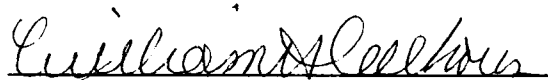
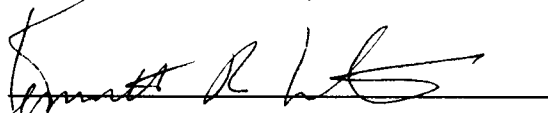
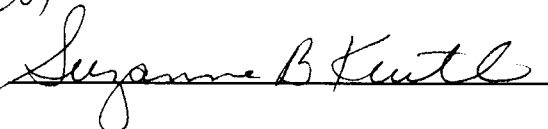


To the Graduate Council:

I am submitting herewith a dissertation written by Becky Jean McKenzie entitled "Causal Attributions, Life Events, and Perceived Social Support of Wives of Alcoholic Men." 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 Psychology.


Cheryl B. Travis, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:


Vice Provost
and Dean of the Graduate School

CAUSAL ATTRIBUTIONS, LIFE EVENTS, AND PERCEIVED SOCIAL
SUPPORT OF WIVES OF ALCOHOLIC MEN

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Becky Jean McKenzie
December 1988

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DEDICATION

As children tend to do, I learned many things from my parents. Somewhere in our family's jumble of talking, laughing, fussing, sporadic mealtimes, and hanging out at the pool I absorbed two particularly important perspectives on life which sustained me through this dissertation process. One was that yeas, sometimes the days are long and full of tedium and frustration. You live through them, and eventually you do get to go to sleep.

But the other was that sometimes you just have to play!

So, with a lot of love I dedicate this dissertation to my mother, Bettye McKenzie, and my father, Gordon McKenzie.

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Finally, I come to the most difficult part of my acknowledgments. I see now that taking an extended period of time to complete this project (not to mention living in three different states) has resulted in a not unpleasant problem. Over the years I've developed a number of important relationships. The love, care, and overall social support many of these people have given me have had a direct impact on my completing this dissertation. Unfortunately, it is impossible to convey adequately my gratitude and affection to each of them herein, and someday I hope to do so personally. For now I

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ABSTRACT

Women married to alcoholic men are often at risk for experiencing psychiatric symptomology. In order to describe and analyze factors contributing to symptomology, 98 women were recruited from five facilities where their husbands were currently undergoing treatment for alcoholism. They completed five instruments: the Life Experiences Survey, the Perceived Social Support Questionnaire, the Attribution Questionnaire, the Symptom Checklist-90, and a page of sociodemographic questions labeled Fact Sheet. It was hypothesized that stressful life events would be associated with greater psychological distress but that perceptions of social support would mitigate these effects. It was additionally hypothesized that psychiatric symptomology would be correlated with a pattern of causal attributions characterized by a focus on internal, stable, and global factors. Data were analyzed by correlational and multiple regression methods. Results indicated a positive correlation between stressful life events and personal symptomology ($p < .0001$), while high levels of social support from both friends ($p < .01$) and family ($p < .05$) were negatively correlated with psychological distress. The tendency to make global attributions for negative events--that is, to believe that causes of a specific event also influence other aspects of life--was highly correlated with psychological dysfunction ($p < .001$). Symptomology, however, was not related to causal attributions that emphasize stable or internal factors. Multiple regression ($p < .0001$) indicated that 30% of the variance in psychological dysfunction could

be explained in descending order of significance by negative life events, perceived social support from friends, global causal attributions, and perceived social support from family.

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CHAPTER I

INTRODUCTION

Recent research has focused extensively on determining the relationship of social and cognitive factors to the development and experience of psychological distress (e.g., Cohen & Wills, 1985; Sweeney, Anderson, & Bailey, 1986). One important focus of this research has been the recognition that family members may not only influence an individual's functioning, but may also respond to the other's psychological symptomology with their own particular problems and perceptions (Finney, Moos, Cronkite, & Gamble, 1983). Alcoholism is one disorder which has been examined extensively in terms of both those who drink alcohol excessively and their family members, especially spouses (Edwards, Harvey, & Whitehead, 1973; Finney et al., 1983; Jacob, Dunn, Leonard, & Davis, 1985). In an effort to understand more fully the impact of alcoholism on women married to alcoholic men, this study adopted questionnaire techniques to characterize wives of alcoholics with respect to: a) stressful life events; b) perceived social support from both friends and family; c) causal attributions for stressful life events; and d) psychological functioning.

Impact of Alcoholism

Examining individuals who are affected by the excessive use of alcohol continues to be an important and timely undertaking. Alcoholism and the alcohol abuse are major problems affecting American

society. Expenses incurred from industrial production loss, health and medical problems, violent crimes, automobile accidents, and fire have been estimated at \$42 billion annually (DeLuca, 1981). On an individual level, those who misuse alcohol increase the risks of severe health problems, accidents, and early death (DeLuca, 1981).

Family members are also likely to be adversely affected. Nonalcoholic spouses report that such behaviors by their partners as failure to participate in family events and maintain adequate hygiene have a disturbing impact on the family functioning (Zweben, 1986). More critically, alcohol abuse has also been associated with family violence, particularly wife battering and rape (Gelles, 1972; Russell, 1982).

Problems Experienced by Other Family Members

Children

Studies indicate that children of alcoholics often exhibit difficulties in both social and psychological realms (Jacob, Favorini, Meisel, & Anderson, 1978). Two problems which have been identified are difficulty in developing close relationships and low self-esteem.

Spouses

Research on husbands and wives of alcoholics also indicates that spouses frequently have psychological problems. Early clinical research suggested that both husbands (e.g., Fox, 1956) and wives (Price, 1945) may have personality disturbances which lead them to select alcoholic partners. Such disturbances included dependency,

passivity, and a need to dominate (Jacob et al., 1978). Subsequent empirical research, however, revealed that psychological problems were not likely to be due to long-standing character traits. Various researchers have found that neither husbands nor wives tend to test outside of normal ranges on standardized personality inventories (e.g., Paolino, McCrady, Diamond, & Longabaugh, 1976; Tarter, 1976). Rather, it appears tht psychological problems of spouses are related to partners' drinking. Problems which have been noted include increased psychiatric symptomology (Jacob et al., 1985) and general disturbances in behavior in both work and social settings (Finney et al., 1983).

Until recently, research on spouses of alcoholics has tended to focus specifically on either husbands or wives. There are, however, far fewer studies of male partners of alcoholics than of female partners of alcoholics. This discrepancy is likely to be due to both demographic and gender differences.

During the 1950's when some of the first publications concerning families with alcoholic members appeared, the ratio of male to female alcohol abusers was estimated to be 5:1 (Jellinek & Keller, 1952). Over the years this estimated difference has lessened markedly. Current reports indicate the proportion of men to women seeking help for drinking problems ranges from 4:1 at public facilities to 1:1 at private agencies (Gomberg, 1981).

The number of husbands available for study continues to be low (e.g., Boyd, 1982; Finney et al., 1983). Factors stemming from two

gender differences may account for this phenomenon. First, women and men exhibit distinct patterns of alcohol abuse, possibly leading women living with alcoholic husbands to have different experiences and perceptions than men living with alcoholic wives. Women tend to be older than men when their drinking problems are first identified (Gomberg, 1981). The length of time from first abuse of alcohol to diagnosis of alcoholism tends to be shorter for women than for men (Gomberg, 1981). Women are more likely to report a life crisis as a precipitator for the excessive drinking, whereas men are more likely to cite general and ambiguous factors (Gomberg, 1981). Additionally, women are more likely to drink at home, have shorter drinking bouts, and be solitary drinkers than men. Men are more likely to engage in morning and daily drinking, experience blackouts, and lose their jobs than women (Gomberg, 1982).

A second gender difference is that women and men respond differently to their alcoholic spouses. Women alcoholics are perceived as more immoral and embarrassing to their families than their male counterparts, thus leading family members, especially husbands, to expend a great deal of energy attempting to hide alcoholic wives (Sandelowski, 1981). Women are more likely than men to show support for their alcoholic spouses' treatment by accompanying them to treatment facilities (Gomberg, 1982). Women are also less likely than men to initiate separation as a means of dealing with alcoholism of the spouse. Husbands of alcoholic women tend to view separation and divorce as viable, whereas wives are more likely to remain in the marriage because they are limited by economic dependency

(Grisham & Estes, 1982). In addition, it has been noted that female alcoholics are more likely to have alcoholic spouses than are male alcoholics (Rimmer, 1974). These different behaviors reflect varying perceptions of alcoholism and its effects on both husbands and wives. To date, the psychological problems of wives and husbands of alcoholics have not been compared. This dissertation was likewise restricted to the experiences and perceptions of wives of alcoholic men.

Research Approaches

Wives of Alcoholic Men

Despite different theoretical orientations, most investigators agree that spouses of alcoholics are at risk for exhibiting psychological problems. In order to describe the psychological functioning of women married to alcoholic men, five major research approaches have evolved. Within a causal framework, three theories have received considerable attention: 1) disturbed personality theory, 2) sociological stress theory, and 3) psychosocial stress theory. Another research approach is the descriptive analysis of coping strategies women have used in dealing with their husbands' alcoholic behavior. The fifth major research orientation expands examination of environmental factors to include stressful life events and social support. Each of these five research strategies are reviewed in Chapter II.

Stressful Life Events/Social Support

In the past ten years, two models predicting correlates of psychological functioning have received considerable attention. The first, the life events/social support model, results from two fairly consistent sets of findings. Researchers have repeatedly found high levels of life stress to be associated with psychological problems (Dohrenwend & Dohrenwend, 1974). Also, it has been noted that social support often serves to mediate the disruptive nature of many stressful events (Heller & Swindle, 1983). Chapter III reviews the theoretical and empirical work regarding both stressful life events and social support and discusses each of these concepts in terms of research history, measurement, and specific application to the study of wives of alcoholics.

Causal Attributions

The second model of psychological functioning suggests that beliefs about the causes of negative events are related to emotional distress. One specific framework which has been developed posits that individuals experiencing depression are more likely to attribute negative events to long-standing and/or intrinsic aspects of themselves which also affect other parts of their lives (Abramson, Seligman, & Teasdale, 1978). Chapter IV discusses the research history of causal attribution theory with a particular focus on the reformulated model of learned helplessness. Measurement issues are also presented.

To date there has been no systematic analysis of attributional

patterns of wives of alcoholic men. There are, however, two areas of research considered relevant for this dissertation. The study of attributions made by alcoholics and the general population is presented, providing a causal perspective on alcoholic drinking. Additionally, an attributional analysis of battered wives is reviewed.

Purpose of This Study

The purpose of this dissertation was two-fold. As alcoholism treatment and prevention strategies continue to evolve, it is important to develop a clear conceptual picture of how alcoholic behavior affects both drinkers and other family members. Therefore, one goal of this dissertation was to describe how one affected group--wives of alcoholic men--perceives and responds to their life situation.

The second goal was to examine how these perceptions and responses are related. Although numerous investigators have utilized the life stress/social support and causal attribution models to determine correlates of psychological functioning for many other populations, to date no one has specifically examined women married to alcoholic men within these frameworks. In light of the frequently reported finding that wives of alcoholics tend to exhibit some degree of psychological problems (e.g., Kogan & Jackson, 1965; Moos, Finney, & Gamble, 1983; Price, 1945; Tarter, 1976), this dissertation was designed to identify whether factors suggested within these two models are also relevant to the functioning of this population.

CHAPTER II

WIVES OF ALCOHOLIC MEN

Disturbed Personality Theory

Disturbed personality theory was developed from early clinical observations of women married to alcoholic men. The primary assumption was that abnormal behaviors among wives stemmed from their own pathological personality traits which predated the marriage.

One of the earliest studies based on this premise concluded that wives of alcoholics were dependent women married to even more dependent men (Price, 1945). As their husbands' alcoholism became evident during marriage, wives reportedly reacted by becoming hostile and aggressive. They made unreasonable demands which husbands could not possibly meet, or made no demands at all, so that husbands felt unnecessary and worthless. Husbands responded to both conditions of inadequacy by increasing their drinking. Thus, wives were perceived as contributing to their husbands' alcoholism.

Subsequent research supported this view. One study interpreting clients' cases within a psychoanalytic framework suggested that women entered alcoholic relationships to satisfy their own deprived oral needs (Lewis, 1954). Another study presented a personality typology based on the theory that women selected husbands to fulfill their own psychological deficits (Whalen, 1953).

A specific hypothesis within disturbed personality theory was that wives unconsciously preferred their husbands to continue drinking

to maintain the wives' own relative superiority (Price, 1945). It was theorized that wives not only unconsciously desired the status quo of the alcoholic relationships, but actually deteriorated in their personality functioning if their husbands quit drinking. This supposition was labeled the decompensation hypothesis (Futterman, 1953).

In their review of the research on wives of alcoholic men, Paolino and McCrady (1977) outlined a number of clinical studies which provided some support for the decompensation hypothesis. However, these authors also pointed out that in all instances the subjects were not representative of the general population, and the methodology was unsound. Other researchers have found no support for the decompensation hypothesis. For example, after following a large cross-section of Al-Anon members for eight years, Jackson (1962) reported only one wife deteriorated at the same time her husband achieved abstinence. Studies using reliable and valid psychological assessment instruments such as the Marriage Adjustment Schedule (Burton & Kaplan, 1968) and the Index of Psychophysiological Disturbance (Haberman, 1964) found no increased disturbance in wives whose husbands quit drinking.

Sociological Stress Theory

As a direct response to the assumption that women's pre-existing personality traits were responsible for their abnormal behavior, an alternative explanation was developed that asserted personality played no role in behaviors exhibited by wives of

alcoholics (Jackson, 1954). Labeled the sociological stress theory, this theory hypothesized that women married to alcoholics exhibited similar behaviors due to similar stresses within marriage, such as changing roles and expectations (Jackson, 1962).

To investigate this, Jackson (1954, 1956, 1962) conducted an extensive longitudinal study by attending Al-Anon meetings in Seattle over a period of eight years. Al-Anon membership consists of both women whose husbands have had some involvement with Alcoholics Anonymous (AA), and women whose husbands have never had contact with AA. After the first three years of the study, Jackson (1954) concluded that these wives had or were going through a sequence of stages in adapting to the crisis of alcoholism. These stages were identified as:

1. Attempts to deny the problems
2. Attempts to eliminate the problems
3. Disorganization
4. Attempts to reorganize in spite of the problems
5. Efforts to escape the problems
6. Reorganization of the family without the husband
7. Recovery and reorganization of the whole family

Subsequent research has not verified the existence of these seven stages (Lemert, 1960). In an attempt to replicate Jackson's (1954) sequence, 116 alcoholic families identified through courts, public agencies, state hospitals, and Al-Anon groups were interviewed (Lemert, 1960). It was found that instead of a specific sequence of

events, there tended to be general clusters of adjustment strategies at early, middle, and late phases of the alcoholic crisis. Thus, while support for the concept of specific stages was not found, it was evident that wives shared similar behavioral responses.

Psychosocial Stress Theory

It was soon recognized that the sociological stress theory does not account for the fact that some wives do exhibit psychological disturbance, and thus a model incorporating both situational and personality factors was developed (Kogan & Jackson, 1965). This theory, called the psychosocial stress theory, posits that although wives may react to situational stress with particular behavioral trends, psychological reactions to their husbands' alcoholism are tempered by wives' idiosyncratic personalities. Consequently, some women experience psychological problems. Disturbed personality theory states that a wife's dysfunction predates marriage; psychosocial stress theory states that a wife's dysfunction is an interaction of the stress of living with an alcoholic husband and her own personality traits.

Empirical examinations of the psychosocial stress theory have measured various psychophysiological and psychoneurotic symptoms (Bailey, Haberman, & Alksne, 1962; Haberman, 1964; Kogan & Jackson, 1965). In one study, 85% of 156 wives reported fewer symptoms of disturbance when husbands were abstinent than when drinking (Haberman, 1964). Another analysis of 69 women who were married to or divorced from either active or abstinent alcoholics found that the occurrence

and frequency of wives' symptoms varied directly with whether husbands were drinking or not (Bailey et al., 1962). Findings that wives' distress varied with husbands' drinking status were replicated in an analysis utilizing the Minnesota Multiphasic Personality Inventory (MMPI) (Kogan & Jackson, 1965).

In a more recent study, 38 wives of alcoholic men in treatment were administered the MMPI in conjunction with the California Psychological Inventory (CPI) (Tarter, 1976). The wives of alcoholics did exhibit a depressed well-being score on the CPI. These scores were attributed to the stress of living within an alcoholic marriage and not to the wives' personalities. There were no other distinct personality traits or pathological disturbances found.

Coping Styles

In the late 1960's, research on women married to alcoholic men changed its focus to examinations of the strategies these women used to help them deal with their husbands' alcoholism. The initial study of coping in wives of alcoholics involved administration of a questionnaire to 80 women married to alcoholic men (Orford & Guthrie, 1968). Factor analysis of these responses revealed five different coping strategies which were interpreted as reflecting specific personality traits of the wives. The coping strategies identified in this initial study were:

1. Safeguarding --giving money to husband
 family interests --hiding money from husband

- paying husband's debts
- borrowing money
- keeping children out of husband's way
- 2. Withdrawal within marriage
 - quarreling about drinking and related problems
 - avoiding husband
- 3. Attack
 - separations sought by wife
 - locking husband out
 - wife's pretense of drunkenness
- 4. Acting-out
 - wife's efforts to stop husband's drinking by getting drunk herself
 - making husband jealous
 - ridiculing husband
 - threatening suicide
- 5. Protection
 - hiding or pouring out alcohol
 - seeing that husband ate
 - getting husband a drink for his hangover
 - asking husband's employer to intervene

Orford & Guthrie (1968)

In an attempt to integrate Orford and Guthrie's (1968) work with Jackson's (1954) sociological stress theory, James and Goldman (1971) suggested that choice of coping behavior was determined not by personality but by situational stress. Eighty-five wives of alcoholics who had been in contact with a family service agency dealing only with alcoholism related problems were asked to recall how often they employed the five coping styles identified by Orford and Guthrie (1968) during four different drinking stages of their husbands. These stages were identified as social drinking, excessive drinking, alcoholic drinking, and abstinence. The most frequently reported coping behavior was emotional and physical withdrawal from the husband while remaining within the marriage. Fifty percent of the

wives used this style, even during the social drinking and abstinence stages. All wives reported using more than one style. Uses of all styles peaked during the alcoholic drinking stage.

Subsequent research expanded on this finding by hypothesizing that different coping patterns would be associated with different drinking outcomes (Orford et al., 1975). One hundred wives whose alcoholic husbands had been referred to the outpatient program of a psychiatric hospital were given the Coping with Drinking Questionnaire designed by these authors. The ten categories of coping identified as most frequently used by these wives were:

- | | |
|---------------------------|---|
| 1. Discord | --arguing
--threatening
--self-destructive behavior |
| 2. Avoidance | --wife avoiding husband |
| 3. Indulgence | --taking care of husband
--pouring alcohol out |
| 4. Competition | --pretending to or getting drunk to
keep up with husband |
| 5. Antidrink | --attempting to get rid of alcohol |
| 6. Assertion | --trying to hurt husband
--paying bills
--making husband embarrassed
--arguing
--making husband uncomfortable |
| 7. Sexual withdrawal | |
| 8. Fearful
withdrawal | --pretending all is well
--being frightened
--keeping children out of husband's way |
| 9. Take special
action | --special financial arrangements |

10. Marital breakdown --leaving husband

Orford, Guthrie, Nicholls, Oppenheimer,
Egert, & Hensman (1975)

Husband drinking status was determined by independent responses from both alcoholic husbands and their wives to questions about frequency of heavy or unacceptable drinking, drinking severity, and percentage of improvement during the year between entering treatment and being interviewed. The findings indicated such coping strategies as wife avoiding husband, wife withdrawing sexually from husband, wife being frightened, and wife making special financial arrangements were associated with bad outcomes. Strategies involving competitive behaviors such as pretending to or actually getting drunk to keep up with the husband and antidrinking actions such as attempting to remove alcohol from the home were related to good outcomes.

In a third attempt to discern the relationship between wives' coping patterns and husbands' current drinking behavior, 124 wives from several Al-Anon groups were recruited and administered the Coping with Drinking Questionnaire developed by Orford et al. (1975) (Schaffer & Tyler, 1979). Factor analysis of the responses produced nine categories of coping:

- | | |
|--------------------------|--|
| 1. Confrontation-discord | --wife aggressively confronting husband concerning drinking and drinking related issues
--confronting indirectly and manipulatively
--feeling angry and helpless |
| 2. Destructive reaction | --wife doing something self-destructive or embarrassing to self |

- | | |
|-----------------------------|--|
| | --wife doing something destructive or embarrassing to husband |
| 3. Avoidance | --wife avoiding husband |
| 4. Spouse-specific reaction | --specific action against husband such as separation or divorce |
| 5. Anti-alcohol reaction | --attempting to get rid of alcohol |
| 6. Seeking outside help | --asking for assistance from outside of family |
| 7. Inaction, fearful action | --unable to take special action
--reacting fearfully, passively |
| 8. Taking care of husband | --attempting to make husband comfortable |
| 9. Financial action | --taking care of money matters |

Schaffer & Tyler (1979)

The criteria for assessing husbands drinking was number of months since last drink, number of AA meetings attended in the past year, and percent of time spent sober in the past year. Although both husbands and wives were asked to provide these data, a number of husbands refused to participate. Different coping patterns were found for wives whose husbands responded (HR) as opposed to wives whose husbands refused to respond (HNR). A series of regression analyses were conducted to determine how coping factors related to drinking behavior. In the HR group, it was found that the strategy of taking specific action against the husband, such as separation, was negatively correlated with husband sobriety. A reaction of fear and passivity by the wife was positively correlated with sobriety. In the HNR group, the researchers determined that a strategy of trying to

make the husband comfortable negatively correlated with sobriety, while coping by attempting to get rid of the alcohol was positively correlated with sobriety.

Two additional studies have examined relationships between treatment issues and wives' coping. The first stems from the methodological criticism of research obtaining respondents solely from Al-Anon populations. The generalization of previous findings had been considered limited because effects of the Al-Anon philosophy had not been examined. This limitation was addressed by specifically analyzing wives' coping within the Al-Anon perspective (Gorman & Rooney, 1979). The Al-Anon program teaches that one is powerless over another's drinking, and that one cannot change another's behavior. Thus, it was speculated that wives involved with Al-Anon would base their coping styles on this concept, and would perceive such strategies as covering up husbands' drinking, nagging, and hiding liquor as counterproductive. To study this, 123 Al-Anon wives were administered a revised version of the Coping with Drinking Questionnaire designed by Orford et al. (1975). It was found that the longer a woman had been involved in Al-Anon, the less likely she was to exhibit "counterproductive" coping patterns.

The second study was based on the observation that wives are involved in intervention efforts early in their recognition of their husbands' alcoholism, and respond with varying ways of coping (Wiseman, 1980). Sixty-seven women recruited through newspaper advertisements who identified themselves as wives of alcoholics were interviewed in-depth. The study indicated that wives use a number of

both direct and indirect approaches in attempting to change their husbands' drinking behavior long before husbands enter professional treatment. It was concluded that an appropriate use of this information would be to focus educational and counseling efforts at women whose husbands are in early stages of alcoholism in order to better adjust the wives' own behaviors and expectations.

The coping perspective primarily examined behavioral strategies for dealing with the alcoholism utilized by women married to alcoholic men. While this approach highlighted several basic coping patterns, this program of research remained narrowly focused on only the alcoholism. The final theoretical approach to be discussed advocated examining the larger influence of other factors within the family environment.

Family Environment/Life Stress

In a 1975 position paper Orford argued against the specialization imposed by the study of alcoholism as separate from other life stresses affecting a family. He pointed out that literature on marriages with an alcoholic member has typically made no mention of general family theory. Generalization from these families to other problematic families has been extremely limited. Thus, it has been suggested that alcoholism be examined within a more inclusive framework of family functioning, including other types of family crises, such as economic depression and unemployment, war separation and reunion, and death of a family member (Orford, 1975).

One relatively recent theoretical development does address these issues. A behavioral systems approach is currently being evaluated as a viable means for understanding the interactions between family variables and alcoholism (Jacob et al., 1985). This conceptualization suggests that the behavior of each individual family member is geared toward establishing complementary relationships between the alcoholism and each individual's own needs and strengths (Steinglass, Davis, & Berenson, 1977, as cited in Boyd, 1982).

One research approach utilizing multivariate analyses has examined a number of environmental variables in relationship to the psychological functioning of spouses of alcoholics (Finney et al., 1983; Moos et al., 1982). This approach, herein labeled the family environment/life stress perspective, incorporates elements of both the psychosocial stress theory and the coping perspective. It is theorized that spouse dysfunction is related to the interaction between existing personality traits and the stress of living with an alcoholic and to coping styles, as well as to factors such as nonalcohol-related stressful life events and social support.

Within this context, associations between nondrinking spouse variables and alcoholic partner variables have been examined (Finney et al., 1983; Moos et al., 1982). One focus of this research has been how spouses of relapsed alcoholics functioned compared to spouses of matched community controls (Moos et al., 1982). A conceptual framework was developed to evaluate nonalcoholic spouse functioning, such as alcohol consumption, depression, physical symptoms, and use of medication. Predictor variables included sociodemographic factors,

the functioning of the alcoholic (or matched control) partner, life events, coping behaviors, and social-environmental resources. The inclusion of the life change variable was based on the belief that while the alcoholism itself would influence the spouse functioning, other stressful events not directly related to the alcoholism might also have an effect. Results indicated that spouses married to relapsed alcoholics exhibited more negative functioning than community controls. Spouses of relapsed alcoholics reported more drinking problems, more negative life events, less cohesive family structures, more depression, and more medical conditions.

Based on these findings, a longitudinal model was developed which incorporated personal and environmental influences on the functioning of a nonalcoholic spouse married to an alcoholic partner (Finney et al., 1983). The predictor variables were alcoholic partner functioning (e.g., alcohol consumption, anxiety, occupational functioning), negative life events, and avoidance coping responses. Nonalcoholic spouse functioning was determined by four criteria: alcohol use, medication use, depression, and physical problems. Results indicated that while overall alcoholic partner functioning emerged as a strong predictor of negative spouse functioning, the alcoholic's drinking behavior per se was not influential. Rather, other components of the alcoholic partner's functioning such as occupational problems and depression had direct significant impact. Additionally, although neither negative life events nor avoidance coping responses were significant predictors for the composite spouse

functioning score, both variables influenced different criteria within that score.

Summary

This chapter has provided an overview of the various research approaches which have been utilized to study women married to alcoholic men. Table 1 presents a summary of the five approaches, principle investigators, research formats, and major conclusions.

It is evident from this review of the literature on wives of alcoholics that research strategies have become increasingly focused on complex interrelationships among numerous variables. The first two theories developed regarding the psychological problems of women married to alcoholics were both methodologically and conceptually limited. The disturbed personality theory, derived primarily from clinical case studies, addresses only the personality characteristics of the wife and does not mention any environmental influences (e.g., Price, 1945).

The sociological stress theory is similarly narrow in its perspective. Based on extensive interviews and observations, it was theorized that wives' psychological problems were due predominately to situational factors (e.g., Jackson, 1954). It is possible that this denial of any impact of personality on wives' functioning was an extreme reaction to the assumption of disturbed personality theory that a wife's pre-existing personality traits contribute to the maintenance of her husband's alcoholism.

The development of the psychosocial stress theory represented

Table 1. Major Research Approaches for Studying Wives of Alcoholics

Theory	Principle Investigators	Methodology	Conclusions
Disturbed Personality	Price (1945) Futterman (1953)	Clinical interview	Wives have psychological impairments which lead them to select alcoholic husbands; wives' problems increase if husbands stop drinking
Sociological Stress	Jackson (1954) Lemert (1960)	Observation/ interview	If wives have psychological impairments, it is due to the stress of living with alcoholic husbands
Psychosocial Stress	Kogan & Jackson (1960)	Survey	If wives have psychological impairments, it is due to a combination of pre-existing personality traits and the stress of living with alcoholic husbands
Coping	Orford & Guthrie (1968) Orford et al. (1975)	Survey	Wives share similar coping behaviors; choice of wives' coping behavior is related to husbands' drinking
Family Environment/ Life Stress	Moos et al. (1982) Finney et al. (1983)	Survey	Spouses' behavior is related to negative family environment and alcoholic partners' functioning

two major changes in research on wives of alcoholics (e.g., Kogan & Jackson, 1965). First, methodology became more empirical, and thus replicable, with the use of personality measures. Second, study conclusions began to take into account the possibility of both personality characteristics and environmental variables influencing wives' psychological functioning.

With the acknowledgment that psychological health of wives is the result of numerous factors, research attention turned for a time to exploratory analyses of wives' behavior. Studies of coping have provided fairly detailed descriptions of behaviors wives have engaged in to deal with their husbands' drinking (e.g., Orford et al., 1975; Schaffer & Tyler, 1979). This information is potentially quite valuable for education and treatment. To develop the most appropriate and effective intervention and prevention programs for women married to alcoholic men, it is essential to conduct comparable descriptive analyses of other aspects of these women's lives.

Studies within the family environment/life stress perspective have included personality, environmental, and coping behavior variables in their analyses of spouses of alcoholics (e.g., Finney et al., 1983). While this more comprehensive approach is advocated over the one- and two-dimensional analyses characteristic of earlier research traditions, it is possible that on a practical level valuable information may be lost. It is difficult to assess the impact of one variable when research constraints mandate that it be measured by only a few items in an extensive array of questions and instruments. The information gleaned in this way can provide guidelines; caution must

be used to avoid negating the role of a factor because of its minimal contribution to the findings of a comprehensive study. For example, using a selective list of ten negative events to evaluate the role of life stress (e.g., Finney et al., 1983) may miss information that a psychometrically sound life events instrument might detect.

Regardless of theoretical orientation, it has frequently been recognized that wives of alcoholics exhibit psychological distress (e.g., Finney et al., 1983; Kogan & Jackson, 1966; Price, 1945). This dissertation was based on this recognition and consequently designed to examine more completely several variables which may influence the psychological functioning of wives of alcoholic men. While this study is less comprehensive than research strategies advocated by the family environment/life stress approach, it is more multidimensional than the psychosocial stress approach.

Life events/social support and attribution models currently are being utilized extensively in efforts to understand psychological functioning in a variety of populations. The life events/social support model states that negative life events are associated with distress, and social support mediates the impact of those events. Aspects of this model have been incorporated into multivariate analyses of spouses of alcoholics (Finney et al., 1983; Moos et al., 1982); however, measurement of both the life stress and the social support constructs has been limited. In order to determine whether psychological problems of wives of alcoholics can be understood within this model, it is important to utilize valid, reliable, and complete

instruments. The following chapter examines the life stress/social support model in terms of historical development, measurement issues, and relevant research on wives of alcoholics.

The second model of psychological functioning is based on causal attributions. This model has provided consistent findings regarding cognitive patterns of individuals experiencing distress (Sweeney et al., 1986). To date the application of this model to women married to alcoholic men has not been evaluated. Chapter IV reviews causal attribution theory.

CHAPTER III

LIFE EVENTS AND SOCIAL SUPPORT

Life Events Research

Negative events and situations are frequently associated with physical malfunctioning (Dohrenwend & Dohrenwend, 1974). Early animal studies by Selye specified causal relationships between exposure to noxious agents and development of physical problems, such as enlarged adrenal glands and stomach ulcers (Selye, 1976). Early stress research was conducted under the premise that the main precipitating factors were physical or chemical in nature (Tache & Selye, 1978). Subsequent analyses of human subjects have strongly suggested that psychological factors are also instrumental in the development of physical stress manifestations (Selye, 1976). For example, researchers have noted relationships between stressful life situations and specific physical problems such as cardiac death (Rahe & Lind, 1971), hypertension (Karasek, Baker, Marxer, Ahlbom, & Theorell, 1981), and impaired immune system functioning (Irwin et al., 1987). Positive correlations of increased negative life events and increases in dysfunctional behavior have been supported in a number of realms. For instance, stressful incidents have been found to be associated with impaired job performance (Clinard, 1973), traffic accidents (Selzer & Vinokur, 1974), and delinquent behavior (Vaux & Ruggiero, 1983).

Of particular salience to this dissertation is the relationship

between stressful life events and psychological functioning. Researchers have consistently found significant, albeit small, associations between these variables across a variety of populations (Dohrenwend & Dohrenwend, 1974; Rabkin & Struening, 1976). This relationship has been reported in recent studies of college students (Rubio & Lubin, 1986), adult community residents (Lin, Woelfel & Light, 1985), married males (Jandorf, Deblinger, Neale, & Stone, 1986), employed working-class mothers (Parry, 1986), older adolescents (Compas, Wagner, Slavin, & Vannatta, 1986), and younger adolescents (Cohen, Burt, & Bjorck, 1987).

In the life events research, psychological functioning has most frequently been conceptualized in terms of depression (e.g., Cohen et al., 1987; Jandorf et al., 1986; Lin et al., 1985; Revicki & May, 1985). However, several other psychological problems have been investigated. Specifically, negative life events have been found to be associated with increased anxiety (e.g., Cohen et al., 1987; Parry, 1986; Sarason, Johnson, & Siegel, 1978) and impaired self-esteem (e.g., Cohen et al., 1987). Additionally, researchers have found significant associations between life stress and general ratings of psychiatric distress (e.g., Kale & Stenmark, 1983; Rubio & Lubin, 1986; Sarason et al., 1978).

Measurement

The earliest empirical investigations of the impact of major life events on an individual's well-being are typically credited to Holmes and Rahe (1967). In response to previous findings that

stressful life events were associated with changes in physical functioning, Holmes and Rahe (1967) developed an instrument to measure the number and extent of life changes individuals experience. This instrument, the Social Readjustment Rating Scale (SRRS), is a self-administered questionnaire evaluating significant changes in an individual's life, including personal, family, occupational, religious, financial, residence, social, and health areas. It is designed to measure the number of life changes reported by an individual within a specified time period. The 43 scale items have each been assigned a Life Change Unit (LCU) score estimated to reflect the degree of adjustment required by each event. These scores are then summed for a total LCU score.

The SRRS and modified versions have been used in a large number of studies evaluating the effects of stress on functioning (McGrath & Burkhart, 1983). Recent critiques of the scale have pointed out theoretical and methodological flaws (Felner, Farber, & Primavera, 1983; Lazarus, DeLongis, Folkman, & Gruen, 1985; Monat & Lazarus, 1977). Weightings of the different events are arbitrary, and comparisons between life events may be inappropriate. Additionally, by using established major life situations, the SRRS does not allow for evaluation of either personally unique life events or ongoing "minor" hassles which may also contribute to changes in functioning.

As a consequence of these concerns, numerous life event scales have been generated. While differences among these instruments have been noted, no one particular scale has emerged as strongly superior to others in measuring the impact of stressful life events. Rather,

different instruments appear to be more or less appropriate depending on the research task (Cohen & Wills, 1985).

Comparisons among the scales can be made on the basis of three features (Kale & Stenmark, 1983). The first feature concerns criteria for defining a life event as stressful. Some researchers propose that the variable of interest is the degree of change (e.g., Holmes & Rahe, 1967; Sarason, deMonchaux, & Hunt, 1975), whereas others suggest that only the negative and "distressful" aspects of a situation are important (e.g., Paykel, 1974). The second feature concerns the number and type of life events examined. While researchers acknowledge that inclusion of large numbers of events is not feasible, disagreement exists as to which items are most useful (Kale & Stenmark, 1983). Additionally, ambiguous wording of the items has been of concern (Sarason et al., 1975). The third issue involves the different scoring systems which have been designed to assess degree of life change. Two methods that have been commonly used are average ratings assigned by objective judges (e.g., Holmes & Rahe, 1967) and individualized ratings assigned by respondents themselves (e.g., Sarason et al., 1978). There appears to be little difference in predictive ability of life stress scores based on simple event counts, objective ratings, or individualized ratings (Cohen & Wills, 1985).

One life events scale developed which addresses these issues is the Life Experiences Survey (LES; Sarason et al., 1978). The LES is a checklist of 57 items with space to include up to three additional items. Respondents are asked to note those items which have occurred

to them within a specified time frame, and to rate how positive or negative each event was. The LES has been found to be correlated with such measures of psychological functioning as the Psychological Screening Inventory (PSI; Lanyon, 1970) (Sarason et al., 1978), the Beck Depression Inventory (BDI; Beck, 1967) (Ganellen & Blaney, 1984), and the Symptoms Checklist-90 (SCL-90; Derogatis, Lipman, & Covi, 1973) (Kale & Stenmark, 1983).

Life Events Research on Wives of Alcoholics

The impact of stressful life situations on psychological functioning of women married to alcoholic men has been investigated from several different perspectives. The earliest theoretical position regarding wives of alcoholics stated that the women had disturbed personalities which predated their selection of alcoholic husbands. This stance was refuted by Jackson and her colleagues with evidence indicating that degree of disturbance varied with drinking status of husbands (Jackson, 1956; Kogan, Fordyce, & Jackson, 1963; Kogan & Jackson, 1965). This research suggested that the stress of living with an alcoholic partner impairs psychological functioning of the nonalcoholic spouse.

To date, little research has been published evaluating life change specifically as a variable affecting wives of alcoholics. One large-scale study comparing spouses (i.e., both wives and husbands) of alcoholics with community controls incorporated elements of the Holmes and Rahe (1967) SRRS into its multivariate analysis (Moos et al., 1982). Twenty-three items were selected from the original scale to

measure life change. Seven of the items reflected positive events, ten were negative, and six were ambiguous.

Findings specifically related to life events revealed that spouses of relapsed alcoholics experienced more negative life events than either spouses of recovering alcoholics or spouses of community controls (Moos et al., 1982). Additionally, high depression scores (as assessed by the number of "yes" responses to seven statements) were significantly correlated with high life stress scores. Analysis of control spouses also indicated a high correlation between negative life events and depression. There were no significant relationships for either group between life stress scores and anxiety or physical symptoms.

A subsequent analysis examined the relative contributions of numerous variables to the functioning of nonalcoholic spouses. In terms of negative life events specifically, this study utilized ten items from the SRRS as a measure of environmental stressors (Finney et al., 1983). It was found that negative life events had no significant direct effect on either psychological or physical functioning of the nonalcoholic spouse. Negative life events were, however, strongly correlated with alcoholic partner dysfunction.

Summary

Life events research on women married to alcoholics is limited. One study which utilized a 23-item life events measure found that the higher life stress score a woman reported, the more likely she was to be depressed (Moos et al., 1982). A second study using a 10-item

instrument reported no association between life events and psychological problems (Finney et al., 1983).

It is suggested that the limited scope of both the life events and the psychological distress measures of the above studies has led to conflicting results about relationships between these variables. In order to address this problem, this dissertation used the Life Experiences Survey (LES; Sarason et al., 1978) and the Symptom Checklist-90 (SCL-90; Derogatis et al., 1973) to determine whether the impact of life events is associated with depression as well as other psychological symptomatology.

The LES is also valuable for descriptive purposes. The format of checking specific items which have occurred allows researchers to examine whether individuals of particular populations share similar life stresses. Additionally, the LES provides space for respondents to write up to three more events (Sarason et al., 1978).

One variable found to play an important role in the relationship between stressful life events and psychological functioning is social support (Cohen & Wills, 1985). The next section provides a brief overview of the construct, as well as various measurement concerns.

Social Support Research

While it has been noted that early researchers were interested in the presence of others as important for emotional well-being (Heller & Swindle, 1983), the concept of social support did not become formalized until the mid-1970's (Caplan, 1974; Cobb, 1976).

Researchers have studied numerous populations experiencing a range of stressful life situations, and have fairly consistently found the presence of supportive others to mediate the impact of stressful events. For example, in the recent past this relationship has been found among family physicians dealing with occupational stress (Revicki & May, 1985), cancer patients (Dunkel-Schetter, 1984), adolescent mothers (Unger & Wandersman, 1985), and adult community residents experiencing an undesirable event (Lin et al., 1985).

Measurement

It is evident that social support is an influential and important construct; however, there has been limited agreement on the definition of social support. In response to this lack of conceptual clarity, recent analyses have prefaced their introductions with discussions of this ambiguity (e.g., Barrera, Sandler, & Ramsay, 1981; Cohen & Wills, 1985; Gottlieb, 1983; Procidano & Heller, 1983; Shumaker & Brownell, 1984). One analytic framework outlines three particular themes of the social support construct: actual structure, actual function, and perceptions of both structure and function (Barrera et al., 1981; Cohen, McGowan, Fooskas, & Rose, 1984; Vaux & Harrison, 1985).

Evaluation of social support from a structural perspective involves analysis of social ties and networks. This approach is exemplified by Hirsch (1980) in his examination of naturally occurring support. Basically, a natural support system (NSS) is defined as "the set of presently significant others who are either members of one's

social network (i.e., family, friends) or affiliated non-mental health professionals (e.g., physicians, clergy)" (Hirsch, 1980, p. 160). To determine the structure of various types of an NSS, Hirsch studied young recent widows and older (i.e., over age 30) undergraduate women. Measures of NSS included a self-report of contact with significant others during a specified time period, a log tracking daily interactions, a mapping of interactions among members of the support system, and a scale rating the helpfulness or unhelpfulness of those members. Analyses of resulting networks indicated that for both groups these structural features had a significant impact on subjects' subsequent successful adaptation to stress.

A second theme of social support research concerns function. One such analysis conducted by Barrera et al. (1981) defined social support as "tangible forms of assistance such as the provision of foods and services as well as intangible forms such as guidance and expressions of esteem" (p. 438). While in many circumstances this type of support has not been found to mediate the impact of negative events, there is evidence of limited influence. For example, individuals with an internal locus of control are more likely than externals to report fewer incidents of depression and anxiety following stressful events if they are receiving tangible support (Sandler & Lakey, 1982). Additionally, support in the specific form of information about love and esteem has been found to enhance psychological well-being (Turner, 1981).

While the first two approaches are concerned with actual

dimensions of support, the third perspective focuses on individual perceptions of availability and use of support networks. Perceived social support (PSS) is thus defined as "the extent to which an individual believes that his/her needs for support, information, and feedback are fulfilled" (Procidano & Heller, 1983, p. 2). PSS is distinguished from actual network support by personal interpretation. It is suggested that the perceptions are likely to vary according to personal characteristics. Both long-standing personality traits and temporal changes in mood or attitude may affect an individual's assessment of social support (Procidano & Heller, 1983). This perception in turn is posited to affect appraisal of and coping with stress.

To tap PSS, Procidano and Heller (1983) developed two scales to measure the extent to which an individual's needs for information and support are met by friends and family. Items reflect subjective beliefs about relationships with others (e.g., "My friends are sensitive to my personal needs"; "My family enjoys hearing about what I think.") Results of administration of these scales to an undergraduate population indicated that perception of social support is related to long-term characteristics such as psychopathology and social competence.

Social Support Research on Wives of Alcoholics

The use of social support per se by wives of alcoholics has not been systematically investigated. For example, in the research utilizing the Coping with Drinking Questionnaire no specific uses of

social support were reported (e.g., Orford & Guthrie, 1968; Orford et al., 1975). Creation of the questionnaire was based on in-depth individual and group interviews with wives of alcoholics. Each of the coping items in the scale had been mentioned by at least one of the wives in the preliminary interviews. While three of the questions asked about sources of professional support (i.e., from a lawyer, a physician, and Al-Anon), none of the items dealt with informal sources of support from friends or family members. However, one recent research program has incorporated different elements of the social support construct into its investigations.

Research conducted by Moos and colleagues has evaluated the contributions of different variables to the overall functioning of the spouse of the alcoholic (e.g., Finney et al., 1983; Moos et al., 1982). One study used two different sets of measures to tap components of social support: social functioning and social-environmental resources (Moos et al., 1982). Social functioning was determined by social contacts (i.e., number of visits in the past month with friends or relatives), social activities (i.e., number of social, recreational, and cultural activities in the past month with family members), and religious participation (i.e., number of services attended in the past month). Social-environmental resources were measured by social network connections (i.e., number of individuals one could confide in), family environment indices, and work environment indices. Results indicated that spouses of both recovering and relapsed alcoholics had fewer informal social contacts than spouses of community controls. Additionally, spouses of the

relapsed partners reported less cohesion in their family environment than the other two groups. No other differences regarding these variables emerged.

A second study predicted that environmental stress would contribute to a negative family environment, which in turn would affect functioning of the nonalcoholic spouse (Finney et al., 1983). Family environment was determined by measures of cohesion, expressiveness, moral and religious emphasis, recreation, organization, and conflict. It was found again that negative family environments were associated with two factors. Both the use of avoidance of tension management strategies by the nonalcoholic spouse and impairment of functioning of the nonalcoholic spouse were related to a negative family environment. No other associations were reported.

Summary

Social support has repeatedly been found to be associated with healthier psychological functioning (e.g., Cohen & Wills, 1985). To date, research on wives of alcoholic men has been limited in its assessment of social support. In order to understand more completely the experience of women married to alcoholic husbands, it is important that any variable possibly contributing to psychological health be considered. Some investigation has been done regarding both social support structure and function (e.g., Finney et al., 1983; Moos et al., 1982). It is suggested, however, that the assessment of perceptions about available support may be a more appropriate strategy

for this population. Families with alcoholic members tend to be disrupted; support structure and function may also be impaired. Women married to alcoholics may respond to these problems by forming alternative support networks. Thus, perceptions of social support, rather than actual structure or function, may more accurately reflect these women's experiences.

This dissertation utilized the Perceived Social Support scales (PSS; Procidano & Heller, 1983) to determine relationships between social support, stressful life events, and psychological functioning. It was predicted that higher perceptions of support from both friends and family would be associated with lower levels of psychological distress.

This dissertation also conducted an exploratory analysis of the role of causal attributions in psychological functioning of wives of alcoholic men. The next chapter reviews the theoretical and empirical work regarding causal attributions.

CHAPTER IV

CAUSAL ATTRIBUTION RESEARCH

Causal attribution models are designed to describe how individuals perceive causes of events and behaviors. Typically the origins of formal attribution theory are traced to Heider (Antaki, 1982). In 1958, Heider published The Psychology of Interpersonal Relations in which he posited that individuals try to understand the world by determining the causes of their own and others' behavior. His initial analysis suggested that individuals attributed behavior to one of two sources: personal (i.e., caused by something internal to a person) or environmental (i.e., caused by an external source).

The second generally acknowledged major contribution to attribution theory comes from the work of Jones and Davis (1965). Based on Heider's (1958) work, these researchers developed the theory of correspondent inferences to explain the process by which individuals determine whether another's behavior is due to personal or environmental causes. They suggested that when an individual's actions can be explained by any number of evident, observable causes, the perceiver is unable to make any dispositional judgments regarding the individual. On the other hand, if the individual's behavior is out of role or noncommon, the perceiver is likely to attribute the cause to internal traits of the individual.

In an elaboration of this analysis, Kelley (1967) developed a model to explain attributional processes based on not just one isolated behavior, as Jones and Davis (1965) had done, but rather on

the perceiver's more extensive knowledge about the individual and the behavior. Kelley proposed that perceivers interpret others' behaviors based on three factors: consistency, distinctiveness, and consensus. Information regarding consistency is based on similarity of behavior by the actor in different situations; and consensus is based on behavior of other people in similar situations. Thus, each of these dimensions contributes to an observer's interpretation of whether another's behavior is internally or externally caused.

Jones and Nisbett (1971) contended that perceivers' information regarding others' behavior was more limited than Kelley's (1967) model would suggest. They suggested that actors and observers tend to attribute behavioral causes to different sources. While an observer may have considerable access to an actor's personal history, the actor typically has more--and more precise--information regarding both personal and environmental causes of his or her behavior. Consequently, as Jones and Nisbett (1971) noted, observers have a tendency to attribute another's behavior to stable, personal causes, whereas actors are more likely to place responsibility for their own behavior on external, situational factors.

This developing framework of attributional processes has generated hundreds of studies (Kelley & Michela, 1980). Out of these, two fairly complete conceptual models have emerged which focus on the impact of attributions. These models--a two-dimensional model of achievement and a three-dimensional model of psychological

functioning--have in turn generated both theoretical evaluation and practical application.

Attributional Theory: Achievement

In their early studies of achievement motivation, Weiner et al. (1971) proposed that individuals cognitively evaluated behavioral outcomes based on two dimensions. The first dimension is the internal/external one initially proposed by Heider (1958) and elaborated upon by others. It was suggested that the earlier locus of causality research was confounded by comparing internal, temporary attributions with external, enduring attributions. Thus it was suggested that the temporal qualities of an attribution--that is, whether the attribution is to a factor that is long-standing and stable versus transitory and unstable--are influential in determining perceptions of outcome.

Weiner et al. (1971) incorporated both dimensions into a 2 x 2 matrix for their study of achievement related cognitions. They predicted that individuals would assign responsibility for their successes or failures to one of four categories:

stability	Locus of causality	
	internal	external
stable	ability	task difficulty
unstable	effort	luck

Empirical research has established that these causal dimensions have important consequences. Whether an individual attributes success or failure to ability, effort, task difficulty, or luck has been associated with differences in both cognitive expectations and affective responses. In evaluating expectations for further outcomes, it has been found that individuals who attribute their successes to stable causes are likely to express expectations for success in future endeavors (Bar-Tal, 1982). Likewise, failure in one situation is likely to lead to expectations for failure in the future. Individuals attributing achievement outcomes to unstable causes may expect different outcomes in the future, depending on the changing causes (Bar-Tal, 1982).

The two-dimensional causal attribution model has also been used to investigate relationships between achievement outcome and affective reactions (Bar-Tal, 1982). Weiner, Russell, and Lerman (1978) analyzed responses by lay persons to a questionnaire associating attributions for success and failure with intensity and quality of emotional experiences. They observed specific relationships between affect and attributions. For instance, when success was attributed to luck, the affective response was typically surprise. When success was attributed to another's effort or personality, the corresponding affect was gratitude. Similar consistent associations were found with failure. When failure was attributed to ability, the corresponding affect was feelings of incompetence. Failure perceived due to another's effort or personality was met with feelings of aggression.

Attributional Theory: Psychological Functioning

Early Research

A second major research focus has examined the influence of causal attributions on psychological impairment, particularly depression. This approach originated with animal studies on learning (Seligman, 1974). Harnessed dogs were subjected to 60 to 80 five-second shocks from which there was no escape. Twenty-four hours later the dogs were placed in a shuttlebox with an available escape route. The researchers found that the dogs were unable to learn to escape from the shock. Three specific deficits were noted. A cognitive deficit was indicated when the dogs were unable to learn to avoid shock. After initially whining and running in circles, the dogs lay down passively and exhibited no overt affective reaction, suggesting an emotional deficit. The third deficit, that of motivation, emerged with the lack of effort to escape the shock. It was speculated that the dogs learned that the shock and their behavior were not related, thus leading to a phenomenon the researchers labeled learned helplessness.

Subsequent laboratory research with humans replicated these basic findings (Hiroto, 1974). Subjects from a university population were asked to sit in a room with headphones on. They were then exposed to one of three conditions: aversive noise which could not be terminated, aversive noise which could be terminated by pressing a button, and no noise. In a second task subjects placed their hands in a shuttlebox, then were subjected to aversive noise. Results were

similar to those of the dog studies. Those who had experienced either no noise or control over the noise in the first part of the study quickly learned the responses to terminate the noise. Those who were originally subjected to uncontrollable noise showed cognitive deficits; that is, they passively accepted the noise and did not learn the behavior to end it.

Reformulated Model

While the basic learned helplessness model was adequate in assessing human behavior in laboratory settings, it soon became evident that generalization to other life situations was limited (Abramson et al., 1978). Several issues were of major concern. One question asked why some negative life events led to global learning deficits while others had only specific consequences. A second concern addressed the permanence of the helplessness response.

In an attempt to account for these cognitive variations, Abramson et al. (1978) elaborated on the basic model to reformulate the learned helplessness model. This model is designed to examine attributional differences in the perceptions of the causes of life events. As with Weiner et al. (1971), this model assesses locus of causality and temporal stability of events. That is, the model predicts individuals will perceive events as being internally or externally caused, and as being temporary or enduring. The reformulation also suggests that a third attributional dimension also exists--that of how specific or global a cause is. Individuals believing that the cause of an event is limited to just that event are

holding specific attributions, whereas those believing that the cause of an event will also affect a variety of outcomes are making global attributions (Peterson & Seligman, 1983).

The primary application of this model has been in the study of depression. This incorporation of cognition into understanding depression is based on theoretical work by Beck (1976). Theorists have been exploring the role of different beliefs, including causal attributions about both specific events and life in general. The reformulated model of learned helplessness has predicted that depressed individuals tend to attribute negative situations to internal and stable causes with global consequences, resulting in lowered self-esteem (Abramson et al., 1978). Additionally, these individuals attribute positive events to external, unstable, and specific causes.

Measurement

Since the inception of the reformulated learned helplessness model, over 100 studies have been generated to examine the relationship between causal attributions and depression (Sweeney et al., 1986). Assessments of attributions during this short history have basically taken three forms. One approach, based on the two-dimension achievement model, involved asking respondents to indicate how much specified important life events (both positive and negative) were due to ability, effort, the situation, and chance (e.g., Harvey, 1981; Rizley, 1978). This measurement format has been found to be problematic. The question has been raised as to whether theorists and

respondents perceive these four causes along the same dimensions (Peterson et al., 1982). That is, while a theorist might ascribe low stability to effort, a respondent might perceive effort as long-standing and stable.

A second measurement format has been to ask respondents open-ended questions about the causes of events in their lives. This approach, however, has been found to be less reliable than structured measures (Elig & Frieze, 1979).

A third procedure evolved as a compromise of the two previous strategies (Peterson et al., 1982), and has consequently been used by most researchers within this area (Sweeney et al., 1986). This format involves asking respondents to generate causes for particular events in their lives, and then to indicate to what extent the causes are internal or external, stable or transient, and global or specific (Gong-Guy & Hammen, 1980; Peterson et al., 1982).

A meta-analysis conducted on over 100 published and unpublished studies revealed that depression was more likely to be associated with attributions which were high in internality, stability, and globality, rather than with attributions low on these dimensions (Sweeney et al., 1986). These findings were consistent across populations (college students, clinical, and other), across outcomes (hypothetical, real-life, and experimental), and across settings (university lab, hospital, classroom, and other).

Development of the learned helplessness model focused on depression as the psychological impairment associated with specific attributions (Abramson et al., 1978). Subsequently, many analyses

have utilized the Beck Depression Inventory (BDI; Beck, 1967) to measure the degree of dysfunction. It has been observed, however, that university students who score high on the BDI are also likely to have high scores on other measures of psychopathology (Gotlieb, 1984). For example, the BDI was found to be highly correlated with all nine subscales of the SCL-90 (Derogatis et al., 1973) (i.e., somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic-anxiety, paranoid ideation, and psychoticism).

Based on these findings, the suggestion was made that the reformulated model of learned helplessness may not only be applicable to depression, but to other types of psychological dysfunction as well (Gotlieb, 1984). Results of one study using university students indicated that internal, stable, and global attributions were associated with anxiety, unassertiveness, and psychosomatic symptoms, as well as with depression (Nezu, Nezu, & Nezu, 1986).

Attributional Research on Wives of Alcoholics

Both the attributional theory of achievement and the attributional reformulation of learned helplessness have been utilized to examine a variety of social problems, such as victimization (Peterson & Seligman, 1983), loneliness (Peplau, Russell, & Heim, 1979), and parole decisions (Carroll, 1979). No analyses to date have examined the role of causal attributions in the life experience of wives of alcoholics. However, there are two areas of research which are particularly relevant to this study. These areas do not directly

assess beliefs about the causes of an inclusive measure of stressful life events. Rather, they both focus on attributions about specific life experiences, such as alcoholism (McHugh, Beckman, & Frieze, 1979) and wife-battering (Frieze, 1979a).

Alcoholism

McHugh et al. (1979) examined the causal theories of alcoholism and subsequent implications for treatment of and behavior toward alcoholics. They noted that etiological beliefs of both the professional and lay populations have changed from the view that alcoholics are morally weak and degenerate to the view that alcoholics are suffering from a physiological addiction.

Working from the premise that what one believes to be the cause of one's alcoholism will determine how effective different treatment modalities are, researchers have begun to examine casual beliefs of alcoholics themselves (McHugh, 1979). To ascertain what causal attribution categories are frequently in use, both alcoholic and nonalcoholic respondents were presented with a scenario depicting an alcoholic individual. Respondents were asked to give the reasons why the hypothetical person (sometimes male; sometimes female) drank. Responses were as listed below. No significant differences were found between the causal perceptions of alcoholics and nonalcoholics.

1. External factors (e.g., job pressures).
2. Dissatisfaction (e.g., general unhappiness).
3. Interaction of personal and external factors (e.g., bad relationship with spouse).

4. Addiction.
5. Personal characteristics (e.g., feeling inadequate).
6. Boredom.
7. Escape (e.g., hiding from problems).
8. Liking to drink.
9. Illness (e.g., physiological causes).

A related study evaluated the attributions of adult nonalcoholic women (Frieze, 1979b). One hundred and fifty-two respondents were asked to explain alcoholism in another woman. While the same basic categories described in the McHugh (1979) study were found, several differences were evident. Both "dissatisfaction" and "escape" were reported significantly more often as causes, with "dissatisfaction" cited as the most common reason. Fewer attributions were made to either "addiction" or "liking to drink," and no attributions were made to "illness."

The actor-observer causal model was used to predict that alcoholics would ascribe (as observers) greater responsibility to internal factors when asked about the reasons for another's alcoholism and (as actors) greater responsibility to external factors when asked about the reasons for their own alcoholism (Beckman, 1979). Nonalcoholics, as observers, were expected to attribute the causes of alcoholism to internal factors. Participants (120 female alcoholics, 120 male alcoholics, 118 female nonalcoholic controls) were asked to rate the importance of different possible causal factors for alcoholism in most people. All three groups rated the individual's

own responsibility highest, and a distressing event next highest; there were no significant differences among the three groups. Questions were then asked to determine the alcoholics' perceptions of their own drinking and the nonalcoholics' perceptions of others' drinking. While there were no differences between the female and male alcoholics' beliefs, a difference did emerge between alcoholic and nonalcoholic women. Distressing events were assigned less importance by alcoholic women for their own alcoholism than by nonalcoholic women for others' drinking.

Various surveys have been conducted to determine causal beliefs held by professionals and preprofessionals dealing with alcoholics (e.g., psychiatrists, physicians, student nurses) (McHugh et al., 1979). To date, however, there has been no comparable report concerning attributions made by wives of alcoholics. Behaviorally, it has been suggested that in relating to their alcoholic husbands, wives hold two conflicting roles--therapists and wives (Wiseman, 1980). They act as therapists in seeking ways to help their husbands admit to and deal with the alcoholism. As wives, they often have the advantages of both being in an already established relationship and having knowledge of the development of the problem. The conflict arises in that they do not possess the same status as professional therapists and are thus perceived as less credible by their husbands. These particular patterns suggest that a systematic analysis of wives' causal attributions would be appropriate to further understanding of the wives' behavior.

Wife-Battering

In examining the relationship between causal attributions and psychological functioning for women married to alcoholics, it is instructive to examine how beliefs of women in other stressful situations have been investigated. This review will discuss exploratory research conducted regarding battered women, as these women are comparable to wives of alcoholics in that both are affected by their husbands' problematic behavior.

Three major factors have been identified as contributing to beliefs battered women might hold about the causes of their husbands' battering (Frieze, 1979a). Both frequency and severity of batterings are expected to influence beliefs. Also women would be expected to be subject to attributional biases. Two conflicting biases may be operating. On the one hand, research on egocentricity predicts that women would believe they are responsible for positive things that happen to them, and others are to be blamed for negative events. Thus, attributions for battering would be made to husbands or other external factors.

On the other hand, the literature on victimization suggests that the women would make internal, characterological attributions for the battering. If either an episode of battering or the entire marriage itself were regarded as a failure, this paradigm might also be applied to the women's perceptions.

Using the framework suggested by the achievement model, a two dimensional format was designed to code possible explanations by women for their husbands' battering (Frieze, 1979a). The dimensions were

identified as stability ("stable," "unstable," "uncertain") and locus of causality ("internal to wife," "internal to husband," "joint responsibility," and "environmental").

To examine attributional trends, 68 women were asked about their husbands' battering. Forty-one respondents were self-identified battered women who had either sought help at a crisis center, filed legal action, or answered public advertisements. Additionally, 27 of 82 women selected for a study on "marriage dynamics" reported experiencing violence within their marriage. Degree of abuse ranged from a few slaps to extreme physical injury.

Within the context of formal interviews the 68 women were asked two open-ended questions designed to tap attributions: "Did you understand at the time why he was violent?" and "Thinking back on all the times he was violent, do you notice any general pattern(s) to his violence, and particular times more than others that you might also expect it?" The majority of responses to the first question were "Don't know." Of those who did give attributions, the tendency was to give unstable reasons. While the women were somewhat more likely to blame themselves, almost as many respondents blamed their husbands for the battering. For the attributions regarding patterns of violence, the women were more likely to give stable, husband-blaming causes.

Summary

Causal attribution theory has been extensively applied in attempting to understand why certain behaviors emerge. Models have

been developed to explain both achievement and depression.

Researchers have also adopted an attributional approach in an effort to understand reactions to specific negative life situations.

Attributional research on women married to alcoholics has thus far not examined beliefs about the causes of their husbands' alcoholism in particular nor beliefs about the causes of other negative life events. This population does manifest psychological problems (e.g., Boyd, 1982; Finney et al, 1983; Jacob et al., 1985). Therefore, in order to have a more complete conceptual understanding of the behavior and functioning of wives of alcoholic men, an examination of attributional patterns could prove valuable. More critically, information derived from these analyses can prove valuable to the development of appropriate treatment and prevention programs in the area of alcoholism.

This dissertation includes an analysis of the causal attributions women married to alcoholics hold about the negative events in their lives. Wives are not asked about causes of their husbands' alcoholism. Rather, they are asked to indicate their beliefs about the causes of negative events in their lives, both in general and as related specifically to their husbands' drinking. These beliefs are: the extent to which the cause of an event is internal (i.e., due to something about the wife); the extent to which the cause is stable and long-lasting; and the extent to which this cause is global (i.e., the extent to which the cause of this event is also the cause of other events in the woman's life).

CHAPTER V

RATIONALE FOR THIS STUDY

Research on women married to alcoholic men indicates that most investigators note that these women frequently experience some degree of psychological symptomology (e.g., Kogan & Jackson, 1965; Moos et al., 1983; Price, 1945). While researchers have utilized numerous strategies to explain and describe impairments among these women, two current and viable models of psychological distress have not been systematically adopted.

Aspects of the life stress/social support model have been incorporated into recent studies of wives of alcoholic men (Finney et al., 1982; Moos et al., 1983). Results from these studies present conflicting information about relationships between negative life events, social support structure and function, and psychological impairment. To examine these relationships more completely, this dissertation adopted instruments which have been used among a variety of other populations. Both the life events inventory (i.e., the LES; Sarason et al., 1978) and the measure of psychological dysfunctioning (i.e., the SCL-90; Derogatis et al., 1973) are more comprehensive than instruments used in the above studies. Additionally, the LES allows for detailed descriptive analyses of stressful life events reported by wives of alcoholics. The rate of environmental disruption could vary greatly among respondents whose husbands are alcoholic, leading to difficulties in assessing support structure or function. Thus, it is suggested that measures of perceptions about social support (i.e., the

PSS-family and the PSS-friends; Procidano & Heller, 1983) may be more appropriate for this population.

The attribution model of psychological dysfunction has to date not been utilized in the study of women married to alcoholic men. It is plausible that use of an instrument such as the Attribution Questionnaire (AQ; Gong-Guy & Hammen, 1980) to tap beliefs about negative events experienced by wives of alcoholics may prove valuable in understanding the manifestation of psychological impairment among these women.

Thus, the variables of interest in this study are:

Predictor Variables

life stress
(as measured by the LES)

perceived social support
(as measured by the PSS)

causal attributions
(as measured by the AQ)

Outcome Variable

psychological distress
(as measured by the SCL-90)

Research Questions

Based on the existing theoretical and empirical research, a number of research questions can be generated to analyze relationships among stressful life events, social support, causal attributions, and psychological functioning of women married to alcoholic men. This dissertation addresses the following research questions:

1. Life events research has consistently indicated that changes which are perceived as negative lead to psychological

distress. Thus, it was hypothesized that negative life events are associated with psychological dysfunction in wives of alcoholics.

2. It was predicted that wives reporting high levels of perceived social support from family tend to have lower levels of psychological distress than wives reporting low levels of social support. That is, the greater social support a woman reports, the less likely she is to have dysfunctional symptomatology. Likewise, it was predicted that wives reporting high perceived social support from friends also have lower levels of psychological dysfunctioning than wives reporting low levels of support.

3. Research has consistently noted that high levels of negative life events are associated with psychological problems, while high levels of social support are related to lower symptomology scores (Cohen & Wills, 1985). The nature of the relationship between life stress and social support, however, has not been clearly delineated (Saldaña, 1988). This dissertation examines two possible relationships:

a. Does social support have a buffering effect? For those women reporting high levels of negative life events, does the existence of social support influence the degree of psychological distress?

b. Does social support have a direct protective effect? That is, do high levels of perceived social support protect wives of alcoholic men from experiencing high levels of symptomology regardless of level of life stress?

4. The research regarding the role of causal attributions on

subsequent psychological functioning is inconclusive. However, one individual prediction is possible. The research on depression indicates that persons in both clinical and student populations holding internal, stable, and global attributions for negative events in their lives are more likely to be depressed than those making external, transient, and specific attributions (Sweeney, Anderson, & Bailey, 1986). Therefore, for this study the following predictions were made:

a. Internal attributions are associated with greater psychological distress among wives of alcoholics.

b. Stable attributions are associated with greater psychological distress among wives of alcoholics.

c. Global attributions are associated with greater psychological distress among wives of alcoholics.

5. This dissertation also examined the relationships between causal attributions and social support. It was an open question as to whether the degrees of internality, stability, and/or globality for either negative life events in general or husbands' alcoholism in particular are associated with perceptions of social support from family members.

6. It was also an open question as to whether internality, stability, and/or globality are associated with perceptions of social support from friends.

CHAPTER VI

METHOD

Subject Recruitment

Research Sites

In selecting research sites for this study, 13 alcoholism treatment programs throughout the United States were contacted by telephone. Each program was then sent a detailed written description of the project, which included a cover letter (Appendix A) and copies of approved requests for use of human subjects from both The University of Tennessee and New Mexico State University (Appendix B).

Five alcoholism treatment facilities agreed to recruit spouses for the study. Written descriptions and relevant program information provided by each facility are presented in Appendixes C-G. The five facilities which participated are: the Residential Treatment Facility, William Beaumont Hospital, El Paso, TX ($n = 64$) (see Appendix C); Hotel Dieu Treatment Center, El Paso, TX ($n = 13$) (see Appendix D); St. Vincent's Stress Center, Indianapolis, IN ($n = 12$) (see Appendix E); the Alcohol and Drug Rehabilitation Center, The University of Tennessee Hospital, Knoxville, TN ($n = 5$) (see Appendix F); and the Addiction Treatment Unit, St. Mary's Medical Center, Knoxville, TN ($n = 4$) (see Appendix G).

The Residential Treatment Facility (RTF) is an alcohol and chemical dependency program operated by the United States Army. All patients are army personnel who have been sent for treatment from

their respective assignments, and are thus not representative of any specific geographical region. Patients are in treatment for six weeks. During the last two weeks, their spouses are required to also enter residential treatment. The treatment program for these spouses includes both individual and couple counseling.

The other four treatment programs utilized in this study are all civilian operated. While treatment for chemically dependent individuals is conducted on an inpatient basis, their spouses participate on an outpatient basis in joint programs with the patients and in groups for the spouses alone.

Procedures

At each of the facilities, a staff member acted as liaison for this study. These designated individuals were responsible for explaining the project as well as distributing and collecting the questionnaires. (For detailed accounts of how the questionnaire packets were handled at the specific facilities, see Appendixes C-G.)

The liaison person for each program informed potential respondents that participation in the study was completely voluntary and independent of treatment. He/she also explained that no individual data would be released to staff members of the facilities, and that anyone at any time could withdraw from the study with no negative consequences. The women were also given this author's home and work telephone numbers and were told to call collect should they have any problems or concerns. No telephone calls were made to the author. These conditions were explained both verbally and on an

informed consent form respondents were asked to sign (see Appendix H for a copy of the consent form). Each respondent also kept a second copy of the informed consent form for her own information.

The liaison person then distributed the questionnaire packets to interested women. Based on a pilot administration of these questionnaires to a university population ($n = 106$) (McKenzie & van Meighem, 1987), it was expected that respondents would complete the surveys within 60 minutes. Upon completion, the liaison person collected the questionnaires and returned them to this author. These staff members also collected the signed consent forms and returned them to this author separately from the completed questionnaires.

Final Sample

Respondents were 105 women whose husbands had been diagnosed as alcoholic and at the time of the study were undergoing treatment for the alcoholism. Seven of the returned questionnaire packets were omitted for the following reasons: three respondents did not complete two or more of the questionnaires; two respondents indicated that their husbands' problems were due to other drugs and not to alcohol; one respondent indicated her husband did not have a drinking problem; and one respondent was a man. The final sample size for the study was 98.

Instruments

Items in the questionnaire packets were stapled in the following order: two informed consent sheets, the Life Experiences

Survey (LES), the Attribution Questionnaire (AQ), Perceived Social Support--Friends (PSS-fr) and Perceived Social Support--Family (PSS-fa) scales, the Symptom Checklist-90 (SCL-90), and a page of sociodemographic items labeled Fact Sheet. Each of these instruments is outlined below. Since the AQ directed respondents to comment on items marked on the LES, it was placed immediately after the LES in the questionnaire packet. To maintain conceptual consistency, however, the social support scales are presented here before the AQ.

Life Experiences Survey (LES)

The original LES is a 57-item self-report measure of significant events which occurred during the preceding 12 months of the respondent's life (Sarason et al., 1978) (see Appendix I). The first 47 items are derived from commonly reported life changes experienced by the general population in areas such as family, community, employment, and health. For example, the remaining 10 items of the LES are specifically geared toward a college population.

Respondents indicate which events they have experienced, and what impact these events have had. Respondents provide their own assessment of the impact, which can range from extremely negative (-3) to extremely positive (+3). Thus, three scores can be derived from this instrument: sum of impact scores of negative life events, sum of impact scores of positive life events, and absolute total of impact scores of all life events. A unique feature of this scale is the inclusion of space to write up to three unlisted experiences which respondents feel have had an impact on their lives.

Psychometric properties. Pearson product-moment correlations have been computed to determine test-retest reliability of the LES (Sarason et al., 1978). Two separate studies tested undergraduate students twice with intervening five to six-week periods. Responses of positive, negative, and total life changes from each administration were analyzed. The first study ($n = 34$) reported significant correlations for the negative (.56, $p < .001$) and total (.63, $p < .001$) life change scores. The second study ($n = 58$) reported significant correlations for all three change scores: positive (.53, $p < .001$), negative (.88, $p < .001$), and total (.64, $p < .001$).

Modifications for this study. The LES was modified somewhat for this study. As this dissertation is concerned specifically with married women who are not necessarily in a university setting, items specific to single individuals, men, and students were eliminated. This included both the 10 items which were included at the end of the original LES for college students as well as those listed below which were deleted for this study:

(Male) Wife/girlfriend's pregnancy

(Married male) Change in wife's work outside the home

(beginning work, ceasing to work, changing to a new job)

(Male) Wife/girlfriend having abortion

Engagement

Breaking up with boyfriend/girlfriend

Leaving home for the first time

Reconciliation with boyfriend/girlfriend.

Through discussion with individuals who have worked directly with alcoholics and their families, it was noted that problems concerning sexuality and violence frequently are associated with alcoholism (see also Frieze, 1980; Russell, 1982). It was decided that inclusion of several additional items would be appropriate. The life events considered of possible relevance to women in general and wives of alcoholic men in particular are listed below.

Physical assault by husband

Physical assault by someone other than husband

Sexual assault by husband

Sexual assault by someone other than husband

Sexual difficulties with husband.

With these two modifications there are a total of 47 items listed on the LES, as well as the three blank spaces. Additionally, the LES instructions for this study were modified so that the respondent indicated stressful life events which she experienced in the three months before her husband was accepted for treatment.

Perceived Social Support Friends (PSS-fr)
and Family (PSS-fa)

The PSS-fr and PSS-fa are two separate scales designed to elicit information regarding feelings and experiences one has with one's friends and family respectively (Procidano & Heller, 1983) (see Appendix J). Each scale is comprised of 20 statements. Respondents are asked to indicate "yes," "no," or "don't know" for each item. To

determine each PSS score, each "yes" response is assigned a value of 1 and each "no" and "don't know" response a value of 0. Thus, the score for each PSS measure can range from 0 to 20.

Psychometric properties. Developers of the PSS measures indicated that a preliminary 35-item instrument was found to have both high test-retest reliability ($r = .83$ over a one-month time period) and internal consistency (Cronbach's alpha = .90) (Procidano & Heller, 1983). Analyses of PSS-fr and PSS-fa revealed that these subsequent scales are also internally consistent (Cronbach's alpha is equal to .88 and .90, respectively).

Modifications for this study. The instructions for the PSS-fa were modified for this study. (The PSS-fr was not modified.) The original PSS-fa instructed respondents to provide thoughts regarding their relationships with their families. Because of possible discrepancies the women of this study might experience between their relationships with their husbands and relationships with other family members, two additional sentences were included to restrict the meaning of "family." These sentences read: "For this questionnaire, please think of your family as being anybody you are related to through blood or marriage except your husband. I am interested in how you related to other family members besides your husband."

Attribution Questionnaire (AQ)

The original AQ was developed by Gong Guy and Hammen (1980) (see Appendix K). This instrument asks respondents to select and

answer questions about specified events. For each event, respondents are directed to answer questions regarding how upsetting the event was and perceptions of control, locus of causality, stability, and globality.

Seven-point Likert-type scales are utilized to measure to what extent respondents indicate the causes of a specified event to be: internal (1: "something about me") or external (7: "something about the situation or other persons"); and transient (1: "something that changes") or stable (7: "something unchanging"). Whether the causes of the event are believed to be global or specific is assessed by responses to the question: "To what extent do the causes of this event affect other areas of your life?" Responses range from 1 ("not at all") to 7 ("a great deal").

Psychometric properties. This instrument has been found to have reasonable concurrent validity with observed attribution ratings of spontaneously presented stressful events (Gong-Guy & Hammen, 1980). Statistically significant agreement between raters evaluating personal interviews and the Attribution Questionnaire has been reported for several of the scales. When the scores from the seven-point scale were converted to a dichotomous scale, agreement was attained at the $p < .01$ level for dimensions of upset (Kappa coefficient = .81), locus of causality (Kappa coefficient = .54), and globality (Kappa coefficient = .46). Agreement was at the $p < .05$ level for the stability dimension (Kappa coefficient = .38).

Modifications for this study. For this study, respondents

answered questions about the most negative event marked on the LES, the second most negative event marked on the LES, the most negative event believed to be directly related to husband's drinking, and the second most negative event believed to be directly related to husband's drinking.

The items listed below from the original Attribution Questionnaire (Gong-Guy & Hammen, 1980) were deleted from the instrument for this study. Dimensions these items were designed to tap were not considered relevant.

a. How likely do you feel it is that a similar event will occur in your life in the next three years? (Try to give an estimate based on your personal feelings rather than based on a rational judgment.)

b. If this event occurred primarily because of something about you, to what extent did you intend for this event to happen?

(or)

If this event occurred primarily because of something about the situation or person, to what extent did the other person or persons intentionally cause this event to happen to you?

c. How much had you expected this event to occur?

d. How much uncertainty have you experienced in your life as a result of this event?

Instructions for the AQ were also modified for this study. The AQ consisted of two sections. For Section I, respondents were asked questions regarding their thoughts about the most negative and second most negative events rated in the previous questionnaire. They were reminded that these events were ones which took place in the three months prior to their husbands' acceptance into treatment. These instructions were changed somewhat in Section II. Respondents were asked to recall events they believed were directly related to their

husbands' drinking, again in the three months prior to acceptance into treatment.

Symptom Check List-90 (SCL-90)

The SCL-90 is a scale which has been developed to measure emotional well-being and adjustment in individuals in both clinical and research settings (Derogatis et al., 1973) (see Appendix L). It is composed of 90 items which can be factored into nine dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism). Respondents are asked to rate how much they have been bothered by each item on a five-point Likert scale from "not at all" to "extremely."

Psychometric properties. Derogatis, Rickels, & Rock (1976) report significant reliability and validity for the SCL-90. Reliability was determined by tests for internal consistency. Correlations with MMPI symptom dimensions were derived to test construct validity. Scores are presented for each of the nine subscales in Table 2. All coefficients listed are statistically significant at the .01 level.

Modifications for this study. As with the PSS scales, the only modification for this instrument was in the instructions. The original instructions were designed to allow for a flexible time frame. For this study respondents were asked to indicate to what degree each of the 90 symptoms had bothered or distressed them from

Table 2. Reliability and Validity Scores for the SCL Subscales

	Reliability ^a	Validity ^a
Somatization (SOM)	.86	.66
Obsessive-compulsive (OBS)	.86	.57
Interpersonal sensitivity (INS)	.86	.64
Depression (DEP)	.90	.75
Anxiety (ANX)	.85	.57
Hostility (HOS)	.84	.68
Phobic anxiety (PHO)	.82	.50
Paranoid ideation (PAR)	.80	.56
Psychoticism (PSY)	.77	.64

^aAll coefficients are significant at $p < .01$.

three months prior to their husbands' acceptance into treatment until the day they completed the form.

Fact Sheet

The last page of the questionnaire packet, labeled Fact Sheet, contained a number of items requesting sociodemographic information (see Appendix M). The first four questions dealt with characteristics of the wife: age; ethnicity; employment; income (in combination with husband's income). Questions five through seven focused on characteristics of the marriage and family: length of marriage; whether the couple has been separated due to conflict; number and ages of children. Questions eight and nine dealt specifically with the husband's drinking: how long he has had a problem; how often and how much he drank. The last two questions asked about the woman's own background in dealing with alcoholism: whether any of her blood relatives are or were alcoholic; whether she has been involved with Al-Anon.

CHAPTER VII

RESULTS

This dissertation was designed to describe and analyze relationships among causal attributions, stressful life events, perceived social support, and psychological symptomology of wives of alcoholic men. Characteristics of the sample are presented first. Second, descriptive information about the measures utilized is discussed. Following this, results of correlational and regression analyses of the measures are presented. Finally, additional findings which were not originally anticipated are presented.

Characteristics of the Respondents

Total Sample

Respondents provided information regarding a number of sociodemographic variables on the page labeled "Fact Sheet." Two of the 98 women did not answer any questions on this page. Other respondents failed to complete various items. For the following analyses, sample size equals 96 unless otherwise indicated.

Average age of the respondents was 34, range 20 to 60 years. Two-thirds of the women reported being employed. Of these, 67% were working full-time. The average number of children reported was 2.1, range 0 to 7. With $n = 94$, 57.4% of the women reported they had been separated from their husbands at least once.

Of the women reporting blood relatives who have or had a drinking problem, 40.4% ($n = 94$) indicated their fathers have a

problem. Of $n = 95$, 54.7% reported that at least one other blood family member also had a drinking problem. Additional information about family members is presented in Table 3.

Of 96 women responding, 72.9% noted that they had attended at least one Al-Anon meeting. However, only 28.7% of $n = 87$ had attended Al-Anon for two or more months.

During data collection, a staff member at Hotel Dieu Hospital in El Paso noted that the ethnic category of "Native American" may be misleading due to that city's proximity to Mexico. An examination of the data indicated a high probability that distribution scores for ethnicity were inaccurate; thus, no scores are presented. Other sociodemographic information obtained in this study is presented in Table 3.

Military vs. Civilian Status

Of the 98 women who participated in the study, 64 were women whose husbands were serving in the military at the time of their treatment. The other 34 women were married to men in civilian positions. Due to differences in life experiences (e.g., frequent and unexpected transfers, potential for husband to be in combat; Martin, 1984), it was considered appropriate to examine whether differences exist between the two subgroups.

Multivariate analysis of variance (MANOVA) procedures were conducted on two sets of variables to determine whether wives of military men were significantly different from wives of civilian men. For the first MANOVA, variables age, length of time husband's drinking

Table 3. Sociodemographic Characteristics of the Study Sample

Item	Response Percentages ^a		
4. Combined income of you and your husband ^b ($\underline{n}$ = 90)	less than \$10,000 5.6% \$10,000 to \$14,999 18.9% \$15,000 to \$19,999 15.6% \$20,000 to \$29,999 27.8% \$30,000 to \$59,999 27.8% more than \$60,000 4.4%		
5. Length of present marriage ^b ($\underline{n}$ = 96)	less than 1 year 10.4% 1 to 2 years 6.3% 2 to 5 years 18.8% 5 to 10 years 21.9% 10 to 20 years 35.4% more than 20 years 7.3%		
8. How long has your husband had a drinking problem? ^c ($\underline{n}$ = 81)	1 to 5 years 19.8% 6 to 10 years 24.7% 11 to 15 years 24.7% 16 to 20 years 18.5% 21 to 25 years 6.2% more than 25 years 6.2%		
9. How often did your husband drink before being accepted into treatment? _____ days each month ^c ($\underline{n}$ = 85)	less than 20 days/mo 28.2% 20 to 29 days/mo 24.8% 30 or 31 days/mo 47.1%		
10. Have any of your blood relatives ever had a drinking problem? ^b	yes	no	don't know
a. mother ($\underline{n}$ = 93)	8.6%	86.0%	5.4%
b. mother's mother ($\underline{n}$ = 91)	7.7%	75.8%	16.5%
c. mother's father ($\underline{n}$ = 90)	21.1%	51.1%	27.8%
d. father ($\underline{n}$ = 94)	40.4%	50.0%	9.6%
e. father's mother ($\underline{n}$ = 90)	3.3%	73.3%	23.3%
f. father's father ($\underline{n}$ = 92)	26.1%	43.5%	30.4%

Table 3. (continued)

Item	Response Percentages ^a
Please list other relatives related to you by blood that you know to have a drinking problem. ^c ($n = 95$)	
0	45.3%
1	26.3%
2	13.7%
3	5.3%
4	4.2%
5-9	5.1%

^aTotals may not equal 100% due to rounding.

^bStructured item with response categories.

^cOpen-ended item.

has been a problem, and estimated number of days husband drinks were input into the model. Results indicated that there was a significant difference between the groups, $F(3,69) = 4.18, p < .01$. Univariate analyses indicated that civilian women were significantly older ($M = 37.7$) than wives of military personnel ($M = 32.0$) ($F(1,71) = 9.68, p < .01$). There were no other significant differences among the sociodemographic variables.

A second MANOVA was conducted to evaluate whether differences existed between the two groups in terms of negative life events, positive life events, perceived social support from friends, perceived social support from family, scores assessing internal, stable, and global attributions, and psychiatric symptomology. Results indicated that there was a significant difference between these two groups, $F(8,85) = 2.13, p < .05$. Subsequent univariate analyses revealed that civilian wives were significantly more likely to perceive social support from family members than military wives were ($F(1,92) = 6.08, p < .05$). Additionally, women married to men in the military were more likely than women married to civilian men to believe the causes of negative events also affected other areas of their lives ($F(1,92) = 5.23, p < .05$). These and additional analyses of the differences between these subgroups are further discussed below.

Characteristics of the Instruments

Life Experiences Survey (LES)

The LES was utilized to determine the amount of life change each respondent experienced during the three months prior to the

admission of her husband into treatment. Each woman indicated which events had occurred and how much impact, either positive or negative, each event had. The factor of interest in this research was the total impact score of those events deemed negative (LES-neg).

LES-neg scores were calculated by summing the absolute values of those events assigned a negative impact score (-3: extremely negative; -2: moderately negative; -1: somewhat negative). These scores are thus sums of weights assigned to each event reported to have occurred, and not sums of events. The range of absolute scores reported for LES-neg is 0 (no negative events) to 64, with mean = 15.68 and standard deviation = 11.78. Further examination of the LES-neg data revealed that the median score was 13.5 and the mode was 14. There were only three scores greater than 40 (i.e., 46, 51, and 64). Thus it is evident that the LES-neg scores were somewhat skewed.

No predictions were made regarding either positive life events scores or total life events scores. It has been argued, however, that a more useful assessment of life change is through evaluating the total impact of stressful events; that is, both negative and positive life events should be considered (Holmes & Rahe, 1967; Sarason et al., 1975). Therefore, both the positive (LES-pos) and the total (LES-total) life events scores were also calculated. For LES-pos, the range of scores was from 0 to 52 ($\bar{M}$ = 6.28, sd = 9.37). For LES-total, the range was from 3 to 116 ($\bar{M}$ = 21.96, sd = 15.52). Both LES-neg and LES-pos were correlated with LES-total at the .0001 level (r =

.80 and $r = .65$ respectively). LES-neg and LES-pos were not found to be correlated.

No predictions were made regarding which items would be selected more frequently than others. It is interesting to note, however, which items emerged as common to a substantial proportion of the respondents. Of the 47 specified events, five were chosen by over 40% of the women. They are: #5 "Sleeping much more or much less than usual" (58%); #18 "Sexual difficulties with husband" (52%); #31 "Arguing a lot more or a lot less with husband" (46%); #7 "Eating much more or much less than usual" (44%); and #21 "Major change in financial status (a lot better off or a lot worse off)" (41%). Other frequently reported events, as well as the percentage of all respondents who assigned values of -3 to each listed event, are presented in Table 4.

Military vs. civilian. Due to the modifications made to the LES for this study, there are no normative data available with which to compare LES scores of wives of alcoholics. It was possible, however, to determine whether women married to military men would differ from women married to civilian men in their assessments of life stress.

To test whether differences existed for the two groups, the analysis of variance (ANOVA) procedure was utilized. The two groups did not differ significantly in their scores on either negative life events ($F(1,92) = 2.34$) or positive life events ($F(1,92) = 1.0$). Next, event frequencies for the two groups were tabulated (see Table

Table 4. LES Events Marked as Having a Negative Impact by at Least 20% of the Respondents: Total Sample

Event	Percent of total n assigning a negative impact value	Percent of total n assigning a value of -3
#5 Sleeping much more or much less than usual	58	7
#18 Sexual difficulties with husband	52	17
#31 Arguing a lot more or lot less with husband	46	22
#7 Eating much more or much less than usual	44	16
#21 Major change in financial status (a lot better off or a lot worse off)	41	18
#38 Major increase or decrease in such social activities as going to parties, going to movies, visiting friends	37	7
#23 Major change in closeness of family members (increased or decreased closeness)	33	10
#39 Children experiencing difficulties at school or with the law	27	8
#3 Husband being held in jail or other similar institution	24	14

5). The groups reported experiencing many of the same events; in fact, the five most frequently reported events held the same ranking for both groups. At this point, however, a distinction between the two groups becomes evident. For most of the events (i.e., #5, #18, #31, #7, #21, #23, #38, #33, #32, #35, and #38), much greater percentages of civilian women than military women indicated that the events had occurred. To determine whether this difference was significant, ANOVAs were conducted. Results indicated that wives of civilian men had significantly higher scores on both the frequency sum of the top five ranked events (i.e., #5, #18, #31, #7, and #21) ($F(1, 92) = 6.53, p < .05$) and on the frequency sum of the nine events both groups ranked in the top 20% ($F(1, 92) = 5.75, p < .05$).

Added items. A unique feature of the LES is the provision of space to write up to three more events. Eighteen women added one more event; eight women added two; and 11 women added three. The majority of events were assigned a negative value (87%). Of these, 79% of the events were given the most negative impact rating of -3.

Several themes are identifiable in the added items, such as issues involving the husband's behavior, finances, and legal issues. Figure 1 presents the added items categorized by prevalent themes.

Some of the added events were elaborations of items provided in the checklist. For example, "husband broke my thumb while fighting" would fall under the general statement "physical assault by husband" (item 15 on the LES), and "Bankruptcy--forced to sell home" is a

Table 5. LES Events Marked as Having a Negative Impact by at Least 20% of the Respondents: Military vs. Civilian

Event	Military (<u>n</u> = 64)		Civilian (<u>n</u> = 34)	
	% of <u>n</u> Assigning Negative Value	% of <u>n</u> Assigning -3 Value	% of <u>n</u> Assigning Negative Value	% of <u>n</u> Assigning -3 Value
#5 Sleeping much more or much less than usual	50 (1) ^a	8	74 (1)	26
#18 Sexual difficulties with husband	47 (2)	14	62 (2)	24
#31 Arguing a lot more or lot less with husband	41 (3)	19	56 (3)	30
#7 Eating much more or much less than usual	38 (4)	17	56 (4)	15
#21 Major change in financial status (a lot better off or a lot worse off)	34 (5)	11	53 (5)	32
#23 Major change in closeness of family members (increased or decreased closeness)	31 (6)	8	35 (7)	15
#39 Children experiencing difficulties at school or with the law	30 (7)	8	21 (11)	9
#38 Major increase or decrease in such social activities as going to parties, going to movies, visiting friends	30 (8)	5	50 (6)	12
#3 Husband being held in jail or other similar institution	25 (9)	14	21 (10)	5

Table 5. (continued)

Event	Military (<u>n</u> = 64)		Civilian (<u>n</u> = 34)	
	% of <u>n</u> Assigning Negative Value	% of <u>n</u> Assigning -3 Value	% of <u>n</u> Assigning Negative Value	% of <u>n</u> Assigning -3 Value
#1 Marriage	22 (10)	11	not in top 20%	
#27 Marital separation from husband due to personal conflicts	20 (11)	11	not in top 20%	
#33 Major change in usual type and/or amount of recreational activities	not in top 20%		35 (8)	9
#32 Change in husband's work (loss of job, beginning new job, retirement, etc.)	not in top 20%		30 (9)	18
#35 Borrowed less than \$10,000 (buying car, TV, etc.)	not in top 20%		21 (12)	9
#28 Increased or decreased attendance at church or other religious activities	not in top 20%		21 (13)	3

^aNumbers in parentheses indicate ranking of event for subgroup.

Issues involving husband's behavior:

Husband's mind confused and distorted
Physically and mentally abused the most in last 2-3 years (more often) episodes would get closer and closer
Husband lying about a lot of things. Most of the time I knew he was being dishonest but couldn't prove it
Disappearing while sister visiting
Husband being obsessed with drinking--no interest in anyone or anything
No communication
Spouse became abusive and was drunk. Tried to take baby out of house in drunken condition
Frenzied activity of husband--can't stay home long
Husband abandoned me and my 2 children, leaving a suicide note
Major loss of communication--uncaring/feeling/no love/loss of respect and trust for the alcoholic
Husband broke my thumb while fighting

Legal issues:

Daughter brought charges against husband for sexual abuse
Uncertainty because husband is facing legal action that could affect pension--no charges brought
DWI
Spouse arrested for a felony which included a weapon (shotgun)
My husband had an accident, hitting a neighbor's parked car, while driving his company car, doing major damage to his car
Spouse received three traffic violations for speeding or reckless driving
Husband was carried out of our quarters in handcuffs
My child riding with my spouse while my spouse was intoxicated

Sexual issues:

Husband had an affair with younger girl
Husband was unfaithful to me
Sexual disinterest of husband
My husband had sex with one of his family members. He had sex with his mother's sister
My husband told me of the above mentioned action before we were to make love. He then expected to continue. I was so repulsed I would not make love to him. He left the house to watch sports on TV at a friend's house. He did not come home when he said he would. I wanted to discuss the situation, but he stayed there and got drunk. I then decided to pack up and leave him.
Another woman

Figure 1. List of Items Added to the LES by Respondents

Financial issues:

Married on November 1st--husband in treatment for 21 days--no
income--vehicle repossessed
Problem with bills
Trailer being repossessed due to husband lying about making
payment
Lost a grant to go to school
No income in December and January
Bankruptcy--forced to sell house

Issues involving respondent's well-being:

Realization that spouse was/is an alcoholic
I worried a lot about his health
Second degree sprain to ankle--had a cast on for 1 month while
separated--made it difficult to function as a single parent
Fear caused by not paying drug dealers
Worried about his stress

Issues involving other family members besides husband:

Babysitter's 4 year-old son hit our 2 month old daughter in face
with plastic toy shovel
Stepdaughter had been living with us for 1 year 2 months. Went
back to live with natural mother--had no idea until papers
were served by police
Death of daughter and mother in 1 week
Living in mother-in-law (87 with Alzheimers) stroke in January--in
hospital 18 days
Stepdaughter tried to commit suicide

Issues involving living situation:

Problem with the neighbors complaining of things and getting
threatened with eviction of quarters
1 year ago we moved out of our condo into a rental home so his
cousin and wife could live with us (a bigger place). They
were to help pay rent, which they did not do, then they had 2
people move in (they were just supposed to spend the night).
Before they left they charged \$500 worth of phone bills.
Never helped pay for anything.

Figure 1. (continued)

specific case of "Major change in financial status (a lot better off or a lot worse off)" (item 21 on the LES).

It is possible that some negative life events scores may have been artificially inflated by inclusion of both a structured item and an added item representing the same event. One way to test for this was to derive a score based on only those negative events marked in the structured items. This score was submitted to correlational analyses with scores from the SCL-90, PSS-fr, PSS-fa, and internal, stable, and global measures. The correlation patterns between this structured score and the variables of interest were the same as correlation patterns between the LES-neg and the variables of interest. Therefore, only the LES-neg scores are reported.

Perceived Social Support from Family (PSS-fa)
and Friends (PSS-fr)

Respondents were asked to indicate whether they agreed with statements regarding social support from family (PSS-fa) and from friends (PSS-fr). There were 20 items for each scale. Due to a missing page in one questionnaire packet, PSS scales for that respondent were only partially complete. As all the other instruments were completed, the scores from this respondent were retained for the other analyses.

Scores for the PSS-fa ranged from 0 to 20, with a mean of 11.30 and a standard deviation of 6.18. For the PSS-fr, the range was 1 to 20, mean = 11.63, standard deviation = 5.33. The PSS-fa and PSS-fr were highly correlated at .0001 ($r = .41$).

Comparisons with other populations. In order to determine whether women married to alcoholics have unique perceptions about social support, it is necessary to compare their scores with those of a control group matched for such variables as age, employment status, and length of marriage. Data from such a group are not available for this study. There are, however, data from two student populations which can provide limited information.

In the process of validating the PSS-fr and PSS-fa scales, Procidano and Heller (1983) derived means and standard deviations for both instruments from 66 female and male undergraduates. PSS scores from 116 female undergraduates were also available for comparison (McKenzie, 1986). It was found that both student samples had significantly higher scores on the PSS-fr and PSS-fa than the women in this study. Table 6 presents information on the t-tests conducted for this analysis.

Military vs. civilian. ANOVAs were conducted to evaluate whether wives of military personnel differed from wives of civilians in their perceptions of social support. It was found that women married to civilians had significantly higher scores on the PSS-fa than women married to men in the military ($F(1,92) = 6.08, p < .05$). There was no difference between the two groups in their perceptