you have been in recovery?

**Mr. Baker:** It has changed but it is still not, it is still different, it is still not what I would consider a close relationship, a real close relationship.

Even with this declaration about continuing lack of

closeness, Mr. Baker still valued family connections.

> Another reason I wanted to leave it [the halfway house] was Thanksgiving Day, when I left, because I wanted to spend the holidays at my parents' house. I wanted to be with my parents because the Christmas prior to that, after I had been kicked out of [the state university], I wasn't even allowed to come home. And so I had to spend Christmas alone so I wanted to be around my family.

Even with the recognition that they did not have a close relationship, he did acknowledge that there had been some improvement. With a certain irony, he stated that "My parents don't try to control me and hopefully I don't manipulate them too much."

Mr. Baker usually described his mother in a positive light, "hardworking and compassionate." He described his father in a less than positive way (negative, hardworking, very smart, and moody).

> Well, I just have trouble communicating with him and I realize now, I mean, today I believe that it is because we have two completely different types of personalities. . . . If there is something that I think is bothering him, he will take it out on someone else and it is usually someone in the family. Not violently, verbally violent, you know, verbally abusive like he used to. He gets real, how do I want to say,

> [pause] just like sandpaper. I don't know what the word is. . . . Abrasive. Yeah. Very abrasive. And he is very quick to point out, very judgmental and I'm a lot like that too.

A notation in the medical record states that Mr. Baker "perceives [his father] as being overly critical and unable to express warmth to patient."

Much of what Mr. Baker has described as his transformation into recovery is an expression of differentiation of self. His hyperemotional responses to conflict, direction, or structure, and his use of mood-altering substances, were used to avoid moving along the differentiation scale to a more balanced position of emotional and intellectual functioning. Though there is some dependence upon parents at the present time, it also appears to have gone through a transformation relative to the differentiation of self. Use of alcohol and drugs can be an attempt at emotional cutoff, and this appears consistent with Mr. Baker. Rather than face the difficult challenges of differentiation, alcohol and drugs were used as a means of emotional cutoff from the dysfunctions of his family of origin.

The family projection process carried the parents' communication problems into the family, where they were reflected in the nuclear family dynamics. The combination of the mother's apparent dominance with matters emotional,

and the father's distancing himself from emotional connection, perpetuate the dynamics of emotional distancing and emotional immaturity. It is difficult to discern the impact of multigenerational influences on Mr. Baker's chemical dependence and particular needs for recovery, apart from conjecture. There are a few points that might indicate intergenerational transmission of problems. Moving up the generations: first, two of the three sons are chemically dependent and the other took a "geographical cure" by moving to Texas, and Mr. Baker is the youngest of three; second, Mr. Baker's description of his father is of a man who is not differentiated, has a possible past problem with drinking, and whose brother died from an alcohol related motor vehicle accident; and, third, his mother is also described as having a possible past problem with drinking, and is working a level well below her educational training [holds a PhD but works as a medical technologist]. Mr. Baker had limited knowledge of his grandparents' generation, which may represent an emotional cutoff.

The genogram (Figure 2) gives indications of a specific emotional cutoff between Mr. Baker and his father that is long standing. It does not appear that this emotional cutoff has been resolved with treatment and recovery, even though there is an apparent desire by both father and son to do so. Both parents are success-oriented, reflected in both holding doctorates in the natural sciences. Their academic

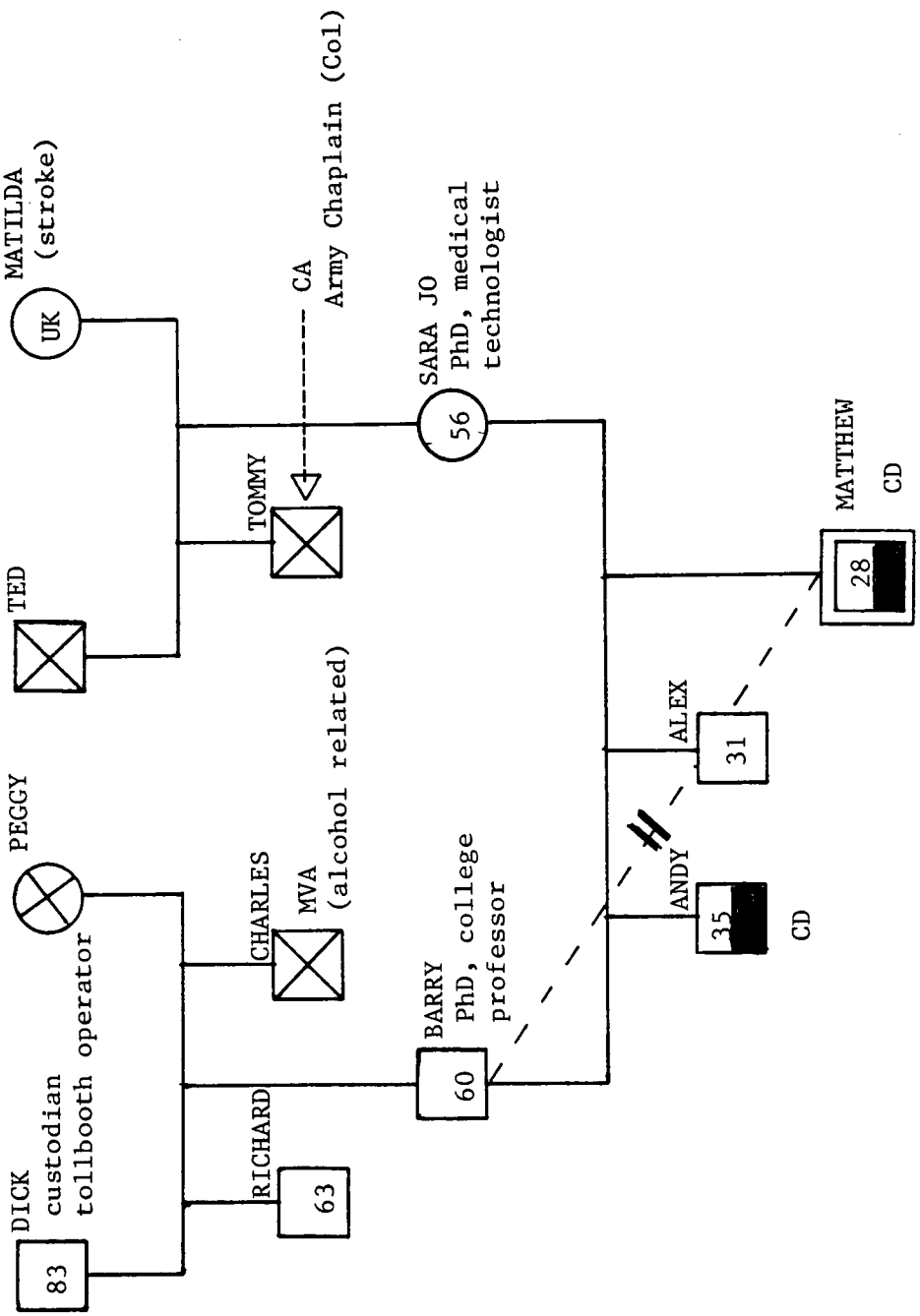



Figure 2 - Matthew Baker (25Jan93)

accomplishments indicate both a determination to accomplish necessary tasks, but also a possible problem with interpersonal skills because of their chosen fields of study ("people skills" are not usually are part of training in the natural sciences). This "success orientation" can also be seen with the maternal uncle and his career success as a Army chaplain and colonel. Mr. Baker's father is a middle-child who rose well above his father's position (custodian, tollbridge operator). Additionally, the lack of knowledge in greater detail of the grandparents' generation is also indicative of possible emotional cutoff or distancing.

The impact of these factors on Mr. Baker becomes important with the emphasis on success. Both his parents hold earned doctorates and an expectation of success would be transmitted down a generation. It is quite possible that alcohol and drug use became the means of escaping some of this pressure to succeed. The changes that came about in treatment and recovery were focused on increased differentiation of self, on beginning to redefine the emotional cutoffs and nuclear family emotional system dynamics, and healthy triangles. It is important to note that Mr. Baker's parents have also been willing to address their participation in the dysfunction, by their involvement in family treatment and Al-Anon from the first treatment to the last.

## Interpretation and Implications

Much of Mr. Baker's definition of self as an adolescent was built around activities that commonly are defined culturally as "masculine pursuits and responses." He was an athlete (swimmer), was sexually active from a relatively young age (including an unplanned pregnancy and abortion while in high school with his then girlfriend), acted out physically rather than confront the feelings, was isolated from his father, and had no close male friends. This is a description of the mythological "stereotypical male" of contemporary American culture. Mr. Baker was denied the standard initiatory rites of our culture that could have been valuable for his transition into a healthly manhood: his graduation from high school was delayed because of poor performance; he "failed" as an athlete because of his drinking and using; he "failed" as a father with the abortion; and he had a spinal cord injury that permanently terminated any opportunity for fatherhood. Using Gilmore's (1990) three cultural criteria of manhood (provider, protector, and impregnator), Mr. Baker was denied these fundamental expressions of manhood as result of his chemical dependence and spinal cord injury, and has had to redefine according to changed circumstance. His recovery has particularly addressed the issues of provider and protector. The determination to complete his education will result in a

greater capacity of economic independence (provider), and his continuing efforts at differentiation of self and adjustment and adaptation to his physical disability result in clearer expression of physical and emotional independence (protector). Though he cannot be an impregnator in the literal sense, his creative urges were finding expression through his life style changes.

Many of the family of origin issues have been addressed above, but it is important to note that much of Mr. Baker's maladaptive behavior arose from familial dysfunction. His transformation during treatment and recovery parallels his increased ability to modify negative behaviors arising from his family of origin into more balanced healthy responses. Some of these family dynamics are visually expressed in the genogram.

There were no issues identified as misrepresentations or prevarications in a comparison of Mr. Baker's "story" and the medical record. When reading the information in the medical record and then reading the transcripts of the interviews (done about 12-15 months after primary treatment), it became apparent that Mr. Baker was a much more demanding judge on himself than the clinical staff. Comparing the interviews with the medical records also gave clear indication that Mr. Baker continued to make good progress in recovery.

When considering "success points," it is important to

remember that this was Mr. Baker's third treatment for chemical dependence. Such items as lectures, videos, and recreational activities had limited impact, compared to someone who was going through treatment for the first time. He did acknowledge that he still found them helpful so these aspects of treatment may be considered success points on a limited level.

There are four issues identified as success points for Mr. Baker in this third treatment. They are not so much program components as experiences in treatment and recovery. The first was the transformation that took place as result of confrontations on maladaptive behavior, and Mr. Baker being held accountable for his behaviors by his peers in primary and secondary treatment therapy groups. Perhaps this treatment experience was the first instance when he heard that he was responsible for his behavior--he experienced accountability and responsibility, and was ready finally to face the consequences of his behavior.

The second success point was his willingness to face the difficult problem of defining self. This was not only dealing with family of origin issues but also gender issues. Mr. Baker addressed those rules and roles, behaviors and beliefs, that limited his ability to become a fully-functioning man. During the interviews, he stated that he was emotional like his mother rather than thinking like his father. Simplistic though this statement may be, he is

identifying his struggle with differentiation of self. His new definition of self not only concerned the above, but also a major rethinking of what is meant by being a man. The 12 Steps require an admission of helplessness that was alien to Mr. Baker's pre-recovery thinking, but he was able to acknowledge this new understanding. Though following his usual pattern of doing things his way, some of this found expression in his new found spirituality.

A third success point comes from Mr. Baker's identification of the clarity of the group process purpose as a significant event within treatment because it was unequivocal in its expectation.

> I mean I could give everybody a recall of the events that happened to me last week for the rest of my life but it's probably not going to do me a whole lot of good. Talking about them and bearing in mind what things I want to change in myself as far as behaviors and the purpose was to change behaviors, attitudes, values and interpersonal relationships.

It was remarkable that he still could recite the "Purpose of Treatment" after many months--the purpose and eight rules of group process were repeated at the beginning of each therapy session.

Mr. Baker's ability to begin to resolve problems with relationships--whether with family or others--was the final success point for him. This can be seen with the conflicted

relationship with his parents, abusive ones with his girlfriends, and aggressive/violent interactions with most anyone else when he had been drinking or using. He acknowledged that he was

> crazy when it came to relationships. . . . I just, you know, the world quit turning and everything else around me quit happening when I got into a relationship. And I became obsessive, possessive and I tried to control my girlfriends and I, just all kinds of manipulations just to keep them there. Definitely codependent. . . . I couldn't separate myself from the relationship. I had no individual identity.

In a similar vein, Mr. Baker reported difficulty with friendships, not that he did not have friends but that the relationships were "real weak. I didn't have any strong relationships." He also reported that he did not have a strong relationship with his parents.

The implications from this case study on understanding the nature of recovery for chemically dependent males comes through in two areas: redefinition of self, and relationship skills. Both of these are clearly related to family of origin issues, the ability to identify dysfunctional behaviors, and how to modify these behaviors into positive behavior. The definition of self is tied principally to the establishment of an adult male persona in opposition to the boy who had ruled before. Perhaps treatment becomes the

rite of passage, the initiatory rite, for those who embrace recovery. The development of appropriate interpersonal skills also is an interplay of gender and family systems issues. Effective treatment and recovery is not just lectures, videos, and recreation, but is also the establishment of an adult identity for those who may be facing their world for the first time as an adult.

## CASE THREE: MARK CHARLES

### Description of Third Participant

The third participant, Mark Charles, was a 28 year old married white male from a small city about one hour's drive from Knoxville. He was admitted to the outpatient unit on 13 January 1992, with an initial diagnosis of Alcohol Dependence (303.90). Two weeks prior to his admission to the treatment center, he had been a patient in a nearby hospital-based psychiatric unit because of two suicide attempts in December 1991. Mr. Charles was employed as a car salesman at the time of the interviews (his third job since completion of treatment), but had been a senior vice president at a bank. He had about three weeks remaining on house arrest, resulting from Federal charges and sentencing relating to misappropriation of funds and computer fraud at the bank. This was his first treatment for chemical dependence. His discharge diagnoses were Alcohol Dependence (303.90) and Major Depression (296.31 - single episode, mild). He was given a regular discharge on 17 February 1992. The initial interview was on 27 January 1993, the second interview was on 3 February 1993, and the medical record was reviewed on 2 February 1993 and 3 February 1993. Both interviews took place in the participant's home, because of the limitations set by his house arrest. The

genogram was developed from the interview data, and was checked against the medical record and with the participant for accuracy.

Mr. Charles was a pleasant and cooperative participant during the interviews. He was articulate and quite verbal, with a self-deprecating sense of humor. There was little need for verbal prompting by the researcher, because of Mr. Charles' willingness to disclose the details of his experience and consequences of chemical dependence. Consistent with what he identified throughout the interviews, there was a certain level of a desire to please. By his demeanor and speech, there was a clear enthusiasm for his continuing transformation into a new person who was self-defined.

Mr. Charles reported that he did not start drinking or using until he entered college and turned eighteen. His father was an active alcoholic and alcohol was readily available in the home, "But I didn't drink until I was eighteen, because it was against the law." About one month after turning eighteen, he got drunk for the first time, experienced a blackout, and he did not remember what had transpired. He reported that

> It wasn't the first or second time [to drink] but it was pretty early on that I got drunk that first time. We were at a party and I got really sick, of course, and went into this tirade about this incident that

> happened when I was four or five, and I don't remember it at all. But my roommate was making fun of me the next morning for doing it. So that's how I know.

Much of Mr. Charles' story pointed to the use of alcohol to anesthetize intrapsychic pain, arising from dysfunctional family of origin dynamics.

Mr. Charles' stated that "There's a great deal of alcoholism in our family." He named his father, paternal grandfather, aunts, uncles, cousins, and his four siblings as either alcoholics or having problems with alcohol. He described his mother as an "enabler" [one whose behaviors permit/support addiction], and his paternal grandmother as the "best damn enabler you'll ever see." His family of origin was defined by alcoholism, with all the resultant deficiencies and dysfunctions typical of alcoholic families ("Don't talk. Don't trust. Don't feel."). He said,

> I just remember growing up one of the first memories I have is [when about four or five years old], we had bunk beds, and I was banging my head on the wall just feeling like nobody loved me, and the very first time I got drunk that's what I started moaning and bellowing about was about that episode.

This sense of isolation was reinforced when he was sent to a boarding school in a nearby city. This was done ostensibly because of poor local public education, but his sense of isolation was amplified regardless of the parental

motivation. Throughout most of Mr. Charles' adolescent years, his father continued to drink heavily. The participant described himself as naive about his father's drinking. It is important to note, again, that Mr. Charles did not drink at all during this period, even with the ready availability of alcohol and drinking by his peers.

Giving in to his father's plans, Mr. Charles entered a small, conservative, religious college within a few hours drive of his home, rather than a large state university. His father had attended this college, and his great-grandfather had set up an educational trust fund for use at this college for Mr. Charles. He declared,

> I was miserable. I didn't know anybody. I was really, really shy and still am, not as much, but I would sit in my room and, you know, the cement walls and the bare floor and no books on the desk because the school had barely started and I wouldn't leave my room. I was just miserable.

Ultimately, he began to meet other people. Though many of his new friends drank, he reported that he felt no pressure to drink. Relatively quickly he joined these new friends in imbibing. His first black out happened fairly soon into his new alcoholic endeavors, "But then I just kept on. I was at the college for two years and by the time I left I was drinking, not every day or whatever, but I was drinking every time there was a party, every weekend."

Mr. Charles acceded to a faustian bargain with his father that required him to major in business or finance, rather than the journalism or photography he loved to do, in exchange for a transfer to the university. He reported that

> this whole time I was trying to figure out what I wanted to do. I was majoring in English with a minor in photography. When I transferred, Dad and I sat down one Summer and he asked me if I was going [to work at the newspaper]. I was working for a newspaper in town. I was the staff photographer. He asked me if I was just going to earn four dollars an hour for the rest of my life. So I ended up, sort of this perverted compromise where, 'Okay, I'll go to the University but I'll major in business or finance,' and that's what I ended up doing.

Though his GPA at the small college was 2.0, he earned a 3.5 during that first semester at the university. There were many opportunities for drinking with new and old friends,

> But I ended up doing pretty well, I don't remember what my grades were, you know, a 3.5. The response I got was 'Hell, I was only taking 12 hours. I should have done well. That's all it took for me to start drinking extra hard and not pay any attention to school.

His drinking increased and academic performance decreased over the next year and a half. His last semester began with him attending the first week's classes, and

> then just started drinking and drank all the time everyday. I drank until I passed out or until I went to sleep or whatever and then get back up around 1:00 or 2:00 and get some lunch and, of course, I had missed all the classes by that time. So I would just hang out and go drink again. I made a 0.00.

Through deceit and slight of hand, Mr. Charles was able to re-enter the small college he had attended previously. He described the situation and said,

> Since I had been on academic probation and then I failed out, I wasn't supposed to be able to go to any accredited school for at least a quarter. I was supposed to have to sit out for a quarter. So what I did I just kept making excuses as to why my transcripts wouldn't get there. Dad is on the Board of Directors at the college, or a Trustee, and was at that time, and so they didn't pressure me too hard.

The trickery was discovered toward the end of the semester, and he was confronted by the Dean of Students. Though permitted to complete the semester, he was not allowed to return the following semester. Mr. Charles said "And, of course, the whole time I was up there I drank. I did better in school but not a lot better. I still barely pulled a 2.0." Though attending a church-affiliated school where drinking was prohibited, he sequestered his vodka in orange juice kept in an in-room refrigerator. He returned to his

home town to complete college in a year and a half at a different church-affiliated school, whose president was his future father-in-law.

Mr. Charles and his wife started dating in high school, maintained the relationship while they went to separate colleges for two years, and initially continued together after their transfers to the university. She completed her degree at the university. The relationship was terminated while both were students at the university,

> We split up for a while because basically of my drinking. I don't remember exactly what the reason was but it was always I would take her home and then I would go back to the party, and I was drunk all the time.

He reported that his wife-to-be, Carla, had not been around people who had problems with drinking and did not know what to expect. He reported that "a lot of times, unless I was just blotto out of mind, she wouldn't know I was drunk."

About four months after the marriage, they found out that they were going to have a child. There were numerous complications with continuing the pregnancy, so much of the time Carla was on bed rest and taking medication that had a strong sedating side effect. During much of the pregnancy, Mr. Charles was able to continue drinking heavily because his wife was asleep from the medication. When he completed his undergraduate education at the hometown college, he

started working for his father at the family bank. About four weeks after the birth of his daughter, Mr. Charles, his father, and a consultant for the bank all got drunk. His wife left their home and went to her parents' home in reaction to this broken promise not to drink. A pattern of deception, confrontation, and chaos about drinking continued in the marriage until hospitalization. He recounted that

> there was one time I remember we went to a party here in town and I got really drunk. It was a big Arts gala. So, like, everybody in town was there and that way I could just embarrass myself in front of everybody at once, instead of having to go through a lot of many embarrassments. I came home and I remember going on and on about 'Why does my dad hate me? I don't want to be like him anymore!' I threw the whiskey down the steps onto the patio in the back of the house and burst all the [liquor]. I had vodka, rum, and bourbon and so I burst all of that. Carla had to call my mom over to get me calmed down. Some of it I remember and some of it she's told me. I didn't remember that Mom came over or whatever.

Mr. Charles' responsibilities at the bank continued to increase. He reported,

> Well, nothing ever let go and I still had all of these other responsibilities, so I finally was just stacked more and more to where it was more than I could handle.

> . . . You couldn't hand me enough guilt. Which, anytime I did well, I accomplished something, I always had plenty of stuff to pull myself back down. I mean, hell, what kind of banker am I if I can't even get the toilets fixed?

With the continuing pressure from work and a second child on the way, his drinking accelerated from "a 6-pack, and then a 12-pack, and tall boys, and then a case, and on and on we went." The second pregnancy provided the cover again for covert drinking at home. The problems got worse with high medical bills, low income, and the costs of drinking,

> So I was in really bad financial shape pretty early on, which just added to my guilt and my pressure. How could I be a good banker when I'm on the verge of bankruptcy myself. And the whole time I was too afraid to go get help.

Mr. Charles was unable to ask his father for a salary comparable to the other equivalent bank officers. He was being paid considerably less than his peers.

Mr. Charles reported that he started to use over-the-counter sleeping pills as a substitute for alcohol. His wife was becoming more suspicious about his drinking, and this was his attempt to divert scrutiny of his behavior. He reported that he would steal medication if he knew what it was and, after dislocating his knee, was able to get hold of painkillers. By July 1991, he was drinking most of the

time. This included a complex plan for drinking at work through the careful use of rum, coffee, peppermints, and Dr. Pepper. Mr. Charles reported that his wife did not know the extent of his drinking.

By chance, a teller's password was left out that gave Mr. Charles access to money in dormant accounts. This became an avenue of escape from financial problems. He would transfer money to his account, with the intention of repaying the "borrowed" funds as soon as possible. The total misappropriation of funds was only about $2400. When the magnitude of his actions settled in, he looked for a way out of his predicament,

> Dad used to always tell me that something he had read, Erma Bombeck or Dear Abby or somebody, that suicide is a permanent solution to a temporary problem. Well, I had that in my head, and I had myself convinced that I was everybody's temporary problem, and my suicide would be the permanent solution to their temporary problem. I was drunk.

While at his parents' home (they were on vacation in Florida, and he had provoked a fight with his wife to justify his drinking and departure), Mr. Charles drank a fifth of whiskey, took several Halcion pills, and had another unknown pill. He passed out, slept for about twelve hours, went to work the next morning unkempt, unshaven, and unclean, and "Nobody says a word. That's a week before

everything blew up." The following week, he became panicked for fear that he would be discovered. By the weekend celebration of his fifth wedding anniversary, he was so anxious that he purchased three or four boxes of sleeping pills in order to commit suicide. He said that "Finally, about 2:00 on a Sunday afternoon I just told Carla what was going on. You know here's what I've done. I've taken this money and in my mind I had it all worked out." She left with the children, first to her parents' home and then to his. There were several telephone calls from her to him, ultimately she returned to their house with his parents.

Mr. Charles' father had been through treatment for chemical dependence at the university medical center treatment unit, so his parents and his wife took him to the unit for evaluation. He said,

> I remember Dad saying, 'Son, I'm not telling you what to say but don't go up there and just tell them that you have taken this money and tried to commit suicide. They will just think you're trying to get out of something.' That really scared me because I didn't want them to think that. I wanted some help.

He was transferred to another hospital for admission in their psychiatric unit because of his two suicide attempts. Mr. Charles was a patient on the psychiatric unit for about two weeks, until his insurance coverage ran out. He remembered that "Dad wanted me to stay at the hospital until

the end of the year. Because as long as I was in the hospital nobody would fire me and then I could get some of my retirement money." When he was discharged from the psychiatric unit, he went to his home and lived in virtual isolation. He recounted that "When I came home I just locked myself in the house. I didn't drink. I didn't take, Carla had gotten everything out of the house." On 13 January 1992, Mr. Charles was admitted to the intensive day program of the outpatient unit, for Alcohol Dependence treatment.

Mr. Charles exhibited some resistance to treatment initially, as he "bargained" about which program he would participate in and possible job opportunities, "I like being in control. I don't consider myself a control freak." This resistance was expressed as a concern for providing for his family, an interesting response considering his previous behavior. Once he was able to recognize treatment as a survival need, Mr. Charles started the intensive day program in the outpatient unit in earnest. There were no great outbursts or attempts at acting out because, after all, he was a person who wished to please those in authority. Much of the focus of treatment for him was on the impact of familial dynamics on the development of his addiction, and on the changes necessary to maintain sobriety and begin recovery. Mr. Charles' greatest task during treatment was a reclaiming of personal authority to be a self-defined

individual--no mean task for someone who had sublimated ego in order to survive the onslaught of family dysfunction.

Treatment required that he address the self-imposed perfectionism, a perfectionism that meant he would never be satisfied with his work, himself, or his own family. It was also a perfectionism that rendered him immobile when he would become stuck with the minutiae of life. He realized that this tendency was improving when he spoke at an AA meeting,

> That really came to me when I spoke the other night. Just sort of as I was standing there. I was trying to talk about how I still had a lot of the same urges and tendencies one of which is I have to know my destiny today. You know I've got to have the whole thing plotted out. It can't just be, you know, something simple. I'm going to go over here and be a teacher. I've got to be the Nobel winning laureate in physics teaching at Yale, or I can't go be a banker, I've got to be Alan Greenspan. It finally dawned on me that who I am is a lot different than what I am, too, or, hopefully it is. Before I was who I was, was what I did, and so I've tried to back away from that a little bit.

Mr. Charles was asked to evaluate family dynamics, particularly the role of his father, in relation to his addiction and resultant behaviors. This will be discussed

further in the Family Systems Information section. He reported that he often felt childlike when in treatment and, when feeling emotionally threatened, he would regress and assume a fetal position. This occurred both at home (from the Family/Concerned Person Questionnaire completed by his wife - "Other behaviors while under influence: 'cries, lays in fetal position, always says his father does not love him. Also, always says no one understands what he is going through.'"), and during his psychiatric hospitalization ("I was defending Dad, of course. 'I'm just this evil thing.' And I don't remember a lot about that meeting. I mean I don't remember the subject matter. I remember just breaking down.")

The points mentioned above also appeared in the Comprehensive Assessment form, which Mr. Charles completed during admitting procedures. Though one is not usually in a positive and upbeat mood on admission to chemical dependence treatment, which makes some of the following reactions understandable, there is a strong undercurrent of negative family of origin dynamics. He also wrote,

> Did you feel loved and cared for by your parents/guardians? - "I knew I was loved and cared for, but I did not always feel that I was."
>
> Did your parents/guardians make you like or dislike yourself? - "I have never had much confidence or thought I was a good person. Even when I did well, I

did not think it was enough."

Were you encouraged to talk about your feelings? - "We seldom talked about feelings (almost never)."

Were you afraid of your parents/guardians? - "I was afraid of my father."

Did your parents/guardians make you feel guilty? - "It seems like I have always felt guilty about everything."

What would you say are your individual strengths? - "Intelligent, good communications, understanding, enjoying doing for others, sense of humor."

What would you say are your weaknesses? - "low self-esteem, can't say no, procrastinate."

Much of the language, many of the descriptors, and most of the behaviors that Mr. Charles used are characteristic of a shame-based definition of self.

Treatment developed into a positive experience for Mr. Charles, but much of the work of recovery took place during secondary treatment. There he dealt with the realities of chemical dependence, his changed circumstances, and the demands of family and life. He recounted that

> In July [1992], when I lost my job [an involuntary termination], I realized that I had done a lot of the same things over again. I had just done them sober. I took on too much responsibility, I didn't ask for help, I didn't stand up for myself. I was working a hundred million hours a week. It didn't matter. Work was

always first and I was always last.

His subsequent job ended because of loss of funding, though he continued to do work there on an occasional basis because he liked what he was doing. His third 1992 job [the one he had during the interviews] was arranged through his own efforts and contacts in recovery, rather than like the first job which was obtained through his father's influence. Though selling cars was not what he hoped to be doing the rest of his life, Mr. Charles took certain pleasure in his reclaiming personal authority by getting the job on his own.

It was also during this time of secondary treatment that Mr. Charles participated on the Emmaus Walk, a three day "short course in Christian spirituality" of the Methodist Church (based on Cursillo, part of the renewal movement within the Roman Catholic and Episcopal Churches). Until his participation on the Emmaus Walk, his religious experiences were not positive.

> I'm a recovering Southern Baptist. The God I knew was far from caring. I remember being really paranoid growing up in church; because our minister would always talk about that he knew these were the last days, and nobody knew when Christ was going to come back but he was.

During this weekend retreat with the Emmaus Walk, Mr. Charles had an experience common for retreatants: experiencing God's unconditional love within the gathered

community of the faithful. He reported that

> I didn't feel like I was some outcast or a leper amongst all of these angels or whatever. I didn't feel a whole lot different from everybody else. I didn't just come out and say 'Hey, I'm a drunken suicidal embezzler.' But, by the same token, I wasn't dishonest. I didn't make any lies. If somebody asked, I told them. Just the whole thing to find out that I had been loved from the beginning and that, for the first time, 'there but for the grace of God' meant something to me.

This continued to be a powerful component in his recovery, and he stated that he hoped to be even more involved in the Emmaus Walk once his house arrest is completed. He noted that his wife had a similar experience as he when she attended the women's weekend.

## Family Systems Information

Much of Mr. Charles' recovery can be tied back to his reworking of family of origin issues--"Accumulation of years of insane upbringing." Essential to his recovery was his differentiation of self, through which he started the process of separating intellectual and emotional functioning and started to protect himself from parental (particularly paternal) manipulation. The emotional system of his family

of origin appeared toxic to him at times, and his recovery was linked with separation from those patterns that impaired his ability to develop into a healthy adult. Additionally, being the oldest child and the oldest son had an impact on his development. The emotional cutoff from his father was not as drastic as it could have been, but it was a necessary act in Mr. Charles' movement toward reclaiming his personal authority. These are the principal Bowen concepts applicable to this participant's situation.

The struggle for differentiation of self was one that started at an early age, as exemplified by the story above of his first memories (in the bunk bed, banging his head against the wall, and feeling that no one loved him). He stated that

> Dad is the president of [name of the local bank], so he needs somebody to mow the yard at the bank and he asked me if I wanted to do it and, of course, being a 12 year old boy, anything but work, I said, no. And he just kicked my ass and said, 'If you won't do it, I'll just get some nigger to do it.' So that was the beginning of my working days and I did something from that time on. . . . I mean that was my, I was really afraid, and so, I guess, talking about the work I always did, whatever, he wanted me to do. I always tried to please him.

His battle for freedom from the dysfunctional emotional

system was joined at the same time as his struggle for differentiation. They cannot be seen separately. Mr. Charles' stories of his father's denigration of an interest in photography and journalism, reduced salary, denial of both their problems with drinking, and suggestion that he not tell about the misappropriation of funds all identify difficulties. He said that he

> always felt subordinate to him. I always felt intimidated by him. I still feel intimidated by him. Not as much or in the same way but, I mean, I, it took me 20 some odd years, I guess, to gain that intimidation. I'm not going to get rid of [it] overnight.

His self-image was distorted by family of origin dynamics, and recovery started a rewriting of his self-definition. Remembering his treatment, he reported that

> Ted [a clinical psychologist], in treatment, could never get me to say, you know, I was a good person. I could never do it. I was finally willing to admit that I might not be bad. I could never say, you know, I was a good person. And now, you know, all in all, I think I am.

Though discussion of sibling issues were not in the interviews, Mr. Charles paid a price for being the oldest child and first-born son. Many of the demands placed upon him reflect a distorted view of primogeniture, with the

father molding the son into an image of the father's creation. He reported that each of his four siblings were alcoholic or had problems with drinking.

Like a weight around the neck of a drowning man, Mr. Charles had to sever the paternal ties that were holding him under. This was not the metaphorical murder of his father, but a declaration of independence from his father's control and rules.

> **Researcher:** How is your relationship with your dad now?
>
> **Mr. Charles:** I'm finally able, at first I was very, almost standoffish. I mean I was going to separate. I'm not going to leave myself for you.

He was able to set boundaries that did not exist before, as means of establishing and protecting himself from an enmeshed family of origin.

> I don't feel, I still fall back into this [old behaviors] out of habit, but I don't feel the need to please him all of the time. Before it didn't matter what he wanted, I did it. And there was a real problem with him being my dad and my boss. I could never differentiate between the two and I used one to offset the other a lot of times. If I needed to say, well, 'He's my boss, I've got to go do what he wants.' I would, or whatever I needed. Which meant that he always came first. It didn't matter what Carla wanted or the kids needed. If Dad needed something. I don't

feel that same restriction anymore. I am much more comfortable telling him to go to hell, if that's what I need to do. I'm a coward, I mean, I am never that forceful.

Perhaps the most significant characteristic of the genogram (Figure 3) was the number of persons identified as having problems with alcohol. The presence of alcoholism on both sides of Mr. Charles' family was staggering. There was little room to doubt the power of genetic predisposition and environmental influences in the development of alcoholism. The conflicted relationship between Mr. Charles and his father becomes very apparent with the "lightning" between them.

Though most of the family dynamics have been discussed above, there are two particular points of interest. First, the bank in which Mr. Charles worked, and of which his father was president, was founded by his maternal grandfather. Status and power in the community come through his mother, and not his father. Perhaps this is an influence on the "driven" nature of his father's personality which, when combined the father's family of origin dysfunction because of familial alcoholism, resulted in a toxic situation for Mr. Charles. The second point did not become apparent until the genogram was constructed. Mr. Charles is the fourth person with the same name (he is Mark Charles IV), and his son is the fifth to possess the same

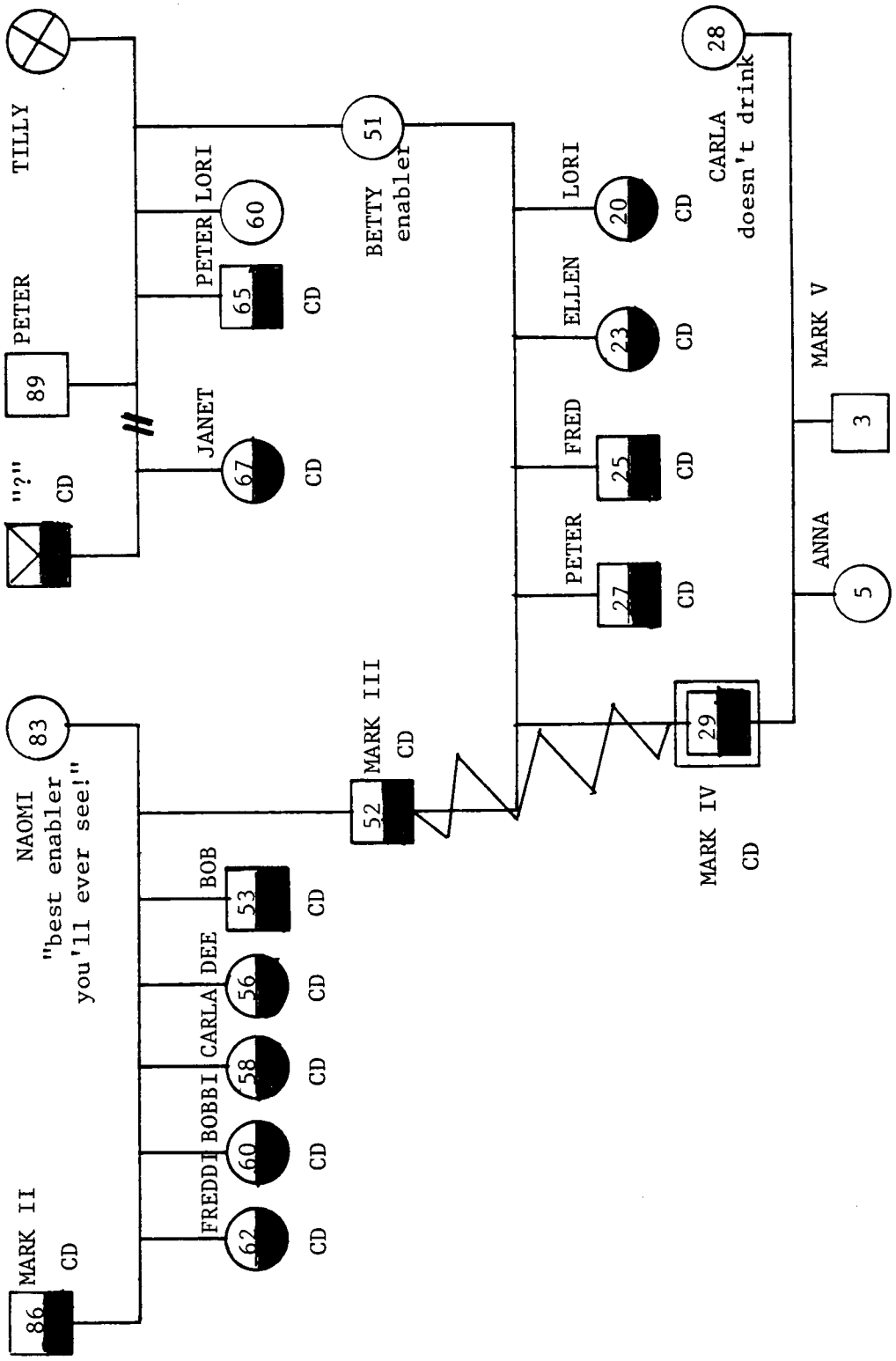



Figure 3 - Mark Charles (28Jan93)

name. It is hard to establish one's own identity when names are distinguished only by Roman numerals.

## Interpretation and Implications

There were no great tales of climbing mountains, diving to coral reefs, or racing motorcycles across Baja. Mr. Charles' life had been a safe life of a protected child. There was no sanctification of a transition from dependence to independence that is necessary for "the making of a man." The sad part of his story, particularly relative to gender issues, is that the very person who should be guiding him into being a healthy, adult man is the person who is smothering him with control. It is possible that the initial adventures into drinking were efforts to be set free from the distorted patriarchy that his father represented. Knowing his father was president of the bank, perhaps the misappropriation of funds was a desperate grab for freedom. Without a doubt, there are much better ways to rebel or to express independence, but the distorted patterns of his family of origin distorted his own vision. For Mark Charles, independence started with separation from his father.

This is not to say that Mr. Charles is a passive non-entity, for he was a personable, humorous, and capable individual. Rather his family of origin dynamics kept him

as a puer, an eternal youth, who was not able to make the transition into adulthood and manhood. Taking Gilmore's (1990) premise that manhood is something made, usually by the father or father-surrogate, then the process of treatment and recovery became the initiatory rite for Mr. Charles. One has only to consider the discussion above on his family of origin issues to recognize Mr. Charles' need to be freed from dysfunctional and distorted rules and roles, beliefs and behaviors.

The review of the medical record was an interesting task. The initial entries clearly reflected Mr. Charles' caution in telling about his suicide attempts, drinking, and misappropriation of funds. There was a consistency of medical record to the story from the interviews, which appears to negate concerns for denial or prevarication in the long term revelation of his story. It appeared that Mr. Charles was consistent in his telling of his story with the medical record information.

Three issues stand out as success points for Mr. Charles: the development of a spiritual dimension to his life; the self-defining process of becoming his own man, an adult of increasing differentiation; and the relationships developed with ADRC staff members. The first point was discussed above at some length in considering the impact of the Emmaus Walk on his life. His previous experience with the church had been either negative or neutral, and

spirituality was not part of his vocabulary. This represented a major point of transformation in his world view and his role in it.

Much of the second success point is tied to the process of breaking free from the oppression of family of origin dynamics, and establishing himself as his own person. This is intimately tied to Mr. Charles' transition from puer to adulthood, as he disengaged himself from old definitions of how he should respond to how he chose to respond. These transitions are related to an initiatory process which, for him, was treatment and recovery.

The final success point was his encounter with the clinical staff, and the relationships that developed from this new experience. Though the staff maintained appropriate professional stances, this was probably the first time that Mr. Charles had to deal consistently with persons who valued emotional health. The value of modelling in the therapeutic process was reinforced with his positive reaction to staff. They became guides for him as he established his independent identity.

Again, the value of moving away from the old destructive patterns to new constructive ones is affirmed through Mr. Charles' developing spirituality, and movement to adulthood through initiatory processes. The development of a holistic, systemic view of personal identity is essential to recovery. Without the balance, there is a

return to chaos--also known as relapse.

# CASE FOUR: LUKE DAVIDSON

## Description of Fourth Participant

Luke Davidson was a 28 year old single white male, admitted to the inpatient unit on 9 July 1992 for Alcohol Dependence (303.90). Though unemployed at the time of his admission for treatment, he subsequently was employed as a support worker in one of the Knoxville hospitals. Based on the admission history and physical examination, the admitting physician gave Mr. Davidson an AXIS I Diagnosis of Polysubstance Dependence (304.61). On 31 July 1992, Mr. Davidson was given a regular discharge with a discharge diagnosis of Alcohol Dependence (303.91). This was his second treatment for chemical dependence, subsequent to treatment while in the US Army at their Fort Benning, Georgia, facility. The first interview was on 23 February 1993, the second on 3 March 1993, and the medical record analysis was done on 5 March 1993. Both interviews took place in one of the therapist offices in a local community counseling agency. The genogram was developed from the interview data, and was checked against the medical record and with the participant for accuracy.

Mr. Davidson reported that he and his younger brother, Mark, first started drinking when they were about eight years old. He said, "I remember when I first started

drinking. I remember we were real little, me and my brother." They would drink when visiting with their maternal grandparents, both of whom were alcoholics,

> But we used to sneak, they had a lot of friends over and play pool and get trashed and everything. And we would wait until everybody went to bed, and we would sneak in there and get beers after everybody had done to sleep. Just get tanked on a tall Bud. Drinking like adults.

Regular drinking did not begin until the tenth or eleventh grade in high school. Neither of Mr. Davidson's parents drank, "My parents didn't drink. My dad might choke down one beer and he would have it, and Mom could drink two mixed drinks and she would be on the table dancing." In one of those quirks of changing laws, Mr. Davidson fell into the category of legal drinking for eighteen year olds and was grandfathered in as the laws changed.

Most of his drinking was with friends, and he reported that "I didn't hang around with people who didn't drink. Most of the people I hung around with did drink, and I just thought everybody did." Even with the beginning of active drinking in high school, Mr. Davidson reported that it did not create problems for him during that time, "I never had a problem with alcohol in high school like with the law or missing classes."

He did report that significant problems started when he

entered college, with an apartment of his own and away from parental supervision. He reported that he "graduated in '87. It took me five years to get out. And a lot of that had to do with drinking and doing drugs. The only time I did drugs was when I drank." Like many of his contemporaries, Mr. Davidson described college as "an endless party," and that it was one of the greatest times of his life. He reported that

> It took me five years to get out. I had one whole quarter of, I had 16 hours of straight Fs but I, well shit, I was lying to my parents about the grades because they [the grades] were coming to the apartment and not going home.

His expected graduation was almost aborted because of poor performance on a final exam and, by the generosity of the professor, he was permitted to retake the exam. His degree is in Physical Anthropology.

Alcohol and drugs brought on self-destructive behavior for Mr. Davidson. He was prone to get drunk and get into fights, "I would get in a bar and get in a fight with somebody. We always seemed to get into fights with the football players for some reason." Mr. Davidson is about 5'8", weighs about 165 pounds, and is very athletic, but his aggressiveness would get played out his pursuit of thrills. He was excited on hearing of a 1300 foot bungee jump in West Virginia, retelling about the rush of jumping out of

helicopters to slide down ropes, or remembering driving fast. It appeared that he was constantly trying to prove himself to unknown persons.

He supported his drinking habit while in college through the use of credit cards. Like many college students, he was issued cards with $1500 credit lines that he used to maximum. Mr. Davidson reported that, during this time, his friends would often ask him to be the driver when the group had been drinking, because of his apparent sobriety. All around him would declare that he was fine, he would do the driving, but would not remember anything in the morning. Blackouts became an early characteristic of his drinking, which was not surprising if actual drinking matched the reported drinking of a case of beer a day.

He reported several instances of brushes with the law, including two DUIs, two Public Drunkenness, petty larceny, trespassing, and possession of a dangerous weapon. The first DUI was in 1989, but was reduced to reckless driving. The second DUI charge was still pending at the time of the interviews. The petty larceny and trespassing charges came from his exploration of a construction site, and taking a small item. Following high school graduation, he was charged with possession of a deadly weapon (a billy club) and jailed while on a trip to Myrtle Beach. He did report that they had been drinking. Mr. Davidson did minimize these several legal issues, "And all of my DUI's have been

just speeding. I've never gotten in a wreck or killed anybody. I have been really lucky." The Public Drunkenness charges were while an undergraduate student.

In keeping with his thrill-seeking patterns, Mr. Davidson had planned to join the US Air Force for flight training. Though he did very well with the assorted "pencil and paper" tests, his eyesight did not match the 20/20 vision needed, and "You know that kind of screwed me up on things." His response was to get a job as a driver with one of the local beer distributors, lasting just a few months. The hard work of the job and drinking with co-workers was too much, "I got burned out in about seven months."

Having been overwhelmed by the job demands of beer distributor driver, he decided to investigate flight school requirements for the US Army. After some arduous cramming, he did well again on the aptitude tests. With correctable 20/20 vision, the Army was going to send him to flight school. Driving home from his going away party, Mr. Davidson was stopped and charged with his first DUI. Army regulations require one year without charges such as DUI if one is to go to flight school. He reported that he "was kind of psyched about going to the military. So I went ahead and joined, which I shouldn't have done and they made me a grunt. I hated the military." He gave mixed messages about being able to deal with the discipline, getting the "riff raff out of there and make everybody do what they are

supposed to do, it was cool. Things worked." Then he complained about being told what to do by young officers, "It just burned me up. Telling me to get down there and push up for no reason. [grunting and growling noises]. It killed me." Issues of authority were clearly an issue.

As soon as he completed basic training, he was shipped of to Advanced Individual Training (AIT), and was on a plane to Saudi Arabia and Desert Storm on AIT graduation day. Through assorted assignments and reassignments, he was not shipped to Germany to join a new unit but ended up with the 101st Airborne, Fort Campbell, Kentucky. Bored with Hopkinsville nightlife, he often travelled with friends to Nashville,

> And I remember I was Spec4 and one day I was out drinking. I don't know what overcame me. I said 'Fuck it,' and I went AWOL. I just got tired of all the nit-picky things that they make you do. I went to Florida for three weeks and I had a blast.

Turning himself in three days before his thirty days were [after thirty days, AWOL becomes desertion]. He reported "That was one of the hardest things I've ever done, going back. Because First Sergeant went off the fucking wall, and then they busted me down to E-2."

Telling his first sergeant and commanding officer that he had a problem with alcohol, they sent him to the Army treatment center at Fort Benning, Georgia, for eight weeks.

Mr. Davidson described the experience like "shock treatment," and "They wanted to, it was kind of like, it was almost as if you didn't cry everyday in group, they weren't going to pass you." He described the lengths to which the treatment center staff went to humiliate a command sergeant major [top NCO ranking], by requiring him to wear civilian clothes, answer to his given name, and carry a teddy bear around with him at all times. Because Mr. Davidson was unable or unwilling to respond to treatment in the way that the staff deemed appropriate, he was discharged from the program and sent back to his commanding officer for action.

He was given a second chance, and sent to Air Assault School. Mr. Davidson graduated on a Friday and received his wings, was promoted back to Spec4, "And then I don't know what the hell happened. I went AWOL on Monday. Budweiser, when I started drinking, I would just twist the way I thought, and it would just make me hate everything I was doing." He drove to California, staying with a friend in Los Angeles for about one week, "At this point, drinking wasn't much fun anymore. Drinking was just, I was just drinking to escape the drinking, to escape reality, I think." He reported that he contemplated suicide,

> And I had a .38 with me that I had bought from a friend of mine in Nashville. I contemplated suicide. I cleaned it for about two hours one might. Shined all the bullets up and everything. I couldn't do it. That

pissed me off. I was drinking tequila and I couldn't even kill myself, what an idiot, what a fucking pussy. Rather he decided to speed up and down California's coastal highway, hoping to be in a wreck or be pulled over by the police.

Facing the reality of his circumstances, he headed back home. Struggling through shortage of funds, Mr. Davidson made it back to Kentucky, returned to Fort Campbell, and

> then I had to go back to the same first sergeant and the same colonel. I have never been so scared in my whole life. . . . Anyway, he [the colonel] told me he busted me down to E-1 but was not going to send me to jail, because he knew that I had a problem with alcohol. And he was just going to get me out of the Army, because I wasn't good for the Army. You wouldn't be good in jail either. We just need to get you out of here. So they kicked me out.

He was given a general discharge under honorable conditions, with a possibility of an upgrade to an honorable discharge in four years, if he completes a civilian treatment program and stays sober.

Mr. Davidson moved to Nashville to live with his girlfriend for about four months. After getting drunk one evening, and getting into a fight with his girlfriend and her friends, she kicked him out. He stayed with friends for a few days, ended up in a motel room in Gatlinburg, and

> I remember looking out at the pool and there were babes walking around everywhere, and I wouldn't leave the hotel room, because I was drinking like a fish. I got really depressed, and said, 'The hell with it,' and went back to Knoxville. I looked up my sister, and we went out, and I told her this was going to be the last time I drank, and for her to take me home. I was going to treatment the next day, and that's what I did.

Though he had no insurance and no job, Mr. Davidson was admitted for treatment through his father's position, influence, and regard in the community. He was in treatment for twenty-one days, and then to a halfway house.

Mr. Davidson's treatment experience at ADRC was diametrically opposed to his experience at the Army's Fort Benning facility. He stated, "I mean they [the Army treatment personnel] were really, it was really humiliating down there." He described his second treatment experience as a place where he felt safe, and where there was broader understanding of the dynamics of chemical dependence. He said,

> It was more relaxed, I think. It was, they took an approach that was not what is that worked this time it was at Benning they told me that there were some psychological, the root of my problem was in my brain. There was some kind of behavioral problem which made me drink. And up here [ADRC], they told me that it was a

> combination of that and they leaned more toward genetics.

Mr. Davidson valued the accessibility of the clinical staff, which reinforced his willingness to address treatment and recovery issues. Describing ADRC staff, he said, "They let you go at your own pace and I like it. I mean I felt real safe over there. . . . I really liked treatment."

During his treatment, Mr. Davidson also started learning how to relate to others without the lubricating assistance of alcohol. This was particularly true as he developed a relationship with his roommate, and with his counselor. Talking to others was not an easy task for him, one that had not been part of his family of origin. The improvement in relationships were focused on one-to-one contact and not to group process, where he still experienced problems. He stated that,

> You know, I did most of my talking out of group. Just individual counseling. I shared some with the group just so they wouldn't think I was an asshole. It was hard for me, it's still hard for me to talk in group.

He reported that his counselor was female, and "I'm glad it was a female. I could talk easier with a female for some reason. I don't know why." Later in the interview, he stated, "It's hard for me to talk about admitting defeat in front of a bunch of guys than it is a girl. I don't know if that's a male thing or just a me thing." Mr. Davidson and

his counselor were able to establish a good therapeutic alliance, even with some difficult spots that needed to be overcome during treatment. He stated,

> I thought I was going to have a hard time talking to her because she wasn't a recovering person herself, and I was, there's a big attitude about that. If you don't have a problem with alcohol or drugs you have no right sitting there telling me what to do. . . . But I think I was ready and I just overlooked it, and she said all of the right things.

He was in treatment for twenty-one days rather than the usual twenty-eight. Mr. Davidson reported that he was discharged because he was driving the staff crazy with his "hyper" activity. It probably had more to do with previous treatment and limited funding than active behavior. He went directly from the hospital to the Jellinek House, a halfway house program for men in Knoxville. Agreeing to stay one month but only planning to stay a week, he had been at Jellinek for seven months at the time of the interviews: "Jellinek's cool." Though there are some factors about Jellinek rules that remind him of the military, such as schedules, meals, and meetings requirements, he reported that he finds it to be comfortable place to be. This has been a significant factor in his recovery.

## Family Systems Information

Mr. Davidson did not describe his family of origin in profoundly dysfunctional terms. In many ways, his parents were concerned for his well-being and did what they thought appropriate to the situation. Unfortunately, much of their support enabled his drinking. This did not continue as he entered treatment at ADRC, and they participated in the family therapy that is part of treatment program. This is not a condemnation of the parents, rather a reflection of the patterns they received from their own families of origin by multigenerational transmission process. In turn, these patterns helped to frame the nuclear family emotional system. These patterns are clearly shown in the genogram (Figure 4).

Mr. Davidson's father was the only child of a family described as devoid of emotion. Mr. Davidson reported that his father's family did not drink, and his father did not drink either. He stated that his paternal grandfather was one of about eighteen children [read many], never got past the sixth grade, and worked as a locksmith. He said,

> I mean, my grandfather, I remember, wouldn't give Dad anything on his birthday. I never saw my grandfather kiss my grandmother. I guess that's just the way he was and passed things down. That's why treatment has been hard for me. I mean, I have had to change a lot

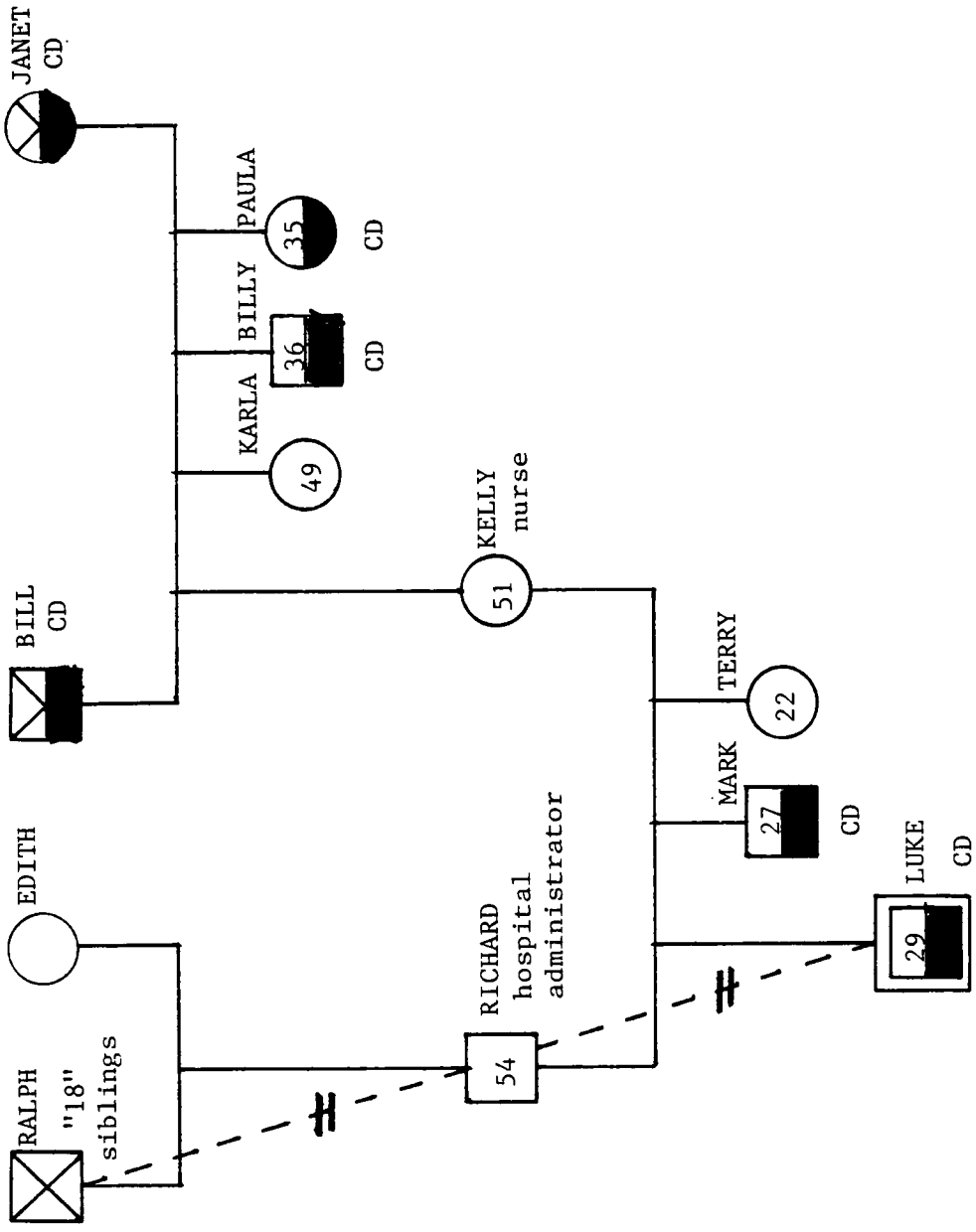



Figure 4 - Luke Davidson (23Feb93)

of things that's been going on in this family for a long time. Thanks a lot guys!

Mr. Davidson reported that his father "put himself through college. You know, Dad, the reason Dad is where he is today is because of Dad." The emotional cutoff of one father from his son was repeated between Mr. Davidson and his father, "I never hugged my dad until after treatment this time." Fortunately, this is one the things changing with recovery.

Mr. Davidson's maternal grandparents both were described as alcohol and nicotine addicts. His first drinking took place in their home when Mr. Davidson was eight years old. Two of his mother's siblings are alcoholics. In a similar dynamic as with his father's family, the emotional dysfunction of an alcoholic family is carried into his family with the typical rules of "Don't talk. Don't feel. Don't trust." Additionally, his mother was the first child and oldest daughter, which often support the development of a pattern of enabling behaviors. Again, this is not a condemnation but rather a recognition of the transmission of family dysfunction from the chaos of an alcoholic home. The ultimate advantage that Mr. Davidson received from his parents was the apparent willingness to address their roles in his continued drinking. His counselor made the following entry in his medical record, "Met with patient's mother and father. Discussed patient's ETOH [ethanol, ethyl alcohol] use since high school. Family

stating they are tired of enabling and requested support in how to stop."

It is interesting to note that Mr. Davidson's father was an only child (an equivalent to an oldest child), his mother was the oldest child, and he was the oldest son of three children. Expectations for success often are placed disproportionately on oldest children, and both parents attained significant success as professionals (his father was a self-made man and successful in his field, and his mother a registered nurse).

The visual image of the genogram was one of arrows pointing toward Mr. Davidson. On one side, there were the lines of the emotional cutoff, transmitted one generation to another. On the other side, there was the multigenerational transmission of alcoholism. It seemed as if a certain air of fatalism was appropriate, as if it was just a matter of time until catastrophe struck. The advantage of the genogram is not only its historical value, but also its preventive value. If there is a probability of a particular action or consequences, then preventive actions sometime can divert what appears inevitable. Knowing that one is at risk may be sufficient to avoid the complication. Unfortunately, it was not the case in this situation.

## Interpretations and Implications

Gender issues are a predominant theme in interpreting Mr. Davidson's story. Much of his behavior and many responses arise out of what can be described as a hypermasculinity. The thrill-seeking behaviors (for example, bungee jumping over 1300 foot bridges, air assault jumps from helicopters, flying, and driving fast) may reflect this. The thrill-seeking also has a certain self-destructive component to it. There was a "driven" nature to his demeanor during the interviews that was probably consistent with the behavior during treatment, that he said the staff described as "hyper." One begins to wonder if Mr. Davidson would be diagnosed as hyperactive.

Hypermasculinity generally develops out of a sense of unsureness about masculinity. Rather than having a healthy expression of manhood, hypermasculinity is often a caricature of masculinity. This caricature develops because the individual either was not "taught how to be a man" or experienced a distortion of masculinity (such as abuse). Often there is a defensiveness and anxiety about sexuality and sexual matters, especially relating to women and homosexuality.

Mr. Davidson's choice of careers within the Armed Forces (flying, air assault), his difficulty in maintaining long-term healthy relationships with women (multiple

girlfriends, two of whom had abortions), and difficulty in establishing relationships with men reflected his struggle with meaning to his manhood. He was looking for external definitions, when internal definitions give answers. For him, women are the gatekeepers of feelings,

> It's hard to talk to a bunch of guys, you know, when you are talking about things you don't want to talk about. Well, we don't, you don't want to, I don't know, you don't want to jeopardize your masculinity or something. I don't know. It's easier to talk with girls about things that's more, I guess I'm prejudiced or male chauvinist or whatever. It is hard to get in touch with that feminine side and cry about things you are not supposed to be crying about. Guys don't cry and all that kind of stuff. That was the way I was raised anyway. Girls made it more of a buffer. They made it easier to do.

Compare this to his extreme feelings about being handcuffed and taken to jail during his last DUI by a female officer. He reported that "One thing I like to remember [as a "talisman" against relapse] is being handcuffed by that female. That pissed me off so bad I couldn't see straight."

> **Mr. Davidson:** . . . There are worse things than that. Speaking in front of a crowd.
>
> **Researcher:** Yeah, or being handcuffed by a woman.
>
> **Mr. Davidson:** When. Boy, that tore me up. I don't

know why that tore me up but it is probably a bad thing to say, too, but it tore me up. Maybe it was just being handcuffed. We will just leave the woman part out of it.

**Researcher:** Well, that could be part of it, too.

**Mr. Davidson:** Might be. I got a real problem with these feminists running around everywhere. I don't know why. But we can get into that or homosexuals.

There were some clear points of conflict and confusion about gender for Mr. Davidson, whether it be gender role, feminism, or homophobia.

It was unfortunate that his therapist was female, because it reinforced this type of thinking rather than challenging him to find an independent way. Mr. Davidson later acknowledged that he found it easier to talk to his mother rather than his father, and his sister rather than his brother. An interesting notation in his medical record stated that it was his father and brother who attended his coin ceremony [graduation from treatment].

There were no obvious discrepancies between the medical record information and that provided through the interviews. It was difficult to assess this issue because of the scarcity of information from inpatient medical records, when compared to the outpatient records. Beyond the limited clinical notes in the chart, there were no continuing care notes. No progress notes are made for the inpatient

continuing care groups, resulting in a paucity of information.

It was difficult to identify success points for Mr. Davidson, because there was constant insistence that his entry and success in treatment was of his own making. This attitude, and his continual struggle over authority issues, demonstrated that control was a vital factor for him. The Sinatra song, "I did it my way," could have been his theme song. This concern is reinforced with his disavowal of spirituality within his treatment and recovery scheme. Perhaps by shear power of will, Mr. Davidson will continue in recovery.

There were two areas that can be considered success points: modification of family of origin dynamics; and the halfway house experience. Both of these points are starting points and not conclusions. They are where Mr. Davidson began recovery rather than complete a particular portion of the process. The modification of family of origin dynamics reflect an alteration in the multigenerational transmission process, and its incorporation into the nuclear family emotional system, so the dysfunctional behavior became supportive behavior. Its impact was not just on Mr. Davidson but also on his parents and siblings. His experiences with the halfway house were significant because they reflect his newly developing ability to redefine relationships and authority. For him, it was a good balance

of structure and freedom. Both of these success points mark a significant alteration from previous self-destructive behavior.

The learning from this case study is built around issues of gender, and the need to be clear in understanding healthy and inclusive definitions of gender. Like such areas as spirituality, treatment center protocols often gloss over gender. This is a mistake. The discovery and realization of healthy masculinity for those in treatment is essential.

# CASE FIVE: JOHN EAGLETON

## Description of Fifth Participant

The fifth participant, John Eagleton, was a 32 year old divorced white male. Employed as a registered nurse at a local university-affiliated medical center, he was rehired recently after a six-month suspension of his nursing license. He was admitted to the inpatient unit on 16 December 1991, with an admitting diagnosis of Narcotic Dependence (304.61). Mr. Eagleton was discharged from ADRC on 20 December 1991, travelled to Minnesota's Pride Institute, and was admitted on 20 December 1991. He remained at Pride for chemical dependence treatment for twenty-three days, when his insurance carrier declined further payment for an out-of-state provider. After a brief stop in Knoxville to put his affairs in order, Mr. Eagleton flew to Los Angeles to participate in the program at Spencer Halfway House for a month. He returned to Knoxville, and participated in an inpatient continuing care group and Impaired Professionals' Group through ADRC. The first interview was on 6 April 1993, the second on 5 May 1993, and both took place in one of the therapist offices of a local community counseling center. The ADRC medical record was analyzed on 25 May 1993. The Pride Institute discharge summary was received and analyzed on or about the same time.

The genogram was developed from interview data, and was checked against the medical record and with the participant for accuracy.

Around the eleventh grade in high school, Mr. Eagleton stayed weekdays with his maternal grandmother as she recuperated from a broken hip. Combining this freedom of living with his grandmother and being away from the immediate gaze of his mother, new friendships were established. He stated that

> About that time I met some friends. They weren't the popular crowd, they were just off to the side, that drank and smoked and cussed and smoked marijuana, and did all that stuff; and I thought it was cool, and I wanted to fit in, so I started drinking. I always hated drinking. I hated it. But I did it anyhow to fit in. I used to get dog ass drunk.

His grandmother consistently went to bed at 8:00 pm and did not rise until morning, and his mother was regular in calling to check in on them around 8:30 pm. This left Mr. Eagleton free to sneak off after that parental phone call, and join his friends for drinking. He reported that

> It was terrible. But, you know, that is the first time in my life that I ever felt acceptance. And the acceptance was not just based on me, but it was based on the alcohol consumption and the cussing and the smoking cigarettes and smoking pot and all that. It

was just like the most wonderful thing in my life. I felt accepted.

He was able to continue this pattern for several months until a cousin saw him drunk at a party, and turned him in to his mother who "beat the shit out of me." His mother told him that he "shouldn't have done that, God is watching you, you sinned and all this kind of stuff." Subsequent to this event, Mr. Eagleton's mother would not let him far from her sight, "would not let me go anywhere or do anything," and listened to his phone calls.

Finishing fortieth out of a high school class of 258, Mr. Eagleton entered surgical technician training course through a small state university in a nearby city. He stated that "I always had this thing about hospitals. I always wanted to be a doctor. I think I just realized for whatever reason that I couldn't do that so I wanted to do the next best thing." While working in a local hospital as an orderly and going to school, he met his future wife, also a student and hospital worker. They dated for about a year and one-half, "It took us about six months before we did [have sex]. And it was great for me because I was able to perform with her. It made me feel like a 'heterosexual.' It made me feel like a 'man.'" He reported that "I always knew all through high school but I always repressed it. I just knew that guys made me excited." Sexuality is a dominant theme in his story, treatment, and recovery.

Mr. Eagleton married when he was twenty years old and his wife was twenty-two. He reported that "I think the reason we got married, she was on the rebound from this guy she was dating and I wanted to get out of the house." He reported that the marriage was good during the first year, with no major problems in their relationship, but that it started to change. Pressures from school and work began to build, combining with a discomfort about the marriage, and

> I started getting a lot of headaches from the anxiety and the pressure. . . . I would go up to them [the ER doctors where he worked as an orderly] and say, 'You know, I'm having these terrible headaches,' or 'My tooth is really hurting.' And I had never had any experience with narcotics.

The physicians would write prescriptions to cover these assortment of real and imagined aches and pains. He reported that he had stopped drinking after completing high school, so this was his first venture into other drugs. First using them to sleep, he ultimately experienced his first "high" from narcotics,

> I remember I didn't get to go right to bed for some reason, something happened and I didn't go to bed and in about thirty minutes I got a buzz. It's like I think that's the point I crossed the bridge to addiction.

Having exhausted his supply of cooperative physicians where

he lived, he "ended up stealing medicine off the medicine cart at the hospital." He also had a friend who worked in the pharmacy from whom he could obtain his illicit narcotics.

Mr. Eagleton reported that this stealing of drugs continued for about a year, while he was working as an orderly and going to nursing school. He would go through patient medicine drawers, take and hide what he thought might give a high, and sneak the drugs home. He said,

> I remember I felt like they were catching on to me, and I was kind of desperate to get drugs. I remember faking an appendectomy. I mean, faking appendicitis because I knew those one doctor that was there who would give you anything you wanted. So I faked an appendicitis attack and had my appendix taken out knowing I would get drugs.

He was about twenty-two years old, and stealing narcotics from patients to support his addiction.

He was very unhappy in his marriage but fearful that it would end. Marriage meant a certain level of security for him, "a wedding band, Mr. and Mrs. on the checkbook, at that point I felt like, 'if I do like men then I won't [if married].'" Marriage started with sex three or four times a day but, after two to three years, sex was "like once or twice a month." His wife then stated that she wanted to have children, much to his distress. There were

complications related to getting pregnant which reduced sexual intimacy to a matter of temperature charts and ovulation schedules, and

> It was just terrible. It really was terrible. You know, it was terrible for me to have to try to perform, it was terrible because I felt like I was lying to her. You know, I'd lose that wedding band and that stuff. All that security. It was really awful.

His wife became pregnant soon after they stopped trying so hard to have a child.

During this same time, Mr. Eagleton's wife started to sense that something was not right and "She had come to the conclusion that it was drugs." Her suspicions were raised because of the large amount of money spent at drug stores for prescriptions. When confronted on these high expenses, he told his wife that the prescriptions were for his headaches. He reported that "She realized that I was addicted. And she told me I had to stop or she would leave me. And she was pregnant, that was terrible." He reduced his drug consumption during the intervening months of the pregnancy, but was using the day his son was born. Mr. Eagleton reported that "It was just such a positive experience for me. I quit taking drugs, cold turkey. All by myself. I did fine. I just quit taking them." So, in 1984, he became a father, stopped using narcotics, graduated from nursing school, passed his state licensing examination,

and became a registered nurse. He said that

> It was really great being a father, you know, I could like focus, I could defocus off of my ex-wife [still his wife] and being gay and all of that into my son. . . . It was neat him growing up and stuff. The next couple of years I didn't do drugs. I didn't address my sexuality. I was just really unhappy and hated it.

By 1986, the excitement of father had waned and the discontent of marriage and repressed sexuality had grown. Having his neck examined for chronic pain, Mr. Eagleton discovered that he had a cervical fracture and was given a prescription for pain. He had been drug-free since his son was born, "And I got a prescription for Tylox and, I tell you what, I took two of them and, when it hit me in whatever length of time, kicked everything right back in." This was his first relapse. He quickly went from prescriptions to stealing from patients again, and

> The drugs just made me forget about everything. Made me feel really good. Gave me, gave me a sense of kind of like, I don't know, just made me feel good. Like I had this overwhelming self-esteem or something only while I was taking them, while I was actually taking them. My use progressively got more and more. At the time I was taking them, they had promoted me to relief supervisor on nights. I had the key to the pharmacy.

Realizing that he was in trouble, he resigned from the

supervisor's job and turned in the pharmacy keys to take a job in the emergency room. He reasoned that he would be safe there because few drugs are administered routinely in emergency rooms. He reported, "Well, it lasted about a week and I started signing out drugs in the emergency room."

His frequent signing out of drugs came to the attention of his superiors, and he was confronted with this in April 1987. When told by another nurse that the charge nurse wanted to see him, he reported,

> I knew what it was. I was in the bathroom actually, shooting up. I knew what it was. At that time of night I knew. So I went ahead and used those drugs real quick and went to the nursing office. And when I went to her office, I saw all of these narcotics sheets laying on her desk and I knew I was fucked. I knew it.

The director of nursing and his supervisor said that, if he went to treatment immediately, they would hold his position open for him and not report him to the state nursing board. He agreed to this plan and entered a treatment facility the next day. Mr. Eagleton stated that his wife "blasted me out and told me how worthless I was and all that stuff." He was clear to report that there were never any incidents of harm to patients in any form from his diversion of drugs. He was a lucky man.

His first treatment experience was of questionable quality. The facility combined its psychiatric and chemical

dependence populations into the same groups most of the time, with very little information or effort focused on the problems and treatment of chemical dependence. The physician at the center chose to focus solely on Mr. Eagleton's statement that he was gay, seeing that as the cause of his addiction, "I remember he pounced on that like a dog on a bone. It's like he didn't even want to deal with my addiction. He thought that was the reason for my addiction. And he, that's all he wanted to talk about." This was the first time that he had said that he was gay, and "I hadn't even had a sexual experience with a man at this point." Mr. Eagleton completed the treatment.

Contrary to what they said, his employer had turned him into the state nursing board and the hospital would not take him back. His advocate on the impaired professionals program told him that he would probably need to move to a larger city to get another nursing job. He said that

> I got out in April of '87, so July of '87, after all that time, I just broke down and finally came to Knoxville. And got a job there. I walked into the medical center, was hired the second I walked in.

Hospitals in larger cities are more experienced in working with persons in recovery. The move to Knoxville meant separation from his son, which was difficult, and from his wife. Mr. Eagleton spent his time working, attending meetings, and travelling up to his home town to visit with

his son. He reported that he "worked a good program [of recovery]. I think that's what kept me clean and sober. It really did."

Mr. Eagleton described the Johnson City Caduceus [health care professionals support group] meetings as very confrontational, perhaps even to the point of being destructive, and "I was real intimidated. It was a really bad experience. I hated it. So I only had to do that for a couple of months, then I moved to Knoxville and I started going to the Caduceus meeting here." The meetings in Knoxville were quite different, and provided solid recovery support. Though he reported that he was working a good recovery program at the time, he stated that he was not addressing sexuality issues. Mr. Eagleton said that he was running away from them as fast as he could go.

Much his thinking at this time was shame-based, because of how he felt about himself and what he had done. Mr. Eagleton reported that he was embarrassed to go to stores for fear that someone he knew would see him. This also applied to his family,

> I couldn't face my family very much. Because my mother, being Southern Baptist, was the type that believed in the Lord. In fact, right after I got out of drug treatment, they never participated in family week at all. They would not. They didn't want to have anything to do with it. They thought it was not an

> illness but a weakness. . . . And when I got out of treatment, I remember her putting the Bible up in my face, if you would have believed in the Lord, it wouldn't have happened. So I didn't go around them very much. They made me feel really bad.

His marriage was one in name only. They ultimately filed for divorce in 1988, and it was finalized in January 1989. He reported that "Right after we got divorced, I went into a crisis. I'm almost 30 years old. I'm overweight, I felt like I was overweight. I'm alone. I don't have a wife anymore. I don't have a life, a social life." He stated that he lost 106 pounds on a diet, and participated in a eating disorders treatment program in early 1993. During the latter part of 1989, while talking to a female friend who was also a nurse, he acknowledged that he was gay, "And it was just like wonderful. I heard bells chiming. For the first time in my life I felt relief and, you know, we talked and talked and talked." Mr. Eagleton stated that he started to socialize with other gay men, though he experienced some false starts during the early stages of his new life. "And then one day, I had a sexual experience with a guy and it was just like, it was like the way it was supposed to be. And it just kind of changed my whole life." These were times of great changes in his life, including changes in his recovery program. Mr. Eagleton stated that he quit going to meetings, and stopped doing all the things that supported

his recovery. At risk was his recovery, his status as a Level V RN (Level VI is the highest, one that Florence Nightingale could not reach), and a $50,000 annual income. Externally, he was very successful, often was the preceptor for the new nurses, did excellent work, and "The whole time that I was going out and being a whore and doing all that stuff." Even in his new-found independence of identity, he could not escape his shame-based thinking.

By Fall of 1990, Mr. Eagleton no longer was working his recovery program, had gained back a lot of the weight he had lost, and was becoming increasingly depressed. Putting together disparate bits of information that included knowledge of unprotected sexual acts, he decided that he was HIV positive. Even with his medical knowledge, this irrational thinking set the course for his actions,

> So, and being depressed, I thought, yeah, I am HIV positive. So, I am going to die. So, if I'm going to die, to make it, you know, better for me, you know, so I thought, 'Well, I'm going to use drugs because that will make me feel better, make it more bearable.' So, one day, I got a whole bunch of drugs from the hospital. Bunch of drugs, probably like 2000 mgs. of Demerol injectable. Went home and decided I'm just going to kill myself, because I just can't go on. I just cannot live with AIDS.

Rather than put his son through the difficulty of his father

dying from AIDS, he decided to overdose on Demerol. The reality of what he was doing struck after he had injected the first of five stolen syringes of the narcotic, when he remembered that he had been abstinent for almost five years. He said, "You know, I just couldn't do it. Just could not do it. So I got the other medicine, and I got the syringes and opened them up, and put them in the commode and flushed it."

Knowing that he needed to act, he made an appointment with an EAP counselor at the medical center. He was guided to speak with his head nurse and clinical coordinator, and this led to testing for HIV (multiple negative results), contact with his nurse advocate, signing a recovery contract, and starting to attend meetings again. These measures did not work. The re-establishment of the addictive processes was already in place with that single IV injection of Demerol. Mr. Eagleton started to divert drugs again,

> So over that period of time, every now and then I would take drugs from the hospital. I would take a couple of doses a week but wouldn't, being in ICU, it was kind of easy. They use so many. But it went to five or six times. Then it went nightly when I worked. And they finally caught onto me. They caught on and they did a confrontation on me on December 16th [1991] at the medical center.

This was his second relapse. After being confronted by his supervisors, he was escorted directly to the treatment unit for admission. He stated, "I cannot put into words how bad I feel about this - it's the worst thing that has happened to me that I know of in my life." He remained there for five days. Based on the recommendations of the ADRC clinical staff, Mr. Eagleton transferred to the Pride Institute in Minnesota for continued treatment. The recommendations were based on his continuing internal conflict regarding his sexual orientation, and its continuing impact on his chemical dependence. He stated,

> It was the right move, the right thing. Absolutely phenomenal thing for me. I was in an environment where I could say anything I wanted to and didn't feel like. The reason I didn't feel like I could be in a traditional treatment setting, one was for acceptance. It was a big thing for me.

It was a positive move because it was a good treatment program, unlike his first experience, and it was a safe place to address both his chemical dependency and homosexuality.

One of the issues identified as a hindrance to continuing recovery from chemical dependence was the maintenance of his "secret" about sexuality. With the support of his therapist and therapy group members, Mr. Eagleton called his parents to tell them that he was gay,

> That building rocked, it was terrible. . . . So I told her and it was really bad. She hollered so loud that people in the next room could hear that we were all going to hell, and that we were all sinners. Just the whole typical reaction.

He also told his ex-wife of his homosexuality, but "she was okay with it. She was fine." This is described in his Discharge Summary from Pride,

> While in treatment, patient also disclosed secrets he had been keeping around his shame-based identity to both his ex-wife and his parents. Although patient experienced much anxiety around these phone calls, with peer support he successfully completed them. His wife responded with a general sense of acceptance. His parents continued to be shaming in their response to him. Patient was able to handle parents' shaming response, and became increasingly direct and clear with them throughout his conversations.

Part of his treatment at Pride dealt with issues of chemical dependence and gay culture, heterosexism, homophobia, and cross-addictions. He stated that "I was able to express myself about how I felt about being gay and living in a heterosexual world, and trying to survive. And how drugs are higher, there is a higher incidence, per se, in the homosexual community."

He remained at Pride for twenty-three days, leaving

only because his insurance carrier would not acknowledge continued treatment value at a "specialty" treatment center. With the assistance of Pride Institute, Mr. Eagleton was able to arrange admission to Spencer Halfway House in Los Angeles, another treatment program that worked specifically with gay men who were chemically dependent. He was to remain there for about one month, with mixed treatment assistance because of management changes happening during his time there. He returned to Knoxville to work once again at the university-affiliated medical center.

Though he was able to work at the medical center as a nurse on his return from Los Angeles, he did have to face suspension of his license a few months later. Not being able to work in the hospital as a nurse, he "worked as a nursing assistant. Well, I stayed at home for a month and didn't do anything. I pouted and felt bad, and didn't use or anything like that, just vegetated. And then I started running out of money." This was a humiliating experience for him, having to step very far down the medical ladder from a Level V nurse to a minimum hourly wage nursing assistant. Mr. Eagleton also had to return his car to the bank because he could not keep the payments up, filed Chapter 11 bankruptcy (consumer debt consolidation repayment), and almost lost his trailer of five years. He was able to turn this into a powerful reinforcement against relapse.

By the time of his interviews, his license had been restored and he was working as a nurse again. He was working closely with his nurse advocate, participating in continuing care groups, an Impaired Professionals group, Caduceus, and is on a narcotic restriction for a year. He said that

> I feel very, very positive about my recovery. I feel better now than I have ever felt as far as my recovery in my entire life. And I think, like I say, because I'm working a program and being responsible. I am not just going through the motions. I am actually working a program.

It appeared that he had sufficient supportive structure for continuing recovery.

Mr. Eagleton identified three learnings about his addiction that were particularly important to him. He reported that

> I think, probably, the biggest 'Aha' was that drugs were not an option anymore in my life, that I had to deal with life no matter what, what it had dealt me. You know, what a bitch it was. I had to deal with it.

Another principal learning was his recognition that it is okay to be whomever or whatever he is. "It doesn't matter whether I'm black or white or straight or gay or whatever. It was okay and I am an okay person." His third learning is most relevant to his search for a lasting recovery, in his

recognition that sobriety is not the same as recovery. He said that he

> had time to kind of build upon it [sobriety], and realize what true sobriety was. It wasn't just not using. It was about working a program is what it was. And before I thought, you know, you were sober if you were just sober and you didn't use drugs. It wasn't like, that just doesn't get it. You have to, like, work a program. And I realized that this time versus the last time.

## Family Systems Information

Mr. Eagleton is the younger of two sons, whose father was a passive, non-drinking, ex-Army sergeant chef, and whose mother was a domineering, religious zealot. He reported that "My family dynamics are fucked. I think that's one reason why I have been so screwed up in the past." His father was from New Hampshire and his mother from a small town in northeast Tennessee. The family moved a great deal because of the Army, living in a number of different places while growing up. The genogram (Figure 5) indicates some of this conflict. He stated,

> My mother was the authoritative person in the family. She was the one who gave the punishment, and she was the one that set the rules. My dad was just kind of

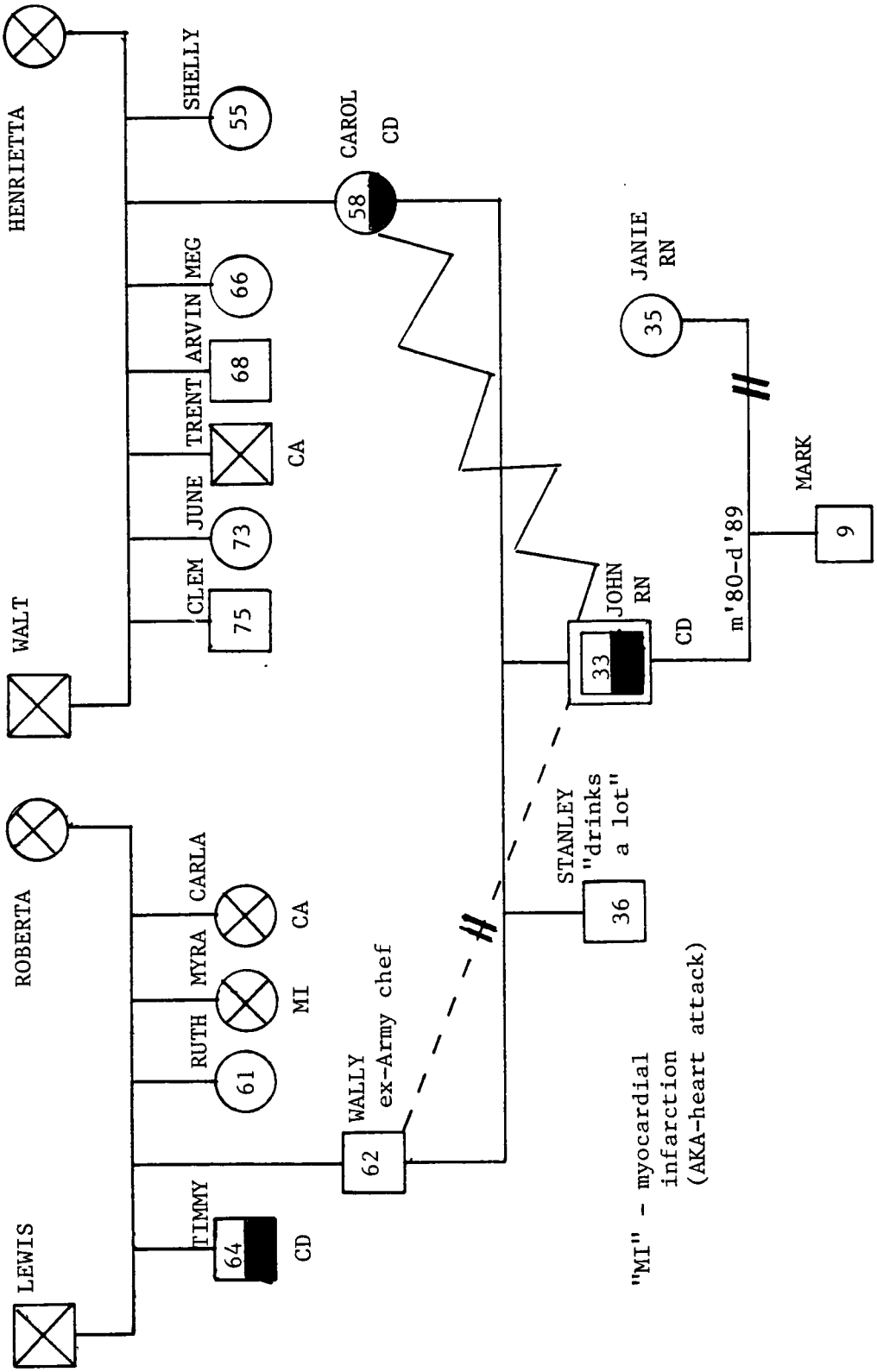



Figure 5 - John Eagleton (7Apr93)

went by her rules. If we wanted anything, we always had to ask her. And that always upset me. I never could understand that, and he never punished us. He always left that up to my mother.

His childhood was filled with the difficulties of moving often, a speech impediment requiring speech therapy, and being overweight. He also reported that he and his brother fought constantly, "My brother and I never got along. I don't know why."

Mr. Eagleton's father favored his older brother and "totally ignored me." At his mother's insistence, he took piano lessons and his father and brother "said I was a sissy for playing the piano. And that I should be out playing ball and stuff like that." The only time that his father chose to attend to his younger son was during his efforts to play high school football, "I hated to got to practice. I hated everything about it." This stopped when his participation in football was terminated because of a problem with high blood pressure (a health problem that continues), and "So I quit playing football and he quit paying attention to me, and it really bothered me a lot. So I went back into the house, and playing my mother's little side person." As a sophomore in high school, he was hospitalized for ulcers "so bad they were almost perforated."

Mr. Eagleton stated that his father was a "tea-

totaller" and his mother condemned drinking. He did say,

> My mother has to have Ativan[1] and she is real nervous. She can't deal with world issues. Starvation, abuse and stuff. . . . And if she hears you [talk about it], she has to take a nerve pill. Which it is real easy for her to get it, because my brother's wife's mom and dad are physicians and that's where she gets it.

Another way of seeing this hysterical response to the ups and downs of life is his mother as an addict. Her chronic use of a powerful mood-altering substance was significant. He described his parents' relationship "as kind of a codependent kind of dysfunctional. My dad, it's like my dad does anything my mother wants. He doesn't have an identity." His mother controls the family.

The nuclear family emotional system clearly was chaotic, starting with the passive-dominant polarity between mother and father. The marital dysfunction gets played out in the treatment of the sons, both the division between father/older son and mother/younger son and her meting out punishment. Punishment was administered through the use of a ping-pong paddle, but the boys were required to remove their shirts and pants. This continued on past puberty. Relationships took on negative characteristics as triangles were set up among the four family members.

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[1] Ativan (lorazepam) is an anti-anxiety medication in the benzodiazepine family. Like other benzodiazepines, it can become addictive with continuing use.

Though there was clear emotional cutoff for Mr. Eagleton from his father, something that caused no small pain to him, there was a cutoff from his mother. This cutoff came from the rigid barriers she established as means for control. This emotional distancing was evident during his years at home, but continued to expand after Mr. Eagleton's treatment for chemical dependence. It was particularly evident after he disclosed his homosexuality to his parents.

His statement above about the differences between just being sober and recovery, and his description of his present recovery program, reflect an increasingly mature differentiation. So much of his recovery from chemical dependence is tied to his separation from his family of origin, and transformation into an individual increasingly independent of their chaos and dysfunction.

The genogram is remarkable principally for its visual imagery of conflict and distance between Mr. Eagleton and his parents. The lightning lines of conflict between mother and son were consistent with her hysterical and controlling personality. The dashed line between father and son described the minimal relationship that they had, which was further blocked with addiction and homosexuality. To a lesser degree there is separation from his family of creation, with the divorce and physical separation from his son. His isolation may have been the best event in his

life. There are also indicators of alcoholism/addiction on both sides of the family (a paternal uncle and his mother). He stated that his brother may have a problem with drinking (the brother denies it and the wife affirms it).

## Interpretation and Implications

The gender-related messages received from his family of origin left little to doubt in their definition of "what it means to be a man." For Mr. Eagleton's father, playing football was a "manly" endeavour but playing the piano was a "sissy" thing to do. These are confusing messages when put beside the father's career as an Army chef and his seemingly total abdication of power within the marriage. In keeping with the family projection process, it appears that the marital discord gets acted out through the sons. Does the father have a need to prove himself in an arena other than marriage, because that is not available to him? Throughout the interviews, the person whose reaction to Mr. Eagleton's issues was greatest and most damning was his mother. There were few references to his father throughout the interviews, apart from a hunger for an accepting and present father.

Though it would be very difficult for most fathers to accept that their son was gay, there was no mention of Mr. Eagleton's father's reaction to the announcement apart from his acquiescence to the mother's hysteria. Though the

etiology of sexual orientation behavior is rarely from environment, one cannot help but think that the development of a healthy sexuality (whether straight or gay or in-between) would be helped by a father's positive guidance. Add to this father deficiency, Mr. Eagleton's mother's "ownership" of him as a child and adolescent, particularly when considering her actions during punishment, with major problems of boundaries that may border on covert incest-like behaviors.

Gender for Mr. Eagleton was a confusing experience for him, where he struggled to find acceptance of his sexuality. His description of his time at Pride Institute was a powerful declaration of acceptance. Like treatment itself, perhaps this was his rite of initiation into adulthood where he experienced the making of his manhood. Gilmore's (1990) three characteristics of culturally defined manhood--Protector, Provider, and Impregnator--are not literal statements, and apply to any man who has attained a healthy understanding of himself.

Though sometimes initially cautious in speaking, Mr. Eagleton was very open during his interviews. Parts of his story are powerful judgments on himself, but he was willing to speak his truth because it ultimately helped him in his own recovery program. This truthfulness in the interviews was reaffirmed during the review of the medical record.

Mr. Eagleton's success points list began in a section

above that identified and discussed three principal learnings. These "ahas" were: drugs are not an option any more in any form; I'm an okay person and I will live what is dealt to me; and sobriety is not the same as recovery. Two other success points occurred as part of treatment and recovery. First, Mr. Eagleton was able to reach an appropriate and accepting understanding of his sexuality, essential to every person's development regardless of orientation. Second, he finally was freed from the strictures of his family of origin that were destroying him.

The implications of this story to the nature of recovery are found in the consistent patterns of restoration of balance. This restored balance is expressed through a more complete and comprehensive understanding of recovery; an establishment of an independent adult identity apart from family of origin definitions; and an integrated redefinition of self relative to being a man that includes a healthy understanding of sexuality.

# CASE SIX: PAUL FRANCIS

## Description of Sixth Participant

Paul Francis, the sixth participant in this study, was a 54 year old widowed African-American male, admitted to ADRC on 20 April 1992 for Alcohol Dependence (303.91). He remained in treatment for twenty-six days until 15 May 1992, when he was given a regular discharge. He was referred for treatment by an EAP-affiliated physician, based on ever increasing cravings for alcohol, though Mr. Francis had been abstinent for about three months. His first attempt at abstinence resulted from the encouragement and support of Thomas Adams (first participant in this study), a coworker at a large government-contract facility near to Knoxville where both worked in support services positions. This initial effort was made solely through attending AA meetings and determination. He was encouraged to seek treatment by his employer, and was supported by his employer during hospitalization. The medical record noted that his employer's physician "recommended the patient to come into inpatient treatment for his alcoholism, because the patient appeared unable to maintain sobriety and would relapse."

There was only one interview with this participant, because cognitive functioning limitations resulted in maximum information gathering in that one interview. This

interview took place on 17 May 1993 in one of the therapist offices at a local community counseling agency. The medical record was evaluated on 25 May 1993. The genogram was developed during the first interview and checked for accuracy during that interview. The interview was postponed once from its first date because of the death of two of Mr. Francis' relatives within a short period of time. Mr. Francis was a pleasant and cooperative participant, with a good sense of humor. Though his thinking and speaking were often tangential (the principal reason for a single interview), he did provide the fundamentals of his story.

Mr. Francis reported that he started drinking while in high school, around the tenth grade. He would get together with some friends after school or after work to drink. Sometimes they would skip school so that Mr. Francis and his friends could go drinking,

> I guess I got off on alcohol about, alcohol and beer, about 1954. My last two years of high school. Then I went in the service and stayed until 1960. And I just been drinking alcohol and using and drinking alcohol for all those years and, well, let's see, I just thought it made me look good.

His introduction to drinking was part of the socialization process at the time of his late adolescence and young adulthood.

Though in the service for four years, he denied any

alcohol-related problems while in the service.

**Researcher:** Did you have any problems with alcohol while you were in the service?

**Mr. Francis:** No, I didn't.

**Researcher:** No arrests or

**Mr. Francis:** No arrests or nothing. I had a perfect record in the service. Then I come out of the service and started running around with the boys and everything.

Mr. Francis then stated that he "probably got stopped by the police going home. Which I did, three times I did." Then he spoke of seeking out Thomas Adams, talking to him about his treatment experience, and deciding to enter into treatment. Over thirty years of life were compressed into a few sentences. This was a characteristic inherent in the interview that created difficulties in telling his story. It was not clear if this cognitive limitation was because of alcohol-induced brain damage, prevarication, wanting to tell a "good" story to the researcher, indifference to time, or simple forgetfulness.

Mr. Francis' wife, Wendy, died on Thanksgiving Day 1984 from cancer. They had a daughter, Sherry (26 years old), who was born three years before they married, and this daughter continued to remain close to her father.

**Mr. Francis:** And she died in '84. She had cancer. And we definitely didn't have no trouble because we

didn't have no trouble at all. We never did have no trouble.

**Researcher:** Did she drink?

**Mr. Francis:** No, she didn't drink. She used to raise hell to me about drinking. I used to drink just to make her mad, and show her I wasn't scared of her.

One person's discussion is another person's fight. It is not clear on what type of relationship Mr. Francis had with his wife, even with the "no-trouble" disagreements about drinking listed above. Based on the limited information available, though, it appeared that the marital relationship probably strong "enabling" characteristics by his wife. He reported that his wife's objection to his drinking focused primarily on money needs, and the cost of continued drinking. Mr. Francis also reported that he had another daughter, Paulette, born as result of a relationship that existed before he met Wendy. Paulette's mother, Dolly, is serving time in the state penitentiary for murder. Both his daughters were supportive during treatment.

His drinking patterns followed the ones established during high school and the service, for Mr. Francis would meet his friends after work to drink. His pattern was not to drink alone but with friends, he was not a solitary drinker. He described his pattern and said,

We [Mr. Francis and his friend, Sherman] put away four small, that's a day, four pints a day, six days a week.

> Then go to a bootlegging joint on Sunday and put away five half pints of beer, and then go down to the other bootlegging joint and put away five pints.

His preference was for "Red liquor, bourbon, that's what I preferred, bourbon." He did not report using any illicit drugs. He spoke of the ready availability of credit to purchase liquor from bootleggers, and joked about one liquor store going out of business when he stopped drinking. He reported that "Begley went out of business after I went into treatment, so I may have been the one keeping them in business. I thought, you know, I was a damn fool. I must have been the one keeping them in business."

Mr. Francis' father was one of ten sons, and the only one who did not drink. His paternal grandfather and great-grandfathers were all Holiness preachers, none of whom drank. He described his family as having their own church,

> Our family was so big and we had our own grocery store. We had our own church, and we had two three-story houses. And a trailer and an apartment in the back of the store. Now it's done got so small [the family], just could get us all in a matchbox.

He reported that his mother did not drink, and neither did any of her six sisters or his maternal grandparents. His sister, Marie, is his only sibling. He reported that she is on dialysis, and he suspects that it resulted from alcohol-related kidney damage.

By comparing Mr. Francis' reports and the diagnostic summary in the medical record, it appeared that he did have a number of alcohol-related legal problems. The medical record stated that he has been charged with Driving Under the Influence (DUI) on five occasions, and Public Drunkenness (PD) on nine occasions. Mr. Francis reported three DUIs and five PDs. He reported that he had an uncle who was a police captain, and helped him get out of some DUI charges. He stated that

> My uncle's the captain on the police department. And he's got a good job, he can pay. So you can figure it out from there. He's got a good job, he pays whatever you all charge. And I say I think I paid him one time $2500. I think one time I paid him that much.

Mr. Francis rambled on some more about this. When asked if the charges were dropped or disappeared, he answered,

> Well, just a fine and a weekend in and went to jail. . . . just go down there on Friday and sign in and then go on back home. See I never did have to stay. I would go down there and sign in on Friday and go on back home. But make sure you don't go nowhere and get in trouble.

Until the change in community attitudes and tightening of legal consequences regarding DUI, most any variance on charges, sentencing, and punishment was possible. It is not possible to determine if this uncle was paid a bribe, or the

money was for lawyers' fees, court costs, or fines. Two of the DUI charges were in 1988, and one recently enough that it was still pending when Mr. Francis entered treatment. The disposition of the nine PD charges was not clear. He did have an interesting "grading system" concerning his DUI charges, "That's a problem. When you get one that's bad. When you get two that's damn bad. When you get three that's a God damn, excuse the French."

Mr. Francis started his self-styled treatment program on 11 December 1991, by stopping drinking and attending AA meetings. He reported that he did okay for about three months, but "Probably, about the first of April, I started getting them cravings." From his perspective, the decision to enter treatment was because he realized that he needed help to maintain his sobriety. The medical record stated that he was encouraged to enter treatment by his employer.

It did not appear that Mr. Francis had job-related problems with alcohol, and there were no reports of drinking on the job. He did report that there was a problem, of unclear dimensions, about him drinking at a place that the FBI held an interest in because of possible illegal drug use by customers. This Federal interest is tied with their institutional concern for security, and the number of sensitive Federal projects at the facility where Mr. Francis worked. He said that he only went their occasionally but there were different stories from others, and

> You know how the FBI will check on you. Well, he went there and he asked and said, 'Do you know Mr. Francis?' Said, ' Shit!' The lady, I call 'em bar girls, bar maids, whatever you call them. She said, 'Yes, he is a frequent customer. And which I was not because they used drugs.

Mr. Francis just had two or three years until he could receive a pension, and this may have been incentive to listen to his employer about seeking treatment for his alcohol dependence.

Much of the first two weeks of treatment were spent denying the magnitude of his problem with alcohol. Once that point was passed, Mr. Francis became actively involved in the treatment process. He stated that "The best thing that I remember about treatment is Father Murphy[2]. Those tapes they used to show us about Father Murphy, about chemical dependency. Best thing I remember about treatment." Mr. Francis also spoke often of the importance of the clinical staff in helping him understand his chemical dependence, and in developing his recovery program. He was able to see the differences in behavior that were detrimental to recovery and those that were. "But I managed

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[2] Father Murphy was a TV character portrayed by Merlin Olsen, who pretended to be a priest and took care of unwanted children. Father Martin is a Roman Catholic priest whose ministry is in chemical dependence treatment. He is particularly well-known for his educational programs. Videos of his talks are used in most treatment centers because of their excellent content.

to, I guess by the grace of God and my higher power, that I watched other people get so mad and fuss. I didn't have time to get mad and fuss."

Through the encouragement of the clinical staff, particularly the Continuing Care Coordinator, Mr. Francis maintains close ties to the treatment unit. He rightly believed that his recovery was enhanced when he helped others who are working on their addiction. He said,

> They got like high hopes about me. I know they got hopes on me and Tommy Adams because she, we only supposed to got over there a year [secondary care lasts one year]. Well, I'll tell Judy I'm coming the rest of my life. She said, 'Good, we will be glad to have you. So I do a little counseling work up there, you know, to help the guys that don't want to stay. I think I have done a pretty good job.

He did regret that it took him this long, "You never too old to learn. I'm just sorry I had to wait until I get 56 years old before I learned." Like the support from ADRC, he found his "new friends" from AA are an invaluable resource to his recovery. Mr. Francis found ways to connect with people in ways that encouraged his recovery, rather than re-establishing relationships with his old drinking buddies. He ended the interview with the following declaration. He said,

> Well, I would like to say that in your book, I would

like for you to mention one thing in that book. That whoever reads it and said it, for God's sake, one drunk to another, take this advice from Paul G. Francis of Knoxville, Tennessee, 'It ain't no good.' That's something I would like for you to publish in that book.

## Family Systems Information

Mr. Francis spoke only briefly about his family of origin. There were the points made in the previous section about his grandparents and parents, and some limited references to his wife and daughters. He did discuss his father briefly during the interview, "I knowed him enough to know that if he was still was living, and he was able to do it, and he knowed I had been drinking, he would bust my ass." He did acknowledge that his father was of a generation and attitude that "You had better not talk back to my daddy." If you did there were dire consequences, "If I could bring charges against my daddy for brutality he never would get out of jail."

Even with statements such as the above, his affect when speaking of his father was positive. His interview was delayed because of two deaths in his family, and Mr. Francis was involved actively with his extended family during these times. He remains in close contact with his daughters, they were very concerned for his well-being when he was still

drinking, and were interested in his treatment and recovery. Family is important to him. Perhaps the genogram (Figure 6) tells more about his family dynamics than does the little information available in the interview.

Because of this very limited information about his family, the researcher was unwilling to apply Bowen's concepts. To do so would be based too much on conjecture and supposition. What did appear is a family that is still involved with one another, is supportive in a generally positive manner, and is not reticent to speak what is on individual and collective minds.

## Interpretation and Implications

It is difficult to discuss gender issues about a man who was comfortable with who he was as a man. He did not demonstrate adolescent, young adult, and middle-aged angst over what it means to be a man. In many ways it was a non-issue for Mr. Francis, perhaps because of maturity or perhaps the result of cultural determinants because of race. He did not express internal or external conflicts with his father, mother, or any other family member. His struggles were more basic--how to stay sober and continue working his recovery program.

There were some conflicting bits of information between what Mr. Francis said, and what was noted in the medical

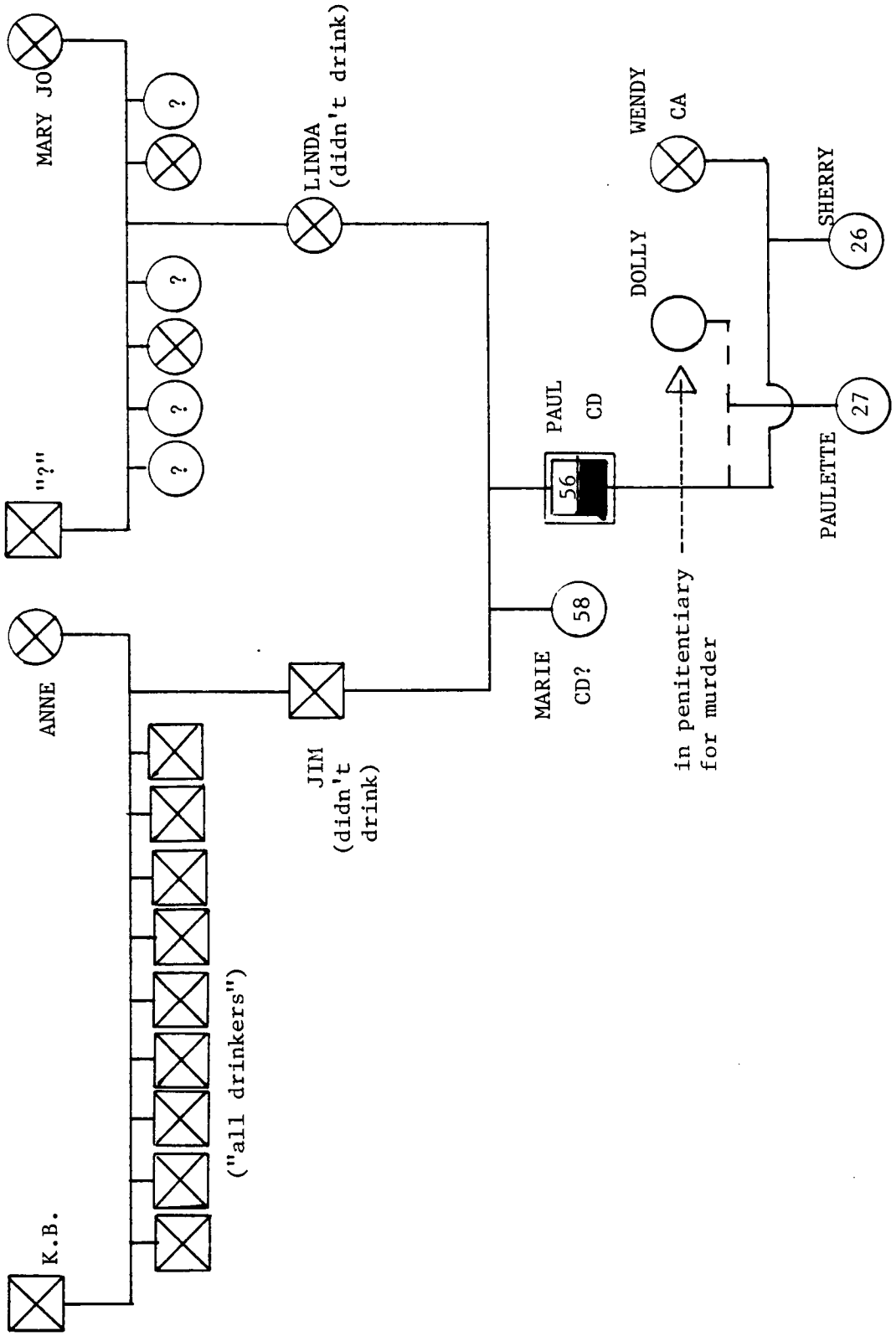



Figure 6 - Paul Francis (17May93)

record. There is some discussion of this issue in the beginning of this case study. Though a subjective evaluation, Mr. Francis seems to be one of those people whose love of a good story is never hampered by something so trivial as accurate details. He is fundamentally a storyteller, so his continuum of fact and fiction is more flexible than that of most persons.

The success points in Mr. Francis' recovery focus around support: the support he was able to give others and the support that he received from others. There were multiple references in the interview about how important he believed helping others was to his own recovery. Being able to reach out to others did much to draw him out from the isolation that addiction creates. Mr. Francis recognized how important it was to him to be able to go out from himself to others. The support, validation, and encouragement that he received from the clinical staff at ADRC was a paramount issue in his transformation. He was not just a number, another in a long line of patients, rather he was someone who was valued because of himself. Perhaps his recovery program would be too simple for most persons, but it meets his needs for continued recovery and that is what is ultimately important.

## CHAPTER SUMMARY

This chapter has presented six case studies that describe six different experiences with treatment and recovery. Each case study has a "personality" that is a reflection of the participant so, even though the outline was the same, the results are not. The next chapter is a discussion of the conclusions and implications that come from this research.

# CHAPTER V

# CONCLUSIONS AND IMPLICATIONS

## INTRODUCTION

There is a tendency within most human institutions to attempt to categorize persons, and mental health and chemical dependence treatment programs are usually no different. It is much easier to use a code number from Diagnostic and Statistical Manual (Third Edition-Revised) (DSM-III-R) (American Psychiatric Association, 1987), than to take the time to describe an individual's unique situation. Clearly, there are patterns of behavior, similar psychological and physiological responses, and shared need for education that characterize those persons who are experiencing similar diseases or dysfunctions. This does not mean that "one size fits all" in health care, and it especially does not mean so in chemical dependence treatment. This diversity of experience and need was evidenced in each story presented in the case studies. Each story had a richness and diversity that called for particular attention to the development of a balanced, holistic approach to recovery consistent with family systems theory and the biopsychosocial model of addiction.

The research objective was to better understand the

nature of recovery for at least six chemically dependent males. These men revealed much about themselves, as they took a chance in opening themselves to tell their stories. Through their willingness to risk disclosure, a better understanding of the nature of recovery has begun to evolve. Their stories varied with a richness consistent with the diversity of paths to recovery.

The path to recovery is not a single, narrow path. Sobriety may be a narrow path, but recovery from chemical dependence is not. Recovery from chemical dependence for each of these six men came with the discovery of a balance within their lives. Although their experiences were different, recovery for these six men was a balancing of the emotional, physical, and spiritual components of life, consistent with family systems theory.

There are those who wish to reduce recovery to a simple formula, one that can be packaged and marketed. There is no doubt that there are "pieces" that encourage recovery more than discourage. Without question, not ingesting mood-altering substances is an essential part of recovery, but treatment cannot be codified, systemized, organized, and sequenced down into micromanagement of the therapeutic process. The inherent danger in packaging, marketing, or codification is a myopia, a tunnel-vision that often does not give the needed tools to the person in treatment, nor an understanding of recovery appropriate for long-term

restoration of health.

The four secondary questions in this research (the role of gender in recovery; the impact of family of origin on recovery; consistency of story to medical record data; and success points in recovery) addressed some specific issues within the total picture of understanding the nature of recovery. The remainder of this chapter addresses the conclusions drawn from this research. These conclusions do focus on particular issues within the recovery process. The final section focuses on the implications of this research for treatment and recovery, education, and for further research needs.

## CONCLUSIONS

Perhaps the most important conclusion from this research was the recognition of the diversity represented by the six men. The diversity of life experience, variety of education and vocation, the "costs" of chemical dependence, and motivation for treatment were great among these six men. Any reductionistic tendencies to develop a model of persons who enter chemical dependence treatment would only meet with failure. The differences among the six men were too great to justify "one size fits all."

There was a thirty-five year difference between the oldest and the youngest participant. Mr. Adams had served

with the US Army in Korea during the 1950s, while Mr. Davidson served with the US Army in Saudi Arabia during Desert Storm in the 1990s. Two of the men had completed college (Mr. Baker and Mr. Davidson), one had completed college-level professional training as a nurse (Mr. Eagleton), one was attending a community college with plans to earn an undergraduate degree (Baker), and one had completed two years before entering the work force (Mr. Adams). Costs of chemical dependence and motivation for treatment also were closely connected.

The folk wisdom of recovery holds true such statements as: "a person has to hit bottom before he/she is ready for treatment," or "a person has to be motivated for treatment to work." Though each of these men paid a price for the chemical dependence, there was great variation described in the case studies (from being sent by one's boss to conditions of probation, then on to requirements for an upgrade with a military discharge). Motivation at beginning of treatment varied from fear of job loss to fear of jail. This renders the concern over "motivation for treatment" as essentially useless. Even with this small sample of six men it quickly became clear that there is great diversity in recovery.

For each of the six participants in this study, gender issues were important to recovery. The six fell into two groupings: one group was made up of the four males in their

mid-twenties to early thirties (Mr. Baker [26], Mr. Charles [28], Mr. Davidson [28], and Mr. Eagleton [32]); and the other group was made up of the two males in their mid-fifties to early sixties (Mr. Francis [54] and Mr. Adams [61]). Both groups belong to separate generation cohorts facing different transition points identified in life cycle stages of human development. Whether using Levinson's (1978) work on the seasons of a man's life, or Carter and McGoldrick's (1988) life cycles across the lifespan, there are different concerns at different stages of human development. Both groups were in transition stages (chronologically but perhaps not emotionally) from either young adulthood into adulthood, or adulthood into maturity. The developmental delays resulting from addiction affected the normal processes along the continuum of emotional and social development. While the younger cohort was dealing with speeded up moves into responsible adulthood, the older cohort faced a slowing down into "maturity and respectability." A tribal image perhaps appropriate to gender would describe the younger cohort as the warriors prepared to defend hearth and home, and anxious to seek out adventure, fortune, and fame in the outside world. The older cohort were the tribal elders sitting in council, while offering sound wisdom to the younger men. This particularly applicable when looking back at the case studies of Mr. Adams and Mr. Francis, and reviewing their

acquired roles as "recovery elders."

Though the divisions fell along racial lines, race was less important than the "generations" of the two different groups of men when considering gender issues. This is not discounting the importance of race and ethnicity in understanding the nature of recovery. One of the great failures of chemical dependence treatment is its overall poor record with young men of color, particularly young African-American males. Though institutionalized racism does not appear to be a central contribution to this failure of treatment, clearly there are deficits in treatment related to this issue. Among them are insensitivity to familial norms, failure to recognize strengths within "different" definitions of relationships, and expectations of success based on one socioeconomic model. McGoldrick, Pearce, and Giordano (1982) respond to some of these concerns about ethnicity and family therapy by suggesting practitioners recognize and validate diversity, become familiar with ethnic diversity, and not to counsel beyond areas of competence. Apart from some inner-city programs working with urban youth, little is being done to address these treatment shortcomings.

Whether it was an emotionally absent father (Mr. Baker, Mr. Davidson, and Mr. Eagleton), a controlling father (Mr. Charles), a domineering father (Mr. Francis), a controlling mother (Mr. Eagleton), or a physically absent father (Mr.

Adams), all of these men learned a distorted masculinity in their families of origin. The results of this deficit were acted out through passivity, aggression, hypermasculinity, conflicted sexuality, and inhibited ability to develop strong and healthy relationships. Recovery for each participant included a reorientation of his understanding of masculinity to a more balanced, healthier response. This was accomplished primarily through the recognition and correction of deficits that put things out of balance.

Using Gilmore's (1990) three-part characteristics of manhood (provider, protector, and impregnator) as the model of balance, each man was able to come to an acceptance (not an acquiescence) of these three characteristics. The provider sustains hearth and home through his labors. Becoming a provider was attained through: completion of education (Mr. Baker); freedom from family domination to make independent choices (Mr. Charles); retention of long-term employment with honor (Mr. Adams and Mr. Francis); or return to a chosen profession, with eyes open to inherent dangers to continuing recovery (Mr. Eagleton).

The protector not only guards those who are weaker, but also works with his peers in a shared responsibility for communal well-being and security. The protector is also alert to individual needs for protection from the emotional intrusion of family, the demands of addiction, the rigidity or over-flexibility of boundaries, or misplacement of

priorities in maintaining recovery. Each of the men were constantly learning to protect themselves from unhealthy responses that jeopardized their recovery. At the same time, they were protecting their new-found healthy behaviors. A protector is concerned for security and well-being not only of self, but principally for others. This "external protector" was lived out in these men through their involvement in the recovery community, and their support of others on a journey of recovery.

The impregnator role may include the literal beginning of new life, but its essence is the creative desire within human beings to be more than just themselves. This may be expressed in family, work, and art, or it may be in reaching out to others in need at AA meetings, treatment centers, or wherever a fellow traveller struggles. These men remade or created their own manhood as they embraced recovery. Mr. Charles broke free of his father's domination and worked to define himself in more complete ways. Mr. Davidson increasingly became less of a caricature of a man through his hypermasculinity, and became a more balanced individual. Mr. Eagleton became his own man as he set aside the "secrets" in his life, removed the family imposed millstone around his neck, and acknowledged his homosexuality. Mr. Baker created his manhood by an acceptance of both his adulthood and his disabilities. Mr. Adams' and Mr. Francis' self-creation was focused on the respect received from their

peers in recovery, particularly as they helped others.

Environment placed a significant role in beginning the consumption of mood-altering substances. These were environments in which drinking (and perhaps even using drugs) was an acceptable behavior, and was probably encouraged as appropriate behavior for young men. For three of the men, drinking or trouble with drinking started while college (Mr. Baker, Mr. Charles, and Mr. Davidson). Mr. Adams described his Army posting to Korea as one spent drinking with his platoon mates, passing many cold and boring hours in the tents. Mr. Davidson also described drinking as part of his experience of military life. Even Mr. Francis' neighborhood and friends encouraged drinking as a usual pastime. There was, and is, a certain level of expectation placed upon young men to drink when in college or the armed forces. There are parallels of these expectations to initiatory rites but, unfortunately, these expectations are not character-building nor do they provide for the making of manhood.

One of the great short-comings of our industrialized society is the absence of initiation into adulthood. Though it is invigorating going into the woods for pre-industrial rituals like drumming and chanting, it is not necessarily consistent with the needs of those facing recovery. The fundamental need for some form of initiation into adulthood and manhood remains. Regardless of age, much of their

behavior was adolescent in character, or reflected a strong degree of emotional underdevelopment. This is not a judgment of these particular six men. Rather it a recognition of the impact of addiction on human emotional development, and the short-comings of our society to respond to this delayed development.

Treatment was the path of initiation for these six men, whereby they were able to assume a mantle of honor, interdependence, and independence. Treatment was a tangible event, with a definitive place and time, where they were successful in completing the challenges put before them. Not everyone made it through the challenges, for it was available only for those who acknowledged their own powerlessness over alcohol or drugs. In their own acknowledgement of powerlessness, the path to recovery was found. Whether this was described as graduation from chemical dependence treatment, initiation, or conversion, the result was the same. There was now a clear line of demarcation between "before" and "after," addiction and recovery, and childhood and adulthood. This line of demarcation was not the end point (those who see it as success go no further than sobriety), but the beginning point of the life-long journey of recovery from chemical dependence.

Human beings do not exist in isolation from others, but are the products of their families of origin. These six men

who participated in this research were no different. Bowen (1985) identified eight concepts applicable to his understanding of intergenerational family systems theory[1]. They are valuable in understanding the impact of family of origin dynamics on recovery. The holistic view presented by family systems theory is infinitely more effective in understanding the treatment and recovery that these six men experienced, than the traditional, linear views of human interaction. There is a parallel understanding with the biopsychosocial model of addiction over the medical "disease concept."

The Bowen (1985) concepts that predominated were differentiation of self, emotional cutoff, family projection process, multigenerational transmission process, and nuclear family emotional system. Sibling position and triangles were minor considerations with the six participants, and societal regression was not applicable in this setting. Differentiation of self is a balanced separation of the intellectual and emotional processes within an individual. For each of these six men, differentiation of self was intimately tied to recovery. The multifaceted chaos of addiction either trapped or reduced them to emotional reactivity. Recovery started with the development of a

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[1] Differentiation of self; emotional cutoff; family projection process; multigenerational transmission process; nuclear family emotional system; sibling position; societal regression; and triangles. See pp. 38-39 for definitions.

greater sense of differentiation.

There were parallels of differentiation of self, initiation, and life cycle development as critical points in transition from dependence to sobriety, and then on to recovery. This differentiation of self also was tied to the final independence from familial strictures, regardless of the age of the participant. Through their "declarations of independence" by differentiation, initiation, or making of their manhood, these six participants came to individual balances of mind and emotion that were best for each of them. For some this independence came through an emotional cutoff from his family of origin (especially Mr. Charles and Mr. Eagleton), while others' recovery benefitted from the termination of an emotional cutoff (Mr. Adams and Mr. Davidson).

This intertwined process of recovery also addressed the family of origin issues relating to family projection process, multigenerational transmission process, and nuclear family emotional system. The evidence from these case studies was too strong to deny or minimize the impact of transgenerational influences on the addictive process. Though there were indicators in each case, the impact was particularly evident with Mr. Charles, Mr. Davidson, and Mr. Eagleton. The family dynamics crossing generations had direct bearing on each of these men, their inability to deal with chemical dependence, and the actions that they had to

take to achieve recovery. The negative expressions of these family concepts were set aside, as the participants freed themselves of familial dysfunction through treatment and recovery. They became their own men. Thus, they were not under the control of family "craziness," whether its origins were transgenerational or family of origin.

Through the information provided about their families, each participant identified points that disturbed the family equilibrium. Mr. Eagleton faced his mother's need for control and rigidity. Mr. Baker addressed his need not to be enabled, so he could "grow up." Mr. Charles escaped the smothering domination of his father. Mr. Adams started to redefine commitment to his children. Mr. Francis reversed a process of familial isolation. Mr. Davidson found approval within himself rather than from authority figures. This was a recognition of dysfunction-producing environmental factors. Some of these family dynamics were particularly clear through the genograms because of the visual imagery.

The value of the medical records was proven through the process of triangulation of data. This was the intent in including them as part of the research methodology, and they more than did that task. There were no apparent gross misrepresentations by the six participants, but the value of the medical records in clarification of occasional obtuseness (especially Mr. Francis) was proven. They were also of greater value with Mr. Francis' story because of his

cognitive limitations.

The difficulty in using the medical records for triangulation of data related to the inconsistency of content, particularly between type of information recorded by the inpatient unit staff and outpatient unit staff. The record of primary treatment for those from the inpatient unit was adequate, while the secondary treatment record for continuing care was non-existent for the same group. The outpatient unit provided good information on both primary and secondary treatment. It is important to note that there were different criteria for medical record content and format between the inpatient and outpatient units. This, more than anything else, affected the "quality" of the data available in the medical records.

Twenty different success points were identified for the six participants[2]. These success points were the "things that made a difference" in recovery from chemical dependence

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[2] Adams: understanding chemical dependence; non-isolating behavior; breaking down of denial; and a "spiritual awakening". Baker: transformation from confrontation on maladaptive behaviors; willingness to face difficult problems of defining self; identification with group process because of clarity of expectation; and able to resolve relationship problems. Charles: development of spiritual dimension to life; self-defining process of becoming his own man, an adult of increasing differentiation; and modelling of healthy relationships through ADRC staff. Davidson: modification of family of origin dynamics; and halfway house experience. Eagleton: drugs not an option anymore; "I'm an okay person and I'll live with what's dealt me; sobriety does not equal recovery; understanding and accepting homosexuality; and freed from family of origin strictures. Francis: support given to others; and support received from others.

for the six men. The success points were not particular events at specific moments in time, but rather were expressions of process changes within the individual. There were no flashing arrows pointing to one particular success point, declaring "This is it! Do this, and all will recover from chemical dependence!" Recovery is a complex process, and not successfully subject to attempts of reductionistic thinking. Even with this caveat about reductionism, the twenty success points were viewed in six broad categories or characterizations. The first was the straightforward necessity of understanding chemical dependence to recovery. This is not much different than any other aspect of the human condition: the best patient is an informed patient, who participates as fully as possible in the treatment of the disease or dysfunction. There were multiple references to the lectures, videos, readings, and related educational components of treatment by all six of the participants.

The second category of success points focused on relationships, particularly the development of health patterns of response. Some of the relationship changes were the termination of negative behaviors, such as isolating from others and non-resolution of problems with others. Other relationship changes were more positive expressions of growing abilities for healthy interaction with others. Experiencing the affirming structure of a halfway house, the modelling of healthy emotional behavior by clinical staff,

and the experiential benefit of therapy groups structured around emotionally healthy dynamics (both from the clinical staff modelling, and from the stated purpose and rules of group process).

Third in the characterizations are the success points concerned with behavior changes. Maladaptive behaviors were modified by transformation from confrontational responses to conflict resolution. This resulted in a moving away from fights, relational violence, emotional abuse, and aggressive behaviors. Additionally, the behavior changes also expressed recognition that alcohol and drugs were not an option under any circumstances. Parallel to this was the awareness that sobriety did not equal recovery, and that recovery demanded greater behavioral changes than "don't drink" or "just say no."

The fourth category of success points related to family of origin dynamics. These were concerned with either modification or eradication of dysfunctional family of origin dynamics that hindered recovery. Considering the power of the familial dysfunction, independence from family of origin was the appropriate beginning step with two of the participants. The details of this category have been presented above and will not be repeated here. In varying degree, all of the participants had to deal with family of origin issues as part of the journey to recovery.

Spirituality was the fifth category of success points.

For some, this found expression through traditional religious institutions and patterns such as the Emmaus Walk (see Mr. Charles' case study). Fundamental to this was an increased awareness of a world apart from self. Perhaps no more than a willingness to recognize the benefit of helping others. Twelve Step programs such as Alcoholics Anonymous describe themselves as spiritual programs, and it was reasonable to assume that this influenced responses. Though all participants spoke of spirituality, the importance varied. Minimally, spirituality was the abovementioned recognition that there was more to human existence than narcissistic self-centeredness. At the other end of the continuum was a profound spiritual experience, that set the participant free to travel his pilgrimage of recovery.

The final category covered several different aspects of appropriate human development. Like the fifth category, much of this has been addressed within the case studies. Learning how to be a healthy and balanced adult male human being was a primary task of recovery. These success points concerned the making of manhood, the assumption of responsibilities of adulthood, the initiation from adolescence to adulthood, an understanding and comfort with one's sexuality, and becoming a more complete human being.

The restoration of balance within the lives of these six participants characterized their recovery from chemical dependence. The balances were not the same for all of them,

rather they were very individualized responses to individual stories. These balances were also variable according to changing needs and understanding. Recovery is not rigid but is flexible, responsive to the changing circumstances of life. While their lives had become rigid because of addiction, now they were adaptable to the changing demands of life.

## IMPLICATIONS

The danger inherent to chemical dependence treatment is its philosophical connection to the medical model of treatment, with its linear "cause-and-effect" thinking. The "diagnostic trees" found in such texts as the DSM-III-R reflect this sequential thinking. Though there was undisputable value in the removal of chemical dependence from the realm of morality, and its placement within the realm of a treatable medical condition, there is still resistance to the next step. Starting from the fundamental issue of understanding chemical dependence, the completeness of the biopsychosocial model of addiction is favorable compared to the limits of the disease concept, because of its balanced approach. The next step in chemical dependence treatment and recovery calls for a more comprehensive and balanced approach to the problem. The case studies consistently exemplified "balance" as central to recovery.

Each of the men discovered their individual means of either introducing or restoring balance to their lives.

Though the language of family systems theory is often used in chemical dependence treatment, its holistic view is not always properly developed. The practitioner must address all of the multiple issues that the client brings to treatment. If simplistic linear causality is followed, then there is limited chance for the development of balanced recovery. Greater training in systems thinking is needed.

The success points identified in each case study, and reviewed above, also reflected the need for a holistic, balanced approach to treatment and recovery. The particular success points of each participant are identified at the end of their respective case studies. These success points frame a holistic view of the needs of the participants, an inclusive perspective on the essential elements of recovery.

Particularly with the four younger men, gender issues were central to recovery. For each of them, it was essential for their recovery to develop a positive masculinity as they made their manhood. It is essential for the practitioner to be knowledgeable about gender studies, particularly as they relate to developmental stages and initiation. The sense of manhood for each of these men needed balance as much as any other aspect of their lives.

Like gender issues, family of origin dynamics must be addressed directly, rather than just acknowledged and then

pushed aside. Admittedly, there are limitations to the abilities of treatment personnel to work on all the issues that a client may present on admission and during treatment. It is appropriate then to set priorities, but there are some points that must be addressed during treatment. Recovery cannot happen without sobriety, and recovery cannot happen without a response to gender and family of origin dynamics.

This inherent weakness of the medical model was reinforced through the telling of the stories of the six men in this study. The stories of their recoveries from chemical dependence were not simple ones that could be reduced to "I did this, then that occurred." These were complex stories that told of multiple interconnecting issues of recovery--family, friends, work, gender, the law, and profound consequences. The stories called for treatment to address the diversity of those in treatment and not the sameness. This clearly would mean different work for the provider, but it could also mean improved chances for continuing recovery for the patient. Successful recovery from chemical dependence is a highly individualistic process, and treatment center programs will best support those in recovery when they address this fundamental point.

The use of case studies to present these stories on the nature of recovery from chemical dependence has been substantive. Perhaps the greatest benefit was the closeness of the case studies to the language, character, and feel of

the individual participants. Even as the case studies were written, each one took on a different "personality" that seemed close to that of the participant. Admittedly, this was a subjective, intuitive reaction to the process of developing the case studies, but it was also a reflection of the "humanness" inherent in these case studies. The use of the three sources of data (interviews, genograms, and medical records) provided for a richness of information in the development of the case studies.

Interviews provided the substance of the case studies, and were expressive of the personality of the participant. Without them, the case studies would be flat and boring. Even with the limitations posed by the sixth participant, a story can be developed by what is said, not said, and how it is said. The key for these interviews was remaining focused on the relevant issues connected to chemical dependence treatment and recovery. Standing by themselves, the genograms offered little to the research picture. When put in context with the issues of each case study's family systems section, the genograms provided useful data. Genograms are valuable clinical tools, and they can become valuable research tools. The use of medical records as a source of data provided a central learning: there is <u>great</u> diversity in the quality and substance of medical records, even within the same institution. Some records provided substantial data about the participant, while others were

remarkable in their limitations. The researcher would do well to investigate the content and format of medical records before committing to document analysis.

The use of family systems theory in the development of these case studies was appropriate to this research setting. The holistic view of family systems theory demanded a multi-dimensional approach to the development of the case studies. It is sad to note that most family systems theory research is ardently attached to quantitative research. Perhaps research such as this will encourage expanded use of family systems theory with qualitative research.

What is left to do? There are always things left to do with an issue as multifaceted as recovery from chemical dependence. It is difficult to make suggestions to practitioners at this time, because of the changing shape of American healthcare. The thrust of this research toward a more systemic, holistic, or balanced view of treatment and recovery generally is consistent with the developing patterns of utilization review and variable length of stay. Rather than programmatic review, the challenge is to start thinking in a more holistic fashion. Systems thinking is a different way of viewing process, and it permeates the stories of successful recovery. The task of educators is to rework their training programs in ways that encourage systemic or holistic thinking and treatment. Perhaps practitioners can be taught to move away from the simplicity

of the two-dimensional thinking that is preponderant in treatment centers, and to think in more comprehensive and balanced ways.

A study with the same objective, of understanding the nature of recovery from chemical dependence, but from the perspective of women is needed. Socialization and gender identity are major issues in the development of emotionally healthy individuals. As similar issues have been addressed for males, it is equally important that these issues be addressed for females. Contrary to the desires of Professor Henry Higgins, women cannot be more like men and nor should they when faced with treatment and recovery from chemical dependence. Gender issues and family dynamics are significant factors in recovery, and the differences and similarities between men and women in recovery would have great value. In a similar fashion, understanding the treatment and recovery issues that affect members of ethnic and racial minorities would be equally valuable.

# BIBLIOGRAPHY

Abberley, P. (1987). The concept of oppression and the development of a social theory of disability. Disability, Handicap & Society, 2(1), 5-19.

Abbott, F. (Ed.) (1990). Men & intimacy: Personal accounts exploring the dilemmas of modern male sexuality. Freedom, CA: Crossing Press.

Abbott, F. (Ed.) (1987). New men, new minds: Breaking male tradition. Freedom, CA: Crossing Press.

Abrams, D. B., Niaura, R. S., Carey, K. B., Monti, P. M., & Binkoff, J. A. (1986). Understanding relapse and recovery in alcohol abuse. Annals of Behavioral Medicine, 8(2-3), 27-32.

Agar, M. (1976). One-up, one-down, even-up: Some features of an ethnographic approach. Addictive Diseases: An International Journal, 2(4), 619-626.

Agar, M. H. (1986). Speaking of ethnography. Qualitative Research Methods Series 2. Newbury Park, CA: Sage.

Agar, M. H., & Hobbs, J. R. (1983). Natural plans: Using AI in the analysis of ethnographic interviews. Ethos, 11(1/2), 33-48.

Alcoholics anonymous (3rd ed.) (1976). New York: Alcoholics Anonymous World Services.

Alonso-Fernandez, F. (1987). El metodo de los modelos en la representacion de los tipos alcoholicos [Models methodology in the representation of types of alcoholics]. Psicopatologia, 7(1), 9-18.

American Psychiatric Association (1987). Diagnostic and statistical manual of mental disorders (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association (1985). Research on mental illness and addictive disorders: Progress and prospects. Journal of Psychiatry, 142, Supplement A.

Anderson, D. (1987). "If he keeps this up, he'll die...soon." The Family Therapy Networker, 11(3), 38-39.

Annis, H. M. (1974). Patterns of intra-familial drug use. The British Journal of Addiction, 69(4), 361-369.

Apthorp, S. P. (1985). Alcohol and substance abuse: A clergy handbook. Wilton, CT: Morehouse-Barlow.

Arnold, P. M. (1991). Wildmen, warriors, and kings: Masculine spirituality and the Bible. New York: Crossroad.

Asch, A. (1984). The experience of disability: A challenge for psychology. American Psychologist, 39(5), 529-536.

Babbie, E. (1989). The practice of social research (5th ed.). Belmont, CA: Wadsworth.

Baber, A. (1992). Naked at Gender Gap: A man's view of the war between the sexes. New York: Carol Publishing/Birch Lane Press Book.

Babor, T. F., Dolinsky, Z., Rounsaville, B., & Jaffe, J. (1988). Unitary versus multidimensional models of alcoholism treatment outcome: An empirical study. Journal of Studies on Alcohol, 49(2), 167-177.

Babst, D. V., Deren, S., Schmeidler, J., Lipton, D. S., & Dembo, R. (1978). A study of family affinity and substance use. Journal of Drug Education, 8(1), 29-40.

Bahr, K. S. (1990). Student responses to genogram and family chronology. Family Relations, 39(3), 243-249.

Barnett, R. C., Biener, L., & Baruch, G. K. (Eds.) (1987). Gender & stress. New York: Macmillan/Free Press.

Barrado, I. M. (1988). Estudio evolutivo de las anomalias psicologicas y neuropsicologicas halladas en pacientes "alcoholicos cronicos" [Evolving study of psychological and neuropsychological anomolies in "chronic alcoholic" patients]. Actas Luso Espanoles de Neurologia, Psiquiatria y Ciencias Afines, 16(2), 121-143.

Basow, S. A. (1986). Gender stereotypes: Traditions and alternatives. Pacific Grove, CA: Brooks/Cole Publishing.

Beck, R. L. (1987). The genogram as process. The American Journal of Family Therapy, 15(4), 343-351.

Bennett, G. (1988). Stress, social support, and self-esteem of young alcoholics in recovery. Issues in Mental Health Nursing, 9(2), 151-167.

Bennun, I. (1988). Treating the system or symptom: Investigating family therapy for alcohol problems. Behavioral psychotherapy, 16, 165-176.

Bennun, I. (1985). Two approaches to family therapy with alcoholics: Problem-solving and systemic therapy. Journal of Substance Abuse Treatment, 2, 19-26.

Berenson, D. (1987). Alcoholics Anonymous: From surrender to transformation. The Family Therapy Networker, 11(4), 24-31.

Berger, P. L., & Luckmann, T. (1966). The social construction of reality: A treatise in the sociology of knowledge. New York: Anchor Books/Doubleday.

Bergstrom, M. (1988). A ten-year follow-up of female opiate addicts. International Journal of Family Psychiatry, 15(1), 67-91.

Bertalanffy, L. von (1968). General systems theory (rev. ed.). New York: Braziller.

Bessey, J. L., & Borduin, C. M. (1986). Application of behavioral principles within family systems therapy: A conceptual framework for the treatment of alcoholism. Deviant Behavior, 7, 357-369.

Billings, A. G., & Moos, R. H. (1983). Psychosocial processes of recovery among alcoholics and their families: Implications for clinicians and program evaluators. Addictive Behaviors, 8, 205-218.

Bissell, L., & Haberman, P. W. (1985). Alcoholism in the professions: Follow-up sobriety and relapses. Alcoholism Treatment Quarterly, 2(2), 69-79.

Blum, T. C., & Roman, P. M. (1985). The social transformation of alcoholism intervention: Comparisons of job attitudes and performance of recovered alcoholics and non-alcoholics. Journal of Health and Social Behavior, 26(4), 365-378.

Blumer, H. (1969). Symbolic interactionism. Englewood Cliffs, NJ: Prentice-Hall.

Bly, R. (1990). Iron John: A book about men. Reading, MA: Addison-Wesley.

Bly, R. (1988). A little book on the human shadow. W. Booth (Ed.). San Francisco: Harper & Row.

Boone, J. A., & Cadden, M. (Eds.) (1990). Engendering men: The question of male feminist criticism. New York: Routledge.

Bowen, M. (1985). Family therapy in clinical practice. New York: Jason Aronson.

Braunstein, W. B., Powell, B. J., McGowan, J. F., Thoreson, R. W. (1983). Employment factors in outpatient recovery of alcoholics: A multivariate study. Addictive Behaviors, 8, 345-351.

Broderick, C. B. (1993). Understanding family process: Basics of family systems theory. Newbury Park, CA: Sage.

Brown, H. P., & Peterson, J. H. (1990). Values and recovery from alcoholism through Alcoholics Anonymous. Counseling and Values, 35(1), 63-68.

Brown, H. P., Peterson, J. H., & Cunningham, O. (1988). An individualized behavioral approach to spiritual development for the recovering alcoholic/addict. Alcoholism Treatment Quarterly, 5(1/2), 177-196.

Bruno, F. J. (1993). Psychological symptoms. New York: John Wiley & Son.

Bucholz, K. K., & Robins, L. N. (1989). Sociological research on alcohol use, problems, and policy. Annual Review of Sociology, 15, 163-186.

Buxton, M. E., Smith, D. E., & Seymour, R. B. (1987). Spirituality and other points of resistance to the 12-Step recovery process. Journal of Psychoactive Drugs, 19(3), 275-286.

Carter, B., & McGoldrick, M. (1988). The changing family life cycle: A framework for family therapy (2nd ed.). New York: Gardner.

Castaneda, R., & Galanter, M. (1987). A review of treatment modalities for alcoholism and their outcome. The American Journal of Social Psychiatry, 7(4), 237-244.

Castetter, W. B., & Heisler, R. S. (1988). Developing and defending a dissertation proposal (5th ed.). Philadelphia: Graduate School of Education/University of Pennsylvania.

Chapman, R. J. (1988). Cultural bias in alcoholism counseling. Alcoholism Treatment Quarterly, 5(1/2), 105-113.

Chapman, P. L. H., & Huygens, I. (1988). An evaluation of three treatment programmes for alcoholism: An experimental study with 6- and 18-month follow-ups. British Journal of Addictions, 83(1), 67-81.

Chesler, P. (1978). About men. San Diego, CA: Harcourt Brace Jovanovich/Harvest/HBJ Book.

Clifford, J. S. (1983). Self-efficacy counseling and the maintenance of sobriety. The Personnel and Guidance Journal, 62(2), 111-114.

Clinebell, H. J. (1984). Understanding and counseling the alcoholic through religion and psychology. Nashville: Abingdon.

Coleman, E. (1987). Chemical dependency and intimacy dysfunction: Inextricably bound. Journal of Chemical Dependency Treatment, 1(1), 13-26.

Coleman, E. (1982). Family intimacy and chemical abuse: The connection. Journal of Psychoactive Drugs, 14(1-2), 153-158.

Coleman, E., & Colgan, P. (1986). Boundary inadequacy in drug dependent families. Journal of Psychoactive Drugs, 18(1), 21-30.

Coleman, S. B., & Davis, D. I. (1978). Family therapy and drug abuse: A national survey. Family Process, 17(1), 21-29.

Colon, I., & Massey, R. K. (1988). Patient attitudes and beliefs as predictors of treatment outcome in detoxification: A pilot study. Alcoholism Treatment Quarterly, 5(3/4), 235-244.

Cooper, L. E., & Wilson, E. D. (1988). Some follow-up procedures with alcoholics who have completed an alcohol treatment program in a Veterans Hospital. Journal of Alcohol and Drug Education, 33(3), 58-67.

Corlett, J. A. (1990). Fingarette on the disease concept of alcoholism. Theoretical Medicine, 11(3), 243-249.

Corrington, J. E. (1989). Spirituality and recovery: Relationships between levels of spirituality, contentment and stress during recovery from alcoholism in AA. Alcoholism Treatment Quarterly, 6(3/4), 151-165.

Cottone, R. R., Handelsman, M. M., & Walters, N. (1986). Understanding the influence of family systems on the rehabilitation process. Journal of Applied Rehabilitation Counseling, 17(2), 37-40.

Crabtree, B. F., & Miller, W. L. (Eds.) (1992). Doing qualitative research. Newbury Park, CA: Sage.

Culbertson, P. (1992). New Adam: The future of male spirituality. Minneapolis: Fortress Press.

Dalbey, G. (1988). Healing the masculine soul. Dallas: Word Publishing.

Daley, D. C., Moss, H., & Campbell, F. (1987). Dual disorders: Counseling clients with chemical dependency and mental illness. Hazelden, MN: Hazelden.

Davis, D. I. (1977-78). Family therapy for the drug user: Conceptual and practical considerations. Drug Forum: The Journal of Human Issues, 6(3), 197-205.

DeForest, J. W., Roberts, T. K., & Hays, J. R. (1974). Drug abuse: A family affair? Journal of Drug Issues, 4(2), 130-134.

Denzin, N. K. (1978). The research act: A theoretical introduction to sociological methods (2nd ed.). New York: McGraw-Hill.

Dhooper, S. S., & Sullivan, N. R. (1986). Importance of models for recovery from alcoholism: Another view. Advances in Alcohol & Substance Abuse, 5(4), 47-57.

Dinnerstein, D. (1976). The mermaid and the minotaur: Sexual arrangements and human malaise. New York: Harper & Row/Perennial Library.

Doweiko, H. E. (1990). Concepts of chemical dependency. Pacific Grove, CA: Brooks/Cole.

Druck, K. (1985). The secrets men keep. New York: Ballantine.

Easthope, A. (1990). What a man's gotta do: The masculine myth in popular culture. Boston: Unwin Hyman.

Edwards, J. T. (1990). Treating chemically dependent families: A practical systems approach for professionals. Minneapolis: Johnson Institute.

Eisler, R. (1987). The chalice & the blade: Our history, our future. New York: Harper & Row.

Eldred, C. A., Brown, B. S., & Mahabir, C. (1974). Heroin addict clients' description of their families of origin. The International Journal of the Addictions, 9(2), 315-320.

Ellis, A., McInerney, J. F., DiGiuseppe, R., & Yeager, R. J. (1988). Rational-Emotive Therapy with alcoholics and substance abusers. New York: Pergamon.

Erlanger, M. A. (1990). Using the genogram with the older client. Journal of Mental Health Counseling, 12(3), 321-331.

Etzioni, A. (1964). Modern organizations. Englewood Cliffs, NJ: Prentice-Hall.

Evans, K., & Sullivan, J. M. (1990). Dual diagnosis: Counseling the mentally ill substance abuser. New York: Guilford.

Farrell, W. (1986). Why men are the way they are: The male-female dynamic. New York: Berkley.

Faulkner, W., Sandage, D., & Maguire, B. (1988). The disease concept of alcoholism: The persistence of an outmoded scientific paradigm. Deviant Behavior, 9(4), 317-332.

Fausto-Sterling, A. (1985). Myths of gender: Biological theories about women and men. New York: Basic Books.

Filene, P. G. (1986). Him/herself: Sex roles in modern America (2nd ed.). Baltimore, MD: Johns Hopkins University Press.

Fillmore, K. M., & Kelso, D. (1987). Coercion into alcoholism treatment: Meanings for the disease concept of alcoholism. Journal of Drug Issues, 17(3), 301-319.

Filstead, W. J. (1984). Gender differences in the onset and course of alcoholism and substance abuse. Alcoholism Treatment Quarterly, 1(1), 125-132.

Fisher, B. (1987). The process of healing shame. Alcoholism Treatment Quarterly, 4(2), 25-38.

Flanigan, B. J. (1988). Shame and forgiving in alcoholism. Alcoholism Treatment Quarterly, 4(2), 181-195.

Flores, P. J. (1985-86). Alcoholism treatment and the relationship of Native American cultural values to recovery. The International Journal of the Addictions, 20(11 & 12), 1707-1726.

Forsberg, L. K., & Goldman, M. S. (1987). Experience-dependent recovery of cognitive deficits in alcoholics: Extended transfer of training. Journal of Abnormal Psychology, 96(4), 345-353.

Forsberg, L. K., & Goldman, M. S. (1985). Experience-dependent recovery of visuospatial functioning in older alcoholic persons. Journal of Abnormal Psychology, 94(4), 519-529.

Fossum, M. (1989). Catching fire: Men's renewal and recovery through crisis. Minneapolis: Hazelden.

Framo, J. L. (1992). Family-of-origin therapy: An intergenerational approach. New York: Brunner/Mazel.

Frances, R. J., & Miller, S. I. (Eds.) (1991). Clinical handbook of addictive disorders. New York: Guilford.

Frank, G. (1984). Life history model of adaptation to disability: The case of a 'congenital amputee'. Social Science and Medicine. 19(6), 639-645.

Franklin, C. W. (1988). Men & society. Chicago: Nelson-Hall.

Frawley, P. J. (1987). Neurobehavioral model of addiction. Journal of Drug Issues, 17(1-2), 29-46.

Freeman, E. M. (1993). Substance abuse treatment: A family systems perspective. Newbury Park, CA: Sage.

Friedman, A. S., Utada, A., & Morrissey, M. R. (1987). Families of adolescent drug abusers are "rigid": Are these families either "disengaged" or "enmeshed," or both? Family Process, 26(1), 131-148.

Fuhrmann, B. S., & Washington, C. S. (1984). Substance abuse: An overview. Journal for Specialists in Group Work, 9(1), 2-6.

Galanter, M. (1983). Psychotherapy for alcohol and drug abuse: An approach based on learning theory. Journal of Psychiatric Treatment and Evaluation, 5, 551-556.

Gallagher, R. M., McCann, W. J., Jerman, A., Hughes, J., Langelier, R., & Stewart, F. (1990). The behavioral medicine service: An administrative model for biopsychosocial medical care, teaching, and research. General Hospital Psychiatry, 12(5), 283-295.

Gallant, D. M. (1987). Alcoholism: A guide to diagnosis, intervention, and treatment. New York: W. W. Norton.

Gardner, M. K., Clark, E., Bowman, M. A. C., & Miller, P. J. (1989). Analogical reasoning abilities of recovering alcoholics. Alcoholism: Clinical and Experimental Research, 13(4), 508-511.

Gass, M. A., & McPhee, P. J. (1990). Emerging for recovery: A descriptive analysis of adventure therapy for substance abusers. The Journal of Experiential Education, 13(2), 29-35.

Gerzon, M. (1982). A choice of heroes: The changing face of American manhood. Boston: Houghton Mifflin.

Gfroerer, J. (1987). Correlations between drug use by teenagers and drug use by older family members. American Journal of Drug and Alcohol Abuse, 13(1&2), 95-108.

Gilgun, J. F., Daly, K., & Handel G. (Eds.) (1992). Qualitative methods in family research. Newbury Park, CA: Sage.

Gilmore, D. D. (1990). Manhood in the making: Cultural concepts of masculinity. New Haven, CT: Yale University Press.

Gingold. A. (1991). Fire in the john: The manly man in the Age of Sissification. New York: St. Martin's Press/ Cader Books.

Glynn, T. J. (1982-83). Families and drugs: A life-span research approach. American Journal of Alcohol and Drug Abuse, 9(4), 397-412.

Goetz, J. P., & LeCompte, M. D. (1984). Ethnography and qualitative design in educational research. San Diego: Academic Press.

Goldenberg, I., & Goldenberg, H. (1991). Family therapy: An overview (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Goldman, M. S. (1986). Neuropsychological recovery in alcoholics: Endogenous and exogenous processes. Alcoholism: Clinical and Experimental Research, 10(2), 136-144.

Goldman, M. S., Klisz, D. E., & Williams, D. L. (1985). Experience-dependent recovery of cognitive functioning in young alcoholics. Addictive Behaviors, 10, 169-176.

Goldman, R. S., & Goldman, M. S. (1988). Experience-dependent cognitive recovery in alcoholics: A task component strategy. Journal of Studies on Alcohol, 49(2), 142-148.

Googins, B., & Casey, J. C. (1987). Dynamics of alcoholism in working families. Alcoholism Treatment Quarterly, 4(3), 47-66.

Greene, G. J., Hamilton, N., & Rolling, M. (1986). Differentiation of self and psychiatric diagnosis: An empirical study. Family Therapy, 13(2), 187-194.

Greif, G., & Schwartz, E. (1987). Ten common misconceptions about family therapy. Journal of Psychoactive Drugs, 19(1), 95-96.

Greil, A. L., & Rudy, D. R. (1983). Conversion to the world view of Alcoholics Anonymous: A refinement of conversion theory. Qualitative Sociology, 6(1), 5-28.

Guinan, J. F. (1990). Extending the system for the treatment of chemical dependencies. Journal of Strategic and Systemic Therapies, 9(1), 11-20.

Haddon, B. (1983). Social research/substance abuse. The International Journal of the Addictions, 18(1), 23-35.

Harper, J. (1990). Recovery for the relationship: A treatment model for couples with a recovering chemically dependent partner. Alcoholism Treatment Quarterly, 7(2), 1-21.

Hawkins, J. D., & Wacker, N. (1983). Verbal performances and addict conversion: An interactionist perspective on therapeutic communities. Journal of Drug Issues, 13(3), 281-298.

Hayes, G. A., Templer, D. I., Jansen, M. A., & Graham, C. R. (1989). Alcoholism: Abstinence, improvement, and no improvement in general population. Advances in Alcohol & Substance Abuse, 8(2), 87-96.

Hazelden Foundation (1987). The little red book (rev. ed.). New York: Harper & Row.

Hearn, J., & Morgan, D. (Eds.) (1990). Men, masculinities & social theory. London, UK: Unwin Hyman.

Heather, N., Kissoon-Singh, J., & Fenton, G. W. (1990). Assisted natural recovery from alcohol problems: Effects of a self-help manual with and without supplementary telephone contact. British Journal of Addiction, 85, 1177-1185.

Heller, D. (1990). The soul of a man. New York: Ballantine.

Heller, J. H. (1987). A beginner's guide to the first family interview. The American Journal of Family Therapy, 15(4), 291-304.

Henderson, J. L. (1967). Thresholds of initiation. Middletown, CT: Wesleyan University Press.

Hester, R. K., & Miller, W. R. (1989). Handbook of alcoholism treatment approaches: Effective alternatives. New York: Pergamon.

Hof, L., & Berman, E. (1986). The sexual genogram. Journal of Marital and Family Therapy, 12(1), 39-47.

Hofman, F. G. (1983). A handbook on drug and alcohol abuse: The biomedical aspects (2nd ed.). New York: Oxford University Press.

Hoffman, L. (1981). Foundations of family therapy: A conceptual framework for systems change. New York: Basic Books.

Hoopes, M. H. (1987). Multigenerational systems: Basic assumptions. The American Journal of Family Therapy, 15(3), 195-205.

Howe, K. G. (1990). Daughters discover their mothers through biographies and genograms: Educational and clinical parallels. Women & Therapy, 10(1/2), 31-40.

Huberty, D. J., & Huberty, C. E. (1986). Sabotaging siblings: An overlooked aspect of family therapy with drug dependent adolescents. Journal of Psychoactive Drugs, 18(1), 31-41.

Hunter, T. A., & Salomone, P. R. (1987). Dry drunk symptoms & alcoholic relapse. Journal of Applied Rehabilitation Counseling, 18(1), 22-25.

Hyland, T. (1987). Disability and the moral point of view. Disability, Handicap & Society, 2(2), 163-173.

Ingersoll-Dayton, B., & Arndt, B. (1990). Uses of the genogram with the elderly and their families. Journal of Gerontological Social Work, 15(1/2/), 105-120.

Jellinek, E. M. (1960). The disease concept of alcoholism, New Haven, CT: College and University Press.

Johnson, R. A. (1991). Transformation: Understanding the three levels of masculine consciousness. San Francisco: Harper.

Johnson, R. A. (1989). He: Understanding masculine psychology. New York: Harper & Row/Perennial Library.

Johnson, R. & Brock, D. (1988). Gender-specific therapy. Journal of Psychology and Christianity, 7(4), 50-60.

Johnson, V. E. (1980). I'll quit tomorrow (rev. ed.). San Francisco: Harper & Row.

Joyce, C., & Hazelton, P. (1982). Women in groups: A pre-group experience for women in recovery from alcoholism and other addictions. Social Work with Groups, 5(1), 57-63.

Jurich, A. P., Polson, C. J., Jurich, J. A., & Bates, R. A. (1985). Family factors in the lives of drug users and abusers. Adolescence, 20(77), 143-159.

Kahn, R., & Cannel, C. (1957). The dynamics of interviewing. New York: John Wiley.

Kane, S. (1991). HIV, heroin and heterosexual relations. Social Science and Medicine, 32(9), 1037-1050.

Kanner, A. (1984). Cures of unknown origin. Family Therapy, 11(1), 49-53.

Kaplan, H. I., & Sadock, B. J. (Eds.) (1989). Comprehensive textbook of psychiatry/V (5th ed.). Two volumes. Baltimore, MD: Williams & Wilkins.

Karpel, M. A. (Ed.) (1986). Family resources: The hidden partner in family therapy. New York: Guilford.

Kaufman, E. (1986a). A workable system of family therapy for drug dependence. Journal of Psychoactive Drugs, 18(1), 43-50.

Kaufman, E. (1986b). The family of the alcoholic patient. Psychosomatics, 27(5), 347-360.

Kaufman, E. (1985a). Substance abuse and family therapy. Harcourt Brace Jovanovich/Psychological Corporation.

Kaufman, E. (1985b). Critical issues in family research in drug abuse. Journal of Drug Issues, Fall, 463-475.

Kaufman, E. (1985c). Family systems and family therapy of substance abuse: An overview of two decades of research and clinical experience. The International Journal of the Addictions, 20(6&7), 897-916.

Kaufman, E., & Kaufman, P. (1977). Multiple family therapy: A new direction in the treatment of drug abusers. American Journal of Drug and Alcohol Abuse, 4(4), 467-478.

Keen, S. (1991). Fire in the belly: On being a man. New York: Bantam.

Kelly, K. R., & Hall, A. S. (Eds.) (1992). Mental health counseling for men [Special issue]. Journal of Mental Health Counseling, 14(3).

Kerr, M. E. (1984). Theoretical base for differentiation of self in one's family of origin. Clinical Supervisor, 2(2), 3-36.

Kerr, M. E., & Bowen, M. (1988). Family evaluation: An approach based on Bowen theory. New York: Norton.

Kielhofner, G. (1982). Qualitative research: Part one. Paradigmatic grounds and issues of reliability and validity. The Occupational Therapy Journal of Research. 2(2), 67-79

Kirk, J., & Miller, M. L. (1986). Reliability and validity in qualitative research. Qualitative Research Methods Series 1. Newbury Park, CA: Sage.

Klagsbrun, M., & Davis, D. I. (1977). Substance abuse and family interaction. Family Process, 16(2), 149-173.

Knouse, V. H., & Schneider, H. G. (1987). Recovering alcoholics: Personality and aftercare factors. Psychological Reports, 61, 595-601.

Kramer, J. R. (1985). Family interfaces: Transgenerational patterns. New York: Brunner/Mazel.

Kuper, T. A. (1993). Revisioning men's lives: Gender, intimacy, and power. New York: Guilford.

Kupetz, K., Larosa, J., Klagsbrun, M., & Davis, D. I. (1977). The family and drug abuse symposium. Family Process, 16(2), 141-148.

Kus, R. J. (1988). Alcoholism and non-acceptance of gay self: The critical link. Journal of Homosexuality, 15(1/2), 25-41.

Lacks, H. E., & Leonard, C. A. (1986). Fear of feeling: Addressing the emotional process during recovery. Alcohol Treatment Quarterly, 3(3), 69-80.

Lamarine, R. J. (1988). Alcohol abuse among Native Americans. Journal of Community Health, 13(3), 143-155.

Lang, A. R. (1985). The social psychology of drinking and human sexuality. Journal of Drug Issues, 15(2), 273-289.

Larsen, E. (1985). Stage II recovery: Life beyond addiction. San Francisco: Harper & Row/Perennial Library.

Lawton, M. J. (1984). Challenges in recovery from addiction. Alcoholism Treatment Quarterly, 1(4), 55-66.

Lee, J. (1991a). At my father's wedding: Reclaiming our true masculinity. New York: Bantam.

Lee, J. (1991b). Flying boy: Book II. Journey continues. Deerfield Beach, FL: Health Communications.

Lee, J. (1987). The flying boy: Healing the wounded man. Deerfield Beach, FL: Health Communications.

Lehman, W. (1990). Alcoholism, freedom, and moral responsibility. International Journal of Law and Psychiatry, 13(1-2), 103-126.

Lerner, H. G. (1985). Can a feminist still like Murray Bowen? The Family Therapy Networker, 9(6), 36-39.

Lettieri, D. J. (1986). Problems in predicting recovery from alcoholism. Alcohol Health & Research World, 11(1), 20-23, 70-71.

Leukenfeld, C. G., & Tims, F. M. (1989). Relapse and recovery in drug abuse: Research and practice. The International Journal of the Addictions, 24(3), 189-201.

Levine, B. L. (1985). Adolescent substance abuse: Toward an integration of family systems and individual adaptation theories. The American Journal of Family Therapy, 13(2), 3-16.

Levinson, D. J. (1978). The seasons of a man's life. New York: Alfred Knopf.

Levy, M. (1987). A change in orientation: Therapeutic strategies for the treatment of alcoholism. Psychotherapy, 24(4), 786-793.

Lewis, D. C. (1991). Comparison of alcoholism and other medical diseases: An internist's view. Psychiatric Annals, 21(5), 256-265.

Lewis, K. G. (1989). The use of color-coded genograms in family therapy. Journal of Marital and Family Therapy, 15(2), 169-176.

Lewis, J. A., Dana, R. Q., & Blevins, G. A. (1988). Substance abuse counseling: An individualized approach. Pacific Grove, CA: Brooks/Cole.

Liepman, M. R., Nirenberg, T. D., & Begin, A. M. (1989). Evaluation of a program designed to help family and significant others to motivate resistant alcoholics into recovery. American Journal of Drug and Alcohol Abuse, 15(2), 209-221.

Lincoln, R., & Janze, E. (1988). The process of recovery: Its impact on adult children and grandchildren of alcoholics. Alcoholism Treatment Quarterly, 5(1/2), 249-259.

Locke, L. F., Spirduso, W. W., & Silverman, S. J. (1987). Proposals that work: A guide for planning dissertations and grant proposals (2nd ed.). Newbury Park, CA: Sage.

Lofland, J., & Lofland, L. H. (1984). Analyzing social settings: A guide to qualitative observation and analysis (2nd ed.). Belmont, CA: Wadsworth.

Loosen, P. T., Dew, B. W., & Prange, A. J. (1990). Long-term predictors of outcome in abstinent alcoholic men. American Journal of Psychiatry, 147(12), 1662-1666.

Lorber, J., & Farrell, S. A. (Eds.) (1991). The social construction of gender. Newbury Park, CA: Sage.

Ludwig, A. M. (1985). Cognitive processes associated with "spontaneous" recovery from alcoholism. Journal of Studies on Alcohol, 46(1), 53-58.

Luks, A. (1986). Solving the legal quandary in recovery. Alcohol Health & Research World, 11(1), 40-41.

Madanes, C. (1981). Strategic family therapy. San Francisco: Jossey-Bass.

Mandel, L. L., & North, S. (1982). Sex roles, sexuality and the recovering woman alcoholic: Program issues. Journal of Psychoactive Drugs, 14(1-2), 163-166.

Mariz, C. L. (1991). Pentecostalism and alcoholism among the Brazilian poor. Alcoholism Treatment Quarterly, 8(2), 75-82.

Marlin, E. (1989). Genograms: The new tool for exploring the personality, career, and love patterns you inherit. Chicago: Contemporary Books.

Marshall, C., & Rossman, G. B. (1989). Designing qualitative research. Newbury Park, CA: Sage.

Mason, C. M. (1987). Adolescent chemical dependency aftercare: A non-traditional approach to recovery through group dependence. Alcoholism Treatment Quarterly, 4(4), 43-51.

McAuliffe, W. E., & Ch'ien, J. M. N. (1986). Recovery training and self help: A relapse-prevention program for treated opiate addicts. Journal of Substance Abuse Treatment, 3(1), 9-20.

McCown, W. (1989). The relationship between impulsivity, empathy and involvement in Twelve Step self-help substance abuse treatment groups. British Journal of Addiction, 84, 391-393.

McCracken, G. (1988). The long interview. Newbury Park, CA: Sage.

McGoldrick, M., & Gershon, R. (1985). Genograms in family assessment. New York: Norton.

McGoldrick, M., Pearce, J. K., & Giordano, J. (Eds.) (1982). Ethnicity and family therapy. New York: Guilford.

McNabb, J., Der-Karabetian, A., & Rhoads, J. (1989). Family involvement and outcome in treatment of alcoholism. Psychological Reports, 65, 1327-1330.

Mechanic, D. (1986). Role of social factors in health and well being: Biopsychosocial model from a social perspective. Integrative Psychiatry, 4, 2-11.

Mee-Lee, D. (1988). An instrument for treatment progress and matching: The Recovery Attitude and Treatment Evaluator (RAATE). Journal of Substance Abuse Treatment, 5, 183-186.

Melvin, L. I. (1984). The lifecycle of sobriety in alcoholism. Smith College Studies in Social Work, 54(2), 98-116.

Meth, R. L., & Pasick, R. S. (1990). Men in therapy: The challenge of change. New York: Guilford.

Miles, M. B., & Huberman, A. M. (1984). Qualitative research data analysis: A sourcebook of new methods. Newbury Park, CA: Sage.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Minuchin, S., & Fishman, H. C. (1981). Family therapy techniques. Cambridge, MA: Harvard University Press.

Monick, E. (1987). Phallos: Sacred image of the masculine. Toronto: Inner City Books.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). Treating alcohol dependence. New York: Guilford.

Moore, D., & Leafgren, F. (Eds.) (1990). Problem solving strategies and interventions for "Men in Conflict". Alexandria, VA: American Association for Counseling and Development.

Moore, J. (1980). Sexuality & spirituality: The interplay of masculine and feminine in human development. San Francisco: Harper & Row.

Moore, R., & Gillette, D. (1993). The magician within: Accessing the shaman in the male psyche. New York: William Morrow.

Moore, R., & Gillette, D. (1992). The warrior within: Accessing the knight in the male psyche. New York: William Morrow.

Moore, R., & Gillette, D. (1991). The king within: Accessing the king in the male psyche. New York: William Morrow.

Moore, R., & Gillette, D. (1990). King, warrior, magician, lover: Rediscovering the archetypes of the mature masculine. San Francisco: HarperSanFrancisco.

Moore, T. (1992). Care of the soul: A guide for cultivating depth and sacredness in everyday life. New York: HarperCollins.

Moos, R. H., & Moos, Bernice S. (1984). The process of recovery from alcoholism: III. Comparing functioning in families of alcoholics and matched control families. Journal of Studies on Alcohol, 45(2), 111-118.

Morrison, R. A. (1990). Dream mapping in chemical dependency recovery. Alcoholism Treatment Quarterly, 7(3), 113-120.

Morrison, M. A., Hayes, H. R., & Knauf, K. J. (1989). Progression of chemical dependence and recovery in adolescents. Contemporary Psychiatry, 19(12), 666-

Moyer, M. A. (1987). Achieving successful chemical dependency recovery in veteran survivors of traumatic stress. Alcoholism Treatment Quarterly, 4(4), 19-34.

Murphy, J. P. (1984). Substance abuse and the family. Journal for Specialists in Group Work, 9(2), 106-112.

Murray, C., Anderson, J., Bersani, H., & Mesaros, R. (1986). Qualitative research methods in special education: Ethnography, microethnography, and ethology. Journal of Special Education Technology, 7(3), 15-31.

Nace, E. P. (1987). The treatment of alcoholism. New York: Brunner/Mazel.

Napier, A. Y. (1978). The family crucible: The intense experience of family therapy. New York: Harper & Row.

Nelson, J. B. (1988). The intimate connection: Male sexuality, masculine spirituality. Philadelphia: Westminster Press.

Newfield, N. A., Kuekl, B. P., Joanning, H. P., & Quinn, W. H. (1990). A mini ethnography of the family therapy of adolescent drug abuse: The ambiguous experience. Alcoholism Treatment Quarterly, 7(2), 57-79.

Nichols, M. P. (1984). Family therapy: Concepts and methods. Boston: Allyn and Bacon.

Nichols, W. C. (1988). Marital therapy: An integrative approach. New York: Guilford.

Nichols, W. C., & Everett, C. A. (1986). Systemic family therapy: An integrative approach. New York: Guilford.

Nobles, W. W. (1984). Alienation, human transformation and adolescent drug use: Toward a reconceptualization of the problem. Journal of Drug Issues, 14(2), 243-252.

Noone, R. J., & Reddig, R. L. (1976). Case studies in the family treatment of drug abuse. Family Process, 15(3), 325-332.

Nordstrom, G., & Berglund, M. (1987). Ageing and recovery from alcoholism. British Journal of Psychiatry, 151, 382-388.

O'Farrell, T. J. (1989). Marital and family therapy in alcoholism treatment. Journal of Substance Abuse Treatment, 6, 23-29.

O'Gorman, P., & Oliver-Diaz, P. (1986). Techniques for the recovering person to use in parenting. Alcohol Health & Research World, 11(1), 48-51.

Okiishi, R. W. (1987). The genogram as a tool in career counseling. Journal of Counseling and Development, 66(3), 139-143.

Ornstein, Y. (1991). From the hearts of men. New York: Fawcett Columbine.

Orosz, S. B. (1982). Assertiveness in recovery. Social Work with Groups, 5(1), 25-31.

Osherson, S. (1992). Wrestling with love: How men struggle with intimacy with women, children, parents, and each other. New York: Fawcett Columbine.

Osherson, S. (1986). Finding our fathers: How a man's life is shaped by his relationship with his father. New York: Fawcett Columbine.

Panepinto, W. C., & Simmons, L. (1986). Treating the illness, not the mandate: Techniques for successful referral, engagement, and treatment of alcoholic persons. Alcoholism Treatment Quarterly, 3(3), 37-48.

Parihar, B., & Kirchhoff, S. B. (1985). Alcoholism treatment: An exploratory study of the relationship between treatment variables and outcome behavior. Social Casework, 66(5), 304-309.

Parsons, O. A. (1983). Cognitive dysfunction and recovery in alcoholics. Substance and Alcohol Actions/Misuse, 4(2/3), 175-190.

Pasick, R. (1992). Awakening from the deep sleep: A powerful guide for courageous men. San Francisco: HarperSanFrancisco.

Patton, M. Q. (1990). Qualitative evaluation and research methods (2nd ed.). Newbury Park, CA: Sage.

Pearson, C. S. (1991). Awakening the heroes within: Twelve archetypes to help us find ourselves and transform the world. San Francisco: HarperSanFrancisco.

Pearson, C. S. (1989). The hero within: Six archetypes we live by (expanded ed.). San Francisco: HarperSanFrancisco.

Pederson, L. E. (1993). Sixteen men: Understanding masculine personality types. Boston: Shambala Publications.

Peele, S. (1989). Diseasing of America: Addiction treatment out of control. Lexington, MA: D. C. Heath/Lexington Books.

Peele, S. (Ed.) (1988). Visions of addiction: Major contemporary perspectives on addiction and alcoholism. Lexington, MA: D. C. Heath/Lexington Books.

Piercy, F. P., Sprenkle, D. H., & Associates (1986). Family therapy sourcebook. New York: Guilford.

Pittman, F. (1993). Man enough: Fathers, sons, and the search for masculinity. New York: G. P. Putnam's Sons.

Pittman, F. (1985). Gender myths: When does gender become pathology. The Family Therapy Networker, 9(6), 24-33.

Pleck, J. H. (1981). The myth of masculinity. Cambridge, MA: MIT Press.

Preli, R., Protinsky, H., & Cross, L. (1990). Alcoholism and family structure. Family Therapy, 17(1), 1-8.

Protinsky, H., & Keller, J. F. (1984). Supervision of marriage and family therapy: A family of origin approach. Clinical Supervisor, 2(2), 75-80.

Prugh, T. (1986). Recovery without treatment. Alcohol Health & Research World, 11(1), 24, 71-72.

Ramsey, E. (1987). From guilt through shame to AA: A self-reconciliation process. Alcoholism Treatment Quarterly, 4(2), 87-107.

Ransom, G., Waishwell, L., & Griffin, J. A. (1987). Leisure: The enigma for alcoholism recovery. Alcoholism Treatment Quarterly, 4(3), 103-116.

Raphael, R. (1988). The men from the boys: Rites of passage in male America. Lincoln: University of Nebraska Press.

Rinsley, D. B. (1988). The Dipsas revisited: Comments on addiction and personality. Journal of Substance Abuse Treatment, 5(1), 1-7.

Rogan, A. (1986). Recovery from alcoholism: Issues for Black and Native American alcoholics. Alcohol Health & Research World, 11(1), 42-44.

Rohr, R., & Martos, J. (1992). The wild man's journey: Reflections on male spirituality. Cincinnati, OH: St. Anthony Messenger Press.

Ronan, L., & Reichman, W. (1986). Back to work: Vocational recovery. Alcohol Health & Research World, 11(1), 34-37.

Room, R. (1984). Alcohol and ethnography: A case of problem deflation. Current Anthropology, 25(2), 169-191.

Root, L. E. (1986). Treatment of the alcoholic family. Journal of Psychoactive Drugs, 18(1), 51-56.

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. Health Education Quarterly, 15(2), 175-183.

Salgado de Bernal, C., & Alvarez-Schwarz, M. (1990). El genograma como instrumento de formacion de terapeutas de familia [The genogram as an instrument of formation in family therapy]. Revista Latinoamericana de Psicologia, 12(3), 385-420.

Sanford, J. A., & Lough, G. (1988). What men are like. Mahwah, NJ: Paulist Press.

Sauber, S. R., L'Abate, L., Weeks, G. R., & Buchanan, W. L. (1993). The dictionary of family psychology and family therapy (2nd ed.). Newbury Park, CA: Sage.

Sauer, R. J. (1984). Family therapy in a partial hospitalization setting. Family Therapy, 11(3), 211-215.

Schaefer, S., & Evans, S. (1987). Women, sexuality and the process of recovery. Journal of Chemical Dependency Treatment, 1(1), 91-120.

Schlesinger, S., Susman, M., & Koenigsberg, J. (1990). Self-esteem and purpose in life: A comparative study of women alcoholics. Journal of Alcohol and Drug Education, 36(1), 127-141.

Schultz, S. J. (1984). Family systems therapy: An integration. New York: Jason Aronson.

Seidel, J. V., Kjolseth, R., & Seymour, E. (1988). The Ethnograph (Version 3.0) [Computer program]. Corvallis, OR: Qualis Research Associates.

Shellenberger, S., Couch, K. W., & Drake, M. A. (1989). Elderly family members and their caregivers: Characteristics and development of the relationship. Family Systems Medicine, 7(3), 317-322.

Singer, M. (1984). Spiritual healing and family therapy: Common approaches to the treatment of alcoholism. Family Therapy, 11(2), 155-162.

Skorina, J. K., Bissell, L., & De Soto, C. B. (1990). Alcoholic psychologists: Routes to recovery. Professional Psychology: Research and Practice, 21(4), 248-251.

Smith, L. M. (1991). Issues in managing an alcoholism caseload. Journal of Rehabilitation, 57(4), 41-45.

Spahr, J. H. (1987). The role of the conversion experience in alcohol recovery. Studies in Formative Spirituality, 8(2), 223-241.

Spradley, J. P. (1979). The ethnographic interview. Fort Worth: Harcourt Brace Jovanovich.

Sprey, J. (Ed.) (1990). Fashioning family theory: New approaches. Newbury Park, CA: Sage.

Squyres, E. M. (1987). Approaches to the self: An examination of the work of Bowen and Jung. Family Therapy, 14(3), 165-178.

Stanton, M. D. (1979a). Drugs and the family. Marriage & Family Review, 2(1), 2-10.

Stanton, M. D. (1979b). Family treatment approaches to drug abuse problems: A review. Family Process, 18(3), 251-280.

Stanton, M. D., Todd, T. C., & Associates (1982). The family therapy of drug abuse and addiction. New York: Guilford.

Stanton, M. D., Todd, T. C., Heard, D. B., Kirschner, S., Kleiman, J. I., Mowatt, D. T., Riley, P., Scott, S. M., & Van Deusen, J. M. (1978). Heroin addiction as a family phenomenon: A new conceptual model. American Journal of Drug and Alcohol Abuse, 5(2), 125-150.

Starr, A. M. C. (1989). Recovery for the alcoholic family: Family systems treatment model. Social Casework: The Journal of Contemporary Social Work, 70(6), 348-354.

Staudacher, C. (1991). Men & grief. Oakland, CA: New Harbinger Publications.

Steinglass, P. (1984). Family systems theory and therapy: A clinical application of general systems theory. Psychiatric Annals, 14(8), 582-586.

Stollenberg, J. (1989). Refusing to be a man: Essays on sex and justice. New York: Meridian/Penguin Books.

Strack, S., Carver, C. S., & Blaney, P. H. (1987). Predicting successful completion of an aftercare program following treatment for alcoholism: The role of dispositional optimism. Journal of Personality and Social Psychology, 53(3), 579-584.

Stringer, A. Y., & Goldman, M. S. (1988). Experience-dependent recovery of block design performance in male alcoholics: Strategy training versus unstructured practice. Journal of Studies on Alcohol, 49(5), 406-411.

Sumners, A. D. (1988). Humor: Coping in recovery from addiction. Issues in Mental Health Nursing, 9, 169-179.

Synol, K. M. (1984). Family mapping: Toward an understanding of the interactional dynamic of the alcoholic marital dyad. The International Journal of the Addictions, 19(7), 743-752.

Taffel, R. (1986). Gender myths. The Family Therapy Networker, 10(2), 10-13.

Tannen, D. (1990). You just don't understand: Women and men in conversation. New York: William Morrow.

Tannen, D. (1986). That's not what I meant!. New York: Ballantine Books.

Taylor, S. J., & Bogdan, R. (1984). Introduction to qualitative research methods: The search for meanings (2nd ed.). New York: John Wiley.

Thomas, C. L. (Ed.) (1985). Taber's cyclopedic medical dictionary (15th ed.). Philadelphia: F. A. Davis.

Thompson, K. (Ed.) (1991). To be a man: In search of the deep masculine. Los Angeles: Jeremy P. Tarcher.

Thoreson, R. W., Budd, F. C., & Krauskopf, C. J. (1986). Alcoholism among psychologists: Factors in relapse and recovery. Professional Psychology: Research and Practice, 17(6), 497-503.

Todd, T. C., & Selekman, M. (1989). Principles of family therapy for adolescent substance abuse. Journal of Psychotherapy and the Family, 6(3-4), 49-70.

Tomko, M. K. (1988). Recovery: A multidimensional process. Issues in Mental Health Nursing, 9, 139-149.

Tomm, K. (1987a). Interventive interviewing: Part I. Strategizing as a fourth guideline for the therapist. Family Process, 26, 3-13.

Tomm, K. (1987b). Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. Family Process, 26, 167-183.

Tootle, D. M. (1987). Social acceptance of the recovering alcoholic in the workplace: A research note. Journal of Drug Issues, 17(3), 273-279.

Tuchfeld, B. S., Lipton, W. L., & Lile, E. A. (1983). Social involvement and the resolution of alcoholism. Journal of Drug Issues, 13(3), 323-332.

Twelve steps and twelve traditions (1981). New York: Alcoholics Anonymous World Services.

Usher, M. L., Jay, J., & Glass, D. R. (1982). Family therapy as a treatment modality for alcoholism. Journal of Studies on Alcohol, 43(9), 927-938.

Vaillant, G. E. (1983). The natural history of alcoholism: Causes, patterns, and paths to recovery. Cambridge, MA: Harvard University Press.

Van Gennep, A. (1962). The rites of passage (M. B. Vizedom & G. L. Caffee, Trans.). Chicago: University of Chicago Press.

Van Maanen, J. (Ed.) (1983). Qualitative methodology. Newbury Park, CA: Sage.

Van Wormer, K. (1987). Group work with alcoholics in recovery: A phase approach. Social Work with Groups, 10(3), 81-97.

Vannicelli, M. (1987). Treatment of alcoholic couples in outpatient group therapy. Group, 11(4), 247-257.

Wachtel, E. F. (1982). The family psyche over three generations: The genogram revisited. Journal of Marital and Family Therapy, 8(3), 335-344.

Waddell, J. O. (1981). The alcoholic patient as an ethnographic domain: The anthropologist's role in the therapeutic process. Journal of Studies on Alcohol, 42(9), 846-854.

Waldorf, D. (1983). Natural recovery from opiate addiction: Some social-psychological processes of untreated recovery. Journal of Drug Issues, 13(2), 237-280.

Waldow, M., Bonner, K. H., Klink, M., & Suss, H. M. (1987). Importance of vocational and social reintegration for the maintenance of therapy success with alcohol addicts. International Journal of Rehabilitation Research, 10(4), 233-237.

Walker, K., Sanchez-Craig, M., & Bornet, A. (1982). Teaching coping skills to chronic alcoholics in coeducational halfway house: II. Assessment of outcome and identification of outcome predictors. British Journal of Addiction, 77(2), 185-196.

Wallace, J. (1985). Predicting the onset of compulsive drinking in alcoholics: A biopsychosocial model. Alcohol, 2(4), 589-595.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). The invisible web: Gender patterns in family relationships. New York: Guilford.

Ward, D. A. (1985). Conceptions of the nature and treatment of alcoholism. Journal of Drug Issues, 15(1), 3-16.

Webster's seventh new collegiate dictionary (1971). Springfield, MA: Merriam.

Wermuth, L., Brummett, S., & Sorensen, J. L. (1987). Bridges and barriers to recovery: Clinical observations from an opiate recovery project. Journal of Substance Abuse Treatment, 4, 189-196.

Wermuth, L., & Scheidt, S. (1986). Enlisting family support in drug treatment. Family Process, 25(1), 25-33.

West, A. P., & Gocka, E. F. (1986). Self-ratings of typical mood and behavior during recovery from alcohol abuse: A multivariate study of alcoholic men. Psychopathology, 19(6), 303-308.

Westermeyer, J. (1989). Monitoring recovery from substance abuse: Rationales, methods and challenges. Advances in Alcohol & Substance Abuse, 8(1), 93-106.

Whitfield, C. L. (1984a). Stress management and spirituality during recovery: A transpersonal approach - Part III: Transforming. Alcoholism Treatment Quarterly, 1(4), 1-54.

Whitfield, C. L. (1984b). Stress management and spirituality during recovery: A transpersonal approach - Part II: Being. Alcoholism Treatment Quarterly, 1(2), 1-50.

Whitfield, C. L. (1984c). Stress management and spirituality during recovery: A transpersonal approach - Part I: Becoming. Alcoholism Treatment Quarterly, 1(1), 3-51.

Wille, R. (1983). Processes of recovery from heroin dependence: Relationship to treatment, social changes and drug use. Journal of Drug Issues, 13(3), 333-342.

Williams, J. M., Stout, J. K., & Erickson, L. (1986). Comparison of the importance of Alcoholics Anonymous and outpatient counseling to maintenance of sobriety among alcohol abusers. Psychological Reports, 58, 803-806.

Wilson, G. T. (1987a). Cognitive processes in addiction. British Journal of Addiction, 82, 343-353.

Wilson, G. T. (1987b). Cognitive studies in alcoholism. Journal of Consulting and Clinical Psychology, 55(3), 325-331.

Wing, D. M. (1991). Goal setting and recovery from alcoholism. Archives of Psychiatric Nursing, 5(3), 178-184.

Wolber, G., Carne, W. F., & Alexander, R. (1990). The validity of self-reported abstinence and quality sobriety following chemical dependency treatment. The International Journal of the Addictions, 25(4), 495-513.

Wolcott, H. F. (1990). Writing Up qualitative research. Qualitative Research Methods Series 20. Newbury Park, CA: Sage.

Wolin, S. J., & Bennett, L. A. (1984). Family rituals. Family Process, 23(3), 401-420.

Wynn, J. C. (1982). Family therapy in pastoral ministry. San Francisco: Harper.

Yin, R. K. (1989). Case study research: Designs and methods (rev. ed.). Newbury Park, CA: Sage.

Yohman, J. R., Parsons, O. A., Leber, W. R. (1985). Lack of recovery in male alcoholics' neuropsychological performance one year after treatment. Alcoholism: Clinical and Experimental Research, 9(2), 114-117.

Zackon, F. (1986). Lifestyle rehabilitation: The second recovery track. Alcohol Health & Research World, 11(1), 18, 70.

Zalman-Miller, A. (1990). Relativity (Version 0.90) [Computer program]. Silver Spring, MD: WonderWare.

Zweben, J. E. (1989). Recovery-oriented psychotherapy: Patient resistances and therapist dilemmas. Journal of Substance Abuse Treatment, 6(2), 123-132.

Zweben, J. E. (1987). Recovery-oriented psychotherapy: Facilitating the use of 12-Step programs. Journal of Psychoactive Drugs, 19(3), 243-251.

Zweben, J. E. (1986). Recovery oriented psychotherapy. Journal of Substance Abuse Treatment, 3(4), 255-262.

# APPENDICES

# APPENDIX A

## INSTITUTIONAL REVIEW BOARD PROCEEDINGS

1. Letter to Joseph Fuhr, PhD, UTMC/IRB chair (17Jun92)
2. Letter to Edith Szathmary, PhD, UTK/IRB coordinator (17Jun92)
3. Form B for Human Subjects Research (17Jun92)
   a. Information Sheet
   b. Authorization for Release of Medical Information Concerning Alcohol and Drug Treatment
   c. Support Letter from Denzel Dukes, ADRC Director
4. Letter from Joseph Fuhr, PhD (24Jun92)
5. Letter to Joseph Fuhr, PhD (9Jul92)
   a. Information Sheet
   b. Selection of Participants
   c. Interview Guide
6. Letter from Joseph Fuhr, PhD (14Jul92)
7. Letter to Joseph Fuhr, PhD (24Jul92)
   a. Selection of Participants
   b. Consent to be Contacted Form
8. Letter of Approval from UTMC/IRB (4Aug92)
9. Letter of Approval from UTK/IRB (10Sep92)

THE UNIVERSITY OF TENNESSEE
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17 June 1992

Joseph Fuhr, PhD
Director, Research Center
UT Medical Center
1924 Alcoa Highway
Knoxville, TN 37920

Dear Dr. Fuhr:

Enclosed is Form B for Human Subjects Research, submitted for your consideration regarding my proposed doctoral dissertation research. The research project, "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males", does represent involvement with the Medical Center.

This same Form B for Human Subjects Research has been submitted to Dr. Edith Szathmary for University action, subsequent to your approval.

I look forward to hearing from you.

Thank you.

Sincerely,

L. Murdock Smith

enclosures

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17 June 1992

Edith Szathmary, PhD
Coordinator, Research Administration
404 Andy Holt Tower
The University of Tennessee
Knoxville, Tennessee

Dear Dr. Szathmary:

Enclosed is Form B for Human Subjects Research for your consideration. A duplicate has been sent to Dr. Fuhr for his consideration and action. I will keep you informed of my contact with him, any changes made, and his evaluation.

Your assistance is greatly appreciated.

Thank you.

Sincerely,

L. Murdock Smith

enclosure

THE UNIVERSITY OF TENNESSEE, KNOXVILLE
Form B for Human Subjects Research

17 June 1992

## I. Identification of Project

Principal Investigator:

L. Murdock Smith, MS, CRC
Special Services Education
112 Claxton Addition
The University of Tennessee
Knoxville, TN 37996-3400
615/974-2321, 690-7016, 584-3097

Faculty Advisor:

Tricia McClam, PhD
Special Services Education
135 Claxton Addition
The University of Tennessee
Knoxville, TN 37996-3400
615/974-2321

Title of Project:

"The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"

Department:

Special Services Education

Starting Date:

Upon CRP approval

Estimated Completion Date:

31 July 1993

External Funding Agency and Identification Number:

Not applicable

Grant Submission Deadline:

Not applicable

## II. Objectives of Project

Describe the nature of recovery from chemical dependence by chemically dependent males through the use of qualitative research methods, specifically interviews, genograms, and medical record analysis.

## III. Description of Subjects

Six adult males who have completed primary (inpatient or outpatient) treatment for chemical dependence at the Alcohol and Drug Recovery Center (ADRC), UT Medical Center, and have between nine and twenty-four months post-treatment recovery. Clinical staff from ADRC will assist in the development of the sampling frame. No payment or incentives will be provided.

## IV. Methods or Procedures

Data will be gathered for analysis through three sources: interviews, genograms, and medical records.

There will be three separate interviews with each participant, lasting approximately two hours each session and recorded on audio tape. The participant's description of the nature of their recovery from chemical dependence will come from the interviews. Each interview session will be transcribed as soon as possible in preparation for subsequent interview sessions. The cumulative data from the interviews will give the participant's point of view concerning treatment and recovery. The transcripts of the interviews will be subject to content analysis.

The data for the genograms (a multigenerational schematic representation of families that includes information on family members, relationships, and dynamics consistent with family systems theory) will come from the interviews and medical records. Genograms provide a method to analyze familial interaction and dynamics, which is the intent of their use in this research project.

A narrative chronology of the treatment process (both primary and secondary) will be developed from the information contained in the medical records. Used principally as a means of

triangulation of data, an important element when concerned with chemical dependence, medical record information also provides data for the development of the genograms. In a similar manner to the data above, the narrative chronology will be subject to content analysis.

There will be minimal stress to the participants. Concern for confidentiality may cause some stress--see below for protective measures concerning confidentiality. The "telling of one's story" often has a therapeutic effect, so positive effects are anticipated for those who choose to participate in the research project.

## V. Specific Risks and Protection Measures

Audiotaping - Anonymity is contraindicated in the qualitative interview process because the participant's "story" is the database. Verbatim transcripts of the interviews are mandatory for content analysis. Confidentiality can be maintained, which is essential when working with treatment for chemical dependence, through the removal of identifying information.

The audiotapes from the interviews will be transcribed as soon as possible after each interview. The transcripts will be checked for accuracy by the principal investigator, and modified to remove such information (e.g., name, occupation) that would reveal the participant's identity under usual circumstances. Once accuracy is checked and modifications made, then the audiotapes will be erased. Prior to their erasure, the audiotapes will be kept in a locked cabinet in 135 Claxton Addition. The audiotapes will be heard only by the principal investigator, and the individual (a person familiar with the particular confidentiality requirements concerning persons who are chemically dependent) who will do the initial transcription.

Access to the data will be limited to the principal investigator. The data will be used solely for analysis as set forth in this research project. The data will be used as part of the principal investigator's doctoral dissertation. As stated above, the audiotapes will be erased as soon as possible. The transcripts will be retained for at least three years after the completion of the research project. When they are no longer to be retained, the transcripts will be destroyed.

Genograms - There is minimal risk to the participant in the development of a genogram. Participant confidentiality will be maintained through the modification of identifying information, in similar manner as with the audiotapes. The genograms will be subject to analysis according to family systems theory. Like the transcripts, they will be retained at least three years after the completion of the research project. When they are no longer to be retained, the genograms will be destroyed.

Medical Records - There is minimal risk to the participant in the creation of a narrative chronology of their treatment for chemical dependence, based on the information contained in their medical record. Any information contained in the medical record from other hospitalizations is not relevant to this research project. Participant confidentiality will be maintained through modification of identifying information, in similar manner as with the audiotapes and genograms. Access to the participant's medical records is subject to the conditions set out by the Medical Records Department, UT Medical Center, Knoxville. The participant's authorization for the Medical Records Department to permit the principal investigator to have access will be turned over to the Medical Records Department. This authorization, or copy thereof, will not be retained by the principal investigator, in order to remove one avenue of identifying participants in the research project. The medical records will be examined only within the confines of the Medical Records Department, with the contents being summarized through note-taking. The narrative chronology will be subjected to content analysis. The narrative chronologies will be retained for at least three years after the completion of the research project. When they are no longer to be retained, they will be destroyed.

## VI. Benefits vs. Risks

The risks taken by participants in this project are no more than those encountered in every day life. The anticipated benefits to the participants are indirect, through an increased understanding of the nature of recovery from chemical dependence.

VII. **Method of Obtaining "Informed Consent" From Subjects**

The attached consent form will be used to indicate willingness to participate in the research project, permission to audiotape the interviews, and permission to have access to the participant medical record. The special release form used by the Medical Records Department, UT Medical Center, Knoxville, for persons who have received treatment for chemical dependency will be completed for participant authorization for the principal investigator to have access to medical records (see attachment). The consent forms will be kept in a locked cabinet in 135 Claxton Addition.

VIII. **Qualifications of the Investigator**

The principal investigator is a doctoral student in the Department of Special Services Education (Rehabilitation Counseling), The University of Tennessee, Knoxville, and is a Certified Rehabilitation Counselor. He has done counseling since 1979 in various settings, including chemical dependence treatment facilities.

IX. **Adequacy of Facilities to Support Research**

Not applicable.

X. **Responsibility of Project Director**

By the Compliance with the policies established by The University of Tennessee, Knoxville, Committee on Research Participation, the principal investigator subscribes to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee, Knoxville.

a. Approval will be obtained from the University Committee prior to instituting any change in the research project.

b. Development of any unexpected risks will be reported to the University Committee.

c. A status report (Form D) will be submitted at 12-month intervals or as requested attesting to the current status of the project.

d. Signed consent statements will be kept for the duration of the project and for at least three years thereafter.

Principal Investigator: L. Murdock Smith, MS, CRC

_____ _____
Signature Date

Faculty Advisor: Tricia McClam, PhD

_____ _____
Signature Date

XI. **Departmental Review**

Department Head: Laurence J. Coleman, PhD

_____ _____
Signature Date

The application described above has been reviewed by the departmental committee and has been approved.

Chair, Departmental Review Committee: Tricia McClam, PhD

_____ _____
Signature Date

APPROVED: Edith M. Szathmary, PhD
Coordinator of Compliances
Research Administration
The University of Tennessee
Knoxville, Tennessee

_____ _____
Signature Date

Joseph Fuhr, PhD
Research Center
University of Tennessee Medical Center
Knoxville, Tennessee

_____ _____
Signature Date

"The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"

This research project is interested in hearing from persons, like yourself, who had a successful treatment experience for chemical dependence. There is a great deal of information available that offers particular ways to treat and support persons dealing with chemical dependence. Studies have not been done, though, from the viewpoint of the person in recovery. I am interested in your story about the nature of your recovery from chemical dependence--there is much to be learned from the other side of treatment. Throughout the research process, every measure will be taken to protect your confidentiality. I am fully aware of the importance of maintaining confidentiality, and identifying information will be modified to protect your identity.

The information about your recovery experience will be gathered from three sources: interviews, genograms, and medical records. Your participation in the study means that we meet three times to hear about your story of recovery. These interviews will be audiotaped so I will have an accurate account of your story. As soon as the audiotapes are transcribed, they will be erased and any identifying information will be modified in the transcripts. Your story is essential but so is your confidentiality. Genograms (schematic representations of your family) will be developed from the interviews and medical records. The information from the medical record will offer a different perspective on your recovery, and will assist in the development of the genogram.

No risks beyond those experience in the usual course of events are anticipated. Though there are no direct benefits, there is a clear benefit in an increased understanding of the nature of recovery from chemical dependence. You may withdraw from the research project at any time.

If you have any questions about this project and your rights as a participant in the research, then contact Murdock Smith, 112 Claxton Addition, The University of Tennessee 37996-3400 or call 974-2321.

**********

I have read and understand the explanation of this study and agree to participate.

_____ _____

Name Date

_____

Signature

University of Tennessee Medical Center
Knoxville, Tennessee

Medical Record Department

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION CONCERNING ALCOHOL AND DRUG TREATMENT**

I, _____(patient name), do hereby give my consent to and authorize UT Medical Center, Knoxville to release unto L. Murdock Smith, Department of Special Services Education, The University of Tennessee, Knoxville medical information contained in my medical record compiled from _____ to _____ concerning alcohol or drug treatment: I hereby release UT Medical Center, Knoxville from all liability that may arise from the release of the medical information requested. I understand that this information is to be disclosed for the following purpose and that purpose only:

> To gather data concerning the above named patient's treatment and recovery from alcohol and/or drug addiction, as part of the research project entitled, "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males."

I understand that this consent is subject to written revocation by me at any time, and unless an earlier date is specified. It will automatically expire 60 days after affixed below without express revocation.

PATIENT: _____ DATE: _____

WITNESS: _____ DATE:_____

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations prohibit you from making any further disclosure. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

Alcohol and Drug Recovery Center
1924 Alcoa Highway
Knoxville, TN 37920-6999
(615) 544-9600

June 9, 1992

To Whom It May Concern:

A great deal of research has been done in presenting views on what is the "best way" to treat people for chemical dependence, or what is the most important aspect of the treatment and recovery process. We at the ADRC are supportive of Murdock Smith's research, "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males", because of its unique inquiry into the perspective of persons who have experienced recovery. Rather than looking from the side of those who provide the services, his research seeks to understand those who receive treatment services. This will be invaluable knowledge in the continuing refinement of the treatment experience.

We at the Alcohol and Drug Recovery Center are prepared to assist in this research project, in accordance with the parameters set out by the proposal.

Murdock Smith's competence to perform this research in the field of chemical dependence is clear. Not only has he been a counselor here at ADRC (with both our Inpatient and Outpatient programs), but he also has many years of experience as a counselor or therapist before and after his time with us. He is fully aware of the dynamics of chemical dependence treatment, the significance of confidentiality, and the need for more research in the field.

Thank you.

Sincerely,

Denzel Dukes, CMSW
Director

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

• University Memorial Hospital
• Graduate School of Medicine

Office of Institutional Review Board
1924 Alcoa Highway
Knoxville 37920-6999
(615) 544-9463

June 24, 1992

L. Murdock Smith, M, CRC
Special Services Education
112 Claxton Addition
The University of Tennessee
Knoxville, Tennessee 37996-3400

RE: **Protocol #0295 "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"**

Dear Mr. Smith,

On June 23, 1992, the University of Tennessee Medical Center at Knoxville Institutional Review Board reviewed your above referenced application for possible administrative approval.

Because of the sample population which will be used in this study, the protocol will be given to a subcommittee of the IRB for review. The review process can be facilitated by receiving the following information from you regarding the study design.

1. A signed informed consent may not be necessary. As this will be the only identifier relating the patient to the study, an information sheet would be more appropriate. The patient will have to sign a release for medical records which will be kept on file in that department, and this will imply consent.

2. What will be the method of identifying participants for this study? In other words, how will the subjects be selected?

3. Will there be a sample guide for the "narrative", i.e. areas which the interviewer wishes to cover? Are there specific topics which will be addressed in each of the interviews?

Upon receipt of the information requested, the protocol will again be reviewed for approval. If you have any questions or comments,

please do not hesitate to contact this office at 544-9463.

Thank you for your cooperation.

Sincerely yours,

Joseph E. Fuhr, Ph.D.
Chairman, Institutional Review Board

JEF:tll

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

College of Education
Department of Special Services Education
102 Claxton Addition
Knoxville, Tennessee 37996-3400
(615) 974-2321
FAX (615) 974-8674

9 July 1992

Joseph E. Fuhr, Ph.D.
Chairman, Institutional Review Board
The University of Tennessee
Medical Center at Knoxville
1924 Alcoa Highway
Knoxville, TN 37920-6999

RE: **Protocol #0295 "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"**

Dear Dr. Fuhr:

Enclosed are the responses to the inquiries listed in your letter of 24 June 1992.

Inquiry One - Information Sheet

Inquiry Two - Selection of Participants

Inquiry Three - Interview Guide

Thank you.

Sincerely,

L. Murdock Smith, MS, CRC

enclosures
copy: Edith Szathmary, PhD

# INFORMATION SHEET

## "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"

This research project is interested in hearing from persons, like yourself, who had a successful treatment experience for chemical dependence. There is a great deal of information available that offers particular ways to treat and support persons dealing with chemical dependence. Studies have not been done, though, from the viewpoint of the person in recovery. I am interested in your story about the nature of your recovery from chemical dependence--there is much to be learned from the other side of treatment. Throughout the research process, every measure will be taken to protect your confidentiality, and identifying information will be modified to protect your identity.

The information about your recovery experience will be gathered from three sources: interviews, genograms, and medical records. Your participation in the study means that we will meet three times so you can tell your recovery story in detail. These interviews will be audiotaped so I will have an accurate account of your story. As soon as the audiotapes are transcribed, they will be erased and any identifying information will be modified in the transcripts. Your story is essential but so is your confidentiality. A genogram (schematic representations of your family and family system) will be developed from the interviews and medical record information. The genogram is a "tool" to understand family history and family dynamics. The information from the medical record will offer a different perspective on your recovery, and will assist in the development of the genogram.

No risks beyond those experience in the usual course of events are anticipated. Though there are no direct benefits, there is a clear benefit in an increased understanding of the nature of recovery from chemical dependence. You may withdraw from the research project at any time.

If you have any questions about this project and your rights as a participant in this research, then contact Murdock Smith, 112 Claxton Addition, The University of Tennessee, Knoxville, TN 37996-3400, or call 974-2321.

Thank you.

## SELECTION OF PARTICIPANTS

Participant selection in this research project has two stages. The first stage is the identification of potential participants by Alcohol and Drug Recovery Center (ADRC) clinical staff. The second stage is the recruitment of participants by the researcher, using the list of potential participants developed by the clinical staff.

Stage One - The selection criteria to be used by the clinical staff includes, but is not limited to, successful completion of treatment, maintenance of sobriety, continuing participation in Twelve Step programs, and recommendation of their counselor/case manager. The identification of potential participants will be done collectively, by both Inpatient and Outpatient clinical staff. ADRC staff will mail information packets about the research project to potential participants. These packets will include a cover letter from the researcher, an information sheet about the research project, a letter of support from ADRC, a consent to be contacted form, and a stamped return envelope. If the potential participant is interested in further information about being in the research project, then they will complete the consent to be contacted form and return it to the researcher. The initial mailing will be to twelve potential participants.

Stage Two - The information packet will contain a cover letter from the researcher, an information sheet, a support letter from ADRC, consent to be contacted form, and a stamped return envelope. When a consent form is received, the researcher will call the potential participant to answer questions and, if appropriate to proceed, schedule the first interview. This same procedure will be repeated with each individual who indicates his willingness to be contacted about possible participation in the research. If less than six persons are recruited to participate in the research from the initial mailing, then additional potential participants will be identified by ADRC clinical staff and the above process will be repeated.

INTERVIEW GUIDE

Marshall and Rossman (1989), in Designing Qualitative Research, write that a qualitative interview is "a conversation with a purpose," and "Typically, qualitative in-depth interviews are much more like conversations than formal, structured interviews. The researcher explores a few general topics to help uncover the participant's meaning perspective, but otherwise respects how the participant frames and structures the responses (p. 82)." This understanding of the qualitative interview process forms the basis of this research, particularly since a goal is to have the participants' perspective on the nature of recovery expressed.

Though the above establishes the "method" for the interviews, there are areas of interest relative to the nature of recovery. These areas serve as guides during the interview process for topics of discussion by the participant--ideally resulting in similar areas being discussed in each interview. The areas are as follows:

- Drug use history
- Family history
- Education & employment history
- Treatment experiences
- Post-treatment experiences
- Sex/gender development history
- Life cycle/developmental history

It is anticipated that there will be variability among the participants, and that some areas will be emphasized more than others. Other areas for consideration may arise out of the interview process.

If each interview is one and one-half to two hours each, then discussion of the abovementioned areas will cover more than one interview. Additionally, subsequent interviews will provide opportunities for the researcher to seek clarification and/or expansion on issues raised in previous interviews. For example, the genograms will be developed early in the interview process, and will be presented to the participant for an "accuracy check" during the second interview.

enclosures
copy: Edith Szathmary, PhD

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

• University Memorial Hospital
• Graduate School of Medicine

Office of Institutional Review Board
1924 Alcoa Highway
Knoxville 37920-6999
(615) 544-9463

July 14, 1992

L. Murdock Smith, MS, CRC
Special Services Education
University of Tennessee at Knoxville
102 Claxton Addition
Knoxville, Tennessee 37996-3400

RE: Protocol #0295 **"The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"**

Dear Mr. Smith,

Thank you for responding to the concerns of the committee regarding your proposed study, "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males".

A concern persists, however, regarding identification of participants for this study. A researcher has no right to the identities of patients for potential participation until said patients inform a member of the care-giving team that they are willing to have their identities divulged.

If a former patient has agreed to be contacted for research purposes, please document that this consent applies to researchers not already a part of the care-giving team.

Alternatively, the initial letters could be provided by you to a member of the care-giving staff who will forward them to the potential candidate.

Resolution of this issue should remove any delay in approving your protocol.

Sincerely,

Joseph E. Fuhr, Ph.D., Chairman
Institutional Review Board

JEF:tll

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

College of Education
Department of Special Services Education
102 Claxton Addition
Knoxville, Tennessee 37996-3400
(615) 974-2321
FAX (615) 974-8674

24 July 1992

Joseph E. Fuhr, Ph.D., Chairman
Institutional Review Board
Office of Institutional Review Board
1924 Alcoa Highway
Knoxville, TN 37920-6999

RE: Protocol #0295 **"The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"**

Dear Dr. Fuhr:

On reviewing the agreement by the patient to be contacted about continuing care and/or research, I believe that there is room for differing interpretations concerning outside researchers. Because of the concern for confidentiality with persons who have received treatment for chemical dependence, your alternate suggestion on the recruitment of potential participants is the best path to follow.

In response to this issue, enclosed are two items. The first is a revision of a previously submitted document ("Selection of Participants"), and the second is a consent to be contacted form. The revised "Selection of Participants" reflects the changes in the recruitment process so the researcher does not know the identity of potential participants until they have agreed to be contacted. The second form is a simple information sheet that would be completed and returned to the researcher by the potential participant, indicating a willingness to proceed. Any information concerning the nature of the research has been omitted from this form. These forms will be kept in a locked cabinet until the interview process has been completed, and then they will be destroyed.

I hope that these modifications in the protocol resolve any concern about the identification of potential participants.

If you need additional information then please let me know. I am as concerned as you in assuring confidentiality in this research process.

Thank you.

Sincerely,

L. Murdock Smith, MS, CRC

Enclosures
copy: Edith Szathmary

## SELECTION OF PARTICIPANTS

Participant selection in this research project has two stages. The first stage is the identification of potential participants by Alcohol and Drug Recovery Center (ADRC) clinical staff members. The second stage is the recruitment of participants by the researcher, using the list of potential participants developed by ADRC clinical staff members. It is important to note that during discharge planning, the patient/participant indicates whether or not they are willing to be contacted during the next two years for research and/or continuity of care.

Stage One - The selection criteria to be used by the clinical staff includes, but is not limited to, successful completion of treatment, maintenance of sobriety, continuing participation in Twelve Step programs, recommendation of their counselor/case manager, and expressed willingness at discharge to be contacted. The identification of potential participants will be done collectively in meetings with both Inpatient and Outpatient clinical staff. An initial list of eighteen potential participants will be developed. Once the list is developed, then Stage Two begins.

Stage Two - Though the sampling frame will contain eighteen names, potential participants will be contacted on a one-by-one basis (only as many as are needed to have six agree to participate will be contacted). A letter that includes the Information Sheet and ADRC letter of support will be sent to a potential participant. A follow-up telephone call to the potential participant will be made by the researcher approximately one week after the letter is mailed. The potential participant will be asked during the course of the telephone conversation to state whether or not they are willing to proceed and be a participant in the research. If they are not, then the aforementioned process will begin again. If they are willing to participate, then a time will be set for the first interview. If the potential participant is undecided at the time of this telephone call, then a date will be set for a second telephone call and deadline for a decision by the potential participant. This process will be repeated as many times as necessary, during the course of the research, as the means of recruiting participants. If there is a need for additional names for the sampling frame, then stage one will be repeated.

# CONSENT TO BE CONTACTED

I am willing and interested in being contacted about your project and my possible participation in it. I understand that you will be in contact with me to talk about the project. I also understand that confidentiality will be protected throughout the research process.

Name: _____

Address: _____

_____

Telephone: _____(home)

_____(work)

Comments: _____

_____

_____

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

• University Memorial Hospital
• Graduate School of Medicine

Office of Institutional Review Board
1924 Alcoa Highway
Knoxville 37920-6999
(615) 544-9463

August 4, 1992

L. Murdock Smith, MS, CRC
Department of Special Services Education
College of Education
The University of Tennessee at Knoxville
102 Claxton Addition
Knoxville, Tennessee 37996-3400

**RE: IRB Protocol #0295 - "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"**

Dear Mr. Smith,

Thank you for submitting the modified version of the above referenced protocol, "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males".

This constitutes full approval of your proposal. Any alterations in the protocol must be promptly reported to the Institutional Review Board. In addition, annual reapproval is required, and it is the responsibility of the investigator to initiate said request for approval.

You have individual responsibility for reporting to the Board in the event of adverse occurrences.

Sincerely,

Joseph E. Fuhr, Ph.D., Chairman
Institutional Review Board

JEF:tll

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

Research Administration
Compliances
Grants & Contracts
Proposal Development Services
404 Andy Holt Tower
Knoxville, Tennessee 37996-0140
(615) 974-3466
FAX (615) 974-2805

DATE: 09/10/92

CRP #: 3863 B

Title: "The Nature of Recover: A Qualitative Study of Chemically Dependent Males"

Smith, L. Murdock
Special Services Educ
112 Claxton Addn
Campus

McClam, Dr. Tricia
Special Services Educ
135 Claxton Addn
Campus

Your project listed above was reviewed. It qualified for expedited review and has been approved.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.

2. To retain signed consent forms from subjects for at least three years following completion of the project.

3. To submit a Form D to report termination, to renew approval, or to report changes in the project during the approval period.

The Committee wishes you every success in your research endeavor.

Sincerely,

Edith M. Szathmary

Edith M. Szathmary
Coordinator of Compliances

cc: Laurence J. Coleman
102 Claxton Addn

# APPENDIX B

## PARTICIPANT INFORMATION PACKET

1. Cover letter
2. Information sheet
3. Consent to be Contacted form
4. Support letter from Denny Dukes
5. Stamped, return envelope (not included here)
6. Contained in brown envelope (not included here)

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

College of Education
Department of Special Services Education
102 Claxton Addition
Knoxville, Tennessee 37996-3400
(615) 974-2321
FAX (615) 974-8674

10 November 1992

Dear ADRC Alumni:

Because of your present success with recovery from chemical dependency, you have been suggested as a good candidate to participate in research into the "insiders" experience of recovery. I ask that you take a few minutes to finish reading this letter and the enclosed items. Let me tell you about this very important research.

As I have looked into the many sides of recovery, I have not found information on the nature of recovery as seen through the eyes of persons who have gone through treatment. There are many books and articles about what should happen according to treatment providers--"do this", "don't do that", or "follow my plan." I have not found research on recovery that is from the perspective of persons in recovery. I am interested in hearing from people who have gone through treatment and are working a successful recovery program. I want to hear your story, and then to use what you tell me--the "data"--as a way of describing and analyzing what happened with your treatment and is happening in your recovery.

How the "data" will be gathered is described on the Information Sheet, so I will not repeat it here. I do want to emphasize again that all measures will be taken to protect your confidentiality. Additionally, this information is being sent to you in this "anonymous" way as one way of protecting your identity.

If you are interested in talking more about participating in this important research project, then please complete the enclosed Consent To Be Contacted form. A stamped, self-addressed envelope is enclosed for your convenience. This is not a commitment to be a participant, but is an agreement to be contacted so we can talk more about the project--scheduled to begin the first of the year.

Thank you and I look forward to hearing from you.

Sincerely,

L. Murdock Smith, MS, CRC
Principal Investigator

# INFORMATION SHEET

## "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males"

This research project is interested in hearing from persons, like yourself, who had a successful treatment experience for chemical dependence. There is a great deal of information available that offers particular ways to treat and support persons dealing with chemical dependence. Studies have not been done, though, from the viewpoint of the person in recovery. I am interested in your story about the nature of your recovery from chemical dependence--there is much to be learned from the other side of treatment. Throughout the research process, every measure will be taken to protect your confidentiality, and identifying information will be modified to protect your identity.

The information about your recovery experience will be gathered from three sources: interviews, genograms, and medical records. Your participation in the study means that we will meet three times so you can tell your recovery story in detail. These interviews will be audiotaped so I will have an accurate account of your story. As soon as the audiotapes are transcribed, they will be erased and any identifying information will be modified in the transcripts. Your story is essential but so is your confidentiality. A genogram (schematic representations of your family and family system) will be developed from the interviews and medical record information. The genogram is a "tool" to understand family history and family dynamics. The information from the medical record will offer a different perspective on your recovery, and will assist in the development of the genogram.

No risks beyond those experience in the usual course of events are anticipated. Though there are no direct benefits, there is a clear benefit in an increased understanding of the nature of recovery from chemical dependence. You may withdraw from the research project at any time.

If you have any questions about this project and your rights as a participant in this research, then contact Murdock Smith, 112 Claxton Addition, The University of Tennessee, Knoxville, TN 37996-3400, or call 974-2321.

Thank you.

# CONSENT TO BE CONTACTED

I am willing and interested in being contacted about your project and my possible participation in it. I understand that you will be in contact with me to talk about the project. I also understand that confidentiality will be protected throughout the research process.

Name: _____

Address: _____

_____

Telephone: _____(home)

_____(work)

Comments: _____

_____

_____

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

Alcohol and Drug Recovery Center
1924 Alcoa Highway
Knoxville, TN 37920-6999
(615) 544-9600

June 9, 1992

To Whom It May Concern:

A great deal of research has been done in presenting views on what is the "best way" to treat people for chemical dependence, or what is the most important aspect of the treatment and recovery process. We at the ADRC are supportive of Murdock Smith's research, "The Nature of Recovery: A Qualitative Study of Chemically Dependent Males", because of its unique inquiry into the perspective of persons who have experienced recovery. Rather than looking from the side of those who provide the services, his research seeks to understand those who receive treatment services. This will be invaluable knowledge in the continuing refinement of the treatment experience.

We at the Alcohol and Drug Recovery Center are prepared to assist in this research project, in accordance with the parameters set out by the proposal.

Murdock Smith's competence to perform this research in the field of chemical dependence is clear. Not only has he been a counselor here at ADRC (with both our Inpatient and Outpatient programs), but he also has many years of experience as a counselor or therapist before and after his time with us. He is fully aware of the dynamics of chemical dependence treatment, the significance of confidentiality, and the need for more research in the field.

Thank you.

Sincerely,

Denzel Dukes, CMSW
Director

# APPENDIX C

## OUTLINE FOR A BRIEF GENOGRAM INTERVIEW

**Index Person, Children and Spouses**

Name? Date of birth? Occupation? Are they married? If so, give names of spouses, and the name and sex of children with each spouse. Include all miscarriages, stillbirths, adopted and foster children. Include dates of marriages, separations, and divorces. Also include birth and death dates, cause of death, occupations and education of the above family members. Who lives in the household now?

**Family of Origin**

Mother's name? Father's name? They were which of how many children? Give name and sex of each sibling. Include all miscarriages, stillbirths, adopted and foster siblings. Include dates of the parents' marriages, separations, and divorces. Also, include birth and death dates, cause of death, occupations and education of the above family members. Who lived in the household when they were growing up?

**Mother's Family**

The names of the mother's parents? The mother was which of how many children? Give name and sex of each of her siblings. Include all miscarriages, stillbirths, adopted and foster siblings. Include dates of grandparents' marriages, separations, and divorces. Also include birth and death dates, cause of death, occupations and education of the above family members.

**Father's Family**

The names of the father's parents? The father was which of how many children? Give the name and sex of each of his siblings. Include all miscarriages, stillbirths, adopted and foster siblings. Include dates of grandparents' marriages, separations, and divorces. Also include birth and death dates, cause of death, occupations and education of the above family members.

**Ethnicity**

Give ethnic/religious background of family members and the languages they spoke if not English.

**Major Moves**

Tell about major family moves and migrations.

**Significant Others**

Add others who lived with or were important to the family.

**For All Those Listed, Indicate Any of the Following:**

serious medical, behavioral, or emotional problems;
job problems;
drug or alcohol problems;
serious problems with the law.

**For All Those Listed, Indicate Any Who Were:**

especially close;
distant or conflictual;
cut off from each other:
overly dependent on each other.

(McGoldrick & Gerson, 1985, pp. 157-158)

# APPENDIX D

## GENOGRAM INTERPRETIVE CATEGORIES

**Category 1: Family Structure**

- A. Household composition
  - 1. Intact nuclear household
  - 2. Single-parent household
  - 3. Remarried family households
  - 4. Three-generational household
  - 5. Household including non-nuclear family members
- B. Sibling constellation
  - 1. Birth order
  - 2. Siblings' gender
  - 3. Distance in age between siblings
  - 4. Other factors influencing sibling constellation
    - a. Timing of each child's birth in family's history
    - b. Child's characteristics
    - c. Family's "program" for the child
    - d. Parental attitudes and biases regarding sex differences
    - e. Child's sibling position in relation to that of parent
- C. Unusual family configurations

**Category 2: Life Cycle Fit**

**Category 3: Pattern Repetition Across Generations**

- A. Patterns of functioning
- B. Patterns of relationship
- C. Repeated structural patterns

**Category 4: Life Events and Family Functioning**

- A. Coincidences of life events
- B. The impact of life changes, transitions, and traumas
- C. Anniversary reactions
- D. Social, economic, and political events

**Category 5: Relational Patterns and Triangles**

- A. Triangles
- B. Parent-child triangles
- C. Common couple triangles
- D. Divorce and remarried family triangles
- E. Triangles in families with foster/adopted children
- F. Multigenerational triangles
- G. Relationships outside the family

**Category 6: Family Balance and Imbalance**

A. Family structure
B. Roles
C. Level and style of functioning
D. Resources

(McGoldrick & Gerson, 1985, pp. 159-160)

# APPENDIX E

## PSYCHOACTIVE SUBSTANCE CRITERIA

**Diagnostic criteria for Psychoactive Substance Dependence**

A. At least three of the following:
   (1) substances often taken in larger amounts or over a longer period than the person intended
   (2) persistent desire or one or more unsuccessful efforts to cut down or control substance use
   (3) a great deal of time spend in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects
   (4) frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drive when intoxicated)
   (5) important social, occupational, or recreational activities given up or reduced because of substance use
   (6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking)
   (7) marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount
   **Note:** The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP):
   (8) characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance-induced Organic Mental Disorders)
   (9) substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time

**Criteria for Severity of Psychoactive Substance Dependence**

**Mild:** Few, if any, symptoms in excess of those required to make the diagnosis, and the symptoms result in no

more than mild impairment in occupational functioning or in usual social activities or relationships with others.
**Moderate:** Symptoms or functional impairment between "mild" and "severe."
**Severe:** Many symptoms in excess of those required to make the diagnosis, and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.
**In Partial Remission:** During the past six months, some use of the substance and some symptoms of dependence.
**In Full Remission:** During the past six months, either no use of the substance, or use of the substance and no symptoms of dependence.
(DSM-III-R, 1987, pp. 166-168)

**Diagnostic criteria for Psychoactive Substance Abuse**

A. A maladaptive pattern of psychoactive substance use indicated by at least one of the following:
(1) continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of the psychoactive substance
(2) recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated)

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a long period of time.

C. Never met the criteria for Psychoactive Substance Dependence for this substance.

(DSM-III-R, 1987, p. 169)

**Individual Psychoactive Substance Use Disorders List**

| | |
|---|---|
| 303.90 | Alcohol Dependence |
| 305.00 | Alcohol Abuse |
| 304.40 | Amphetamine or Similarly Acting Sympathomimetic Dependence |
| 305.70 | Amphetamine or Similarly Acting Sympathomimetic Abuse |
| 304.30 | Cannabis Dependence |
| 305.20 | Cannabis Abuse |
| 304.20 | Cocaine Dependence |
| 305.60 | Cocaine Abuse |
| 304.50 | Hallucinogen Dependence |
| 305.30 | Hallucinogen Abuse |
| 304.60 | Inhalant Dependence |
| 305.90 | Inhalant Abuse |
| 305.10 | Nicotine Dependence |
| 304.00 | Opioid Dependence |
| 305.50 | Opioid Abuse |
| 304.50 | Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Dependence |

305.90 Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Abuse
304.10 Sedative, Hypnotic, or Anxiolytic Dependence
305.40 Sedative, Hypnotic, or Anxiolytic Abuse
304.90 Polysubstance Dependence
304.90 Psychoactive Substance Dependence Not Otherwise Specified
305.90 Psychoactive Substance Abuse Not Otherwise Specified

(DSM-III-R, 1987, pp. 173-185)

# VITA

Louis Murdock Smith III was born in Raleigh, North Carolina on 1 December 1948. He attended primary schools in Dublin, Ireland, Pretoria, South Africa, and Fairfax County, Virginia. He attended James Madison High School in Vienna, Virginia for one year, completed his secondary education at The American School of the International Schools of the Hague, the Netherlands, and graduated in June 1967. After language studies at La Universidad de Salamanca in Salamanca, Spain, and La Universidad Internacional de Menendez Pelayo in Santander, Spain, he entered Swarthmore College in Swarthmore, Pennsylvania in September 1967. He received a Bachelor of Arts in Political Science from Swarthmore College in June 1972, after additional studies at The University of North Carolina, Chapel Hill and The University of North Carolina, Greensboro. In August 1979, he entered The Episcopal Theological Seminary of the Southwest in Austin, Texas, and received a Master of Divinity in May 1982. Following the course of studies set out in the "Summers at General" program from June 1984 through December 1989, he eventually received a Master of Sacred Theology in Spiritual Direction from The General Theological Seminary, New York, New York, in May 1990. In the interim, he entered The University of Tennessee, Knoxville in August 1988, and received a Master of Science

in Rehabilitation Counseling in December 1989. His doctoral studies began in January 1990, and he received his Doctor of Philosophy in Education from The University of Tennessee, Knoxville, in May 1994.

He worked during college as a construction laborer, voter registration worker with the Voter Education Project of the Southern Regional Council, night auditor in a motel, worker in the Franklin Mint, dishwasher, and floor mopper. On completion of his undergraduate studies, he returned to North Carolina after twenty-two years to work as bartender, assistant manager, and general manager of the Village Dinner Theatre in Raleigh/Durham; as Assistant Executive Director with the North Carolina Heart Association in Chapel Hill; and Program Administrator with Southeastern Medical Services in Rowland. While attending seminary, he worked from 1979 through 1981 as chaplain at the Ranch Treatment Center of the Brown Schools, Austin, Texas. Returning to North Carolina in 1982, he was Assistant to the Rector, St. Mary's Church, High Point. In 1984, he became Rector of St. Alban's Church, Chattanooga, Tennessee. In 1986, he went on staff at Church of the Ascension in Knoxville, remaining there until May 1988. During 1992 and 1993, he served as Interim Pastor at Trinity Church, Gatlinburg. During 1989-1991, he was a counselor at the Alcohol and Drug Recovery Center, UT Medical Center, Knoxville. He has worked as a psychotherapist at Good Shepherd Counseling Center in

Knoxville since 1992. He is also prone to go where the Bishop of East Tennessee sends him within the Diocese.

He is a Certified Rehabilitation Counselor, will soon complete requirements for Clinical Membership with the American Association of Marriage and Family Therapists, and be license-eligible as a Marriage and Family Therapist. He has an interest in gender studies, chemical dependence, sexual abuse, spiritual direction, and healing. He is a priest with The Diocese of East Tennessee.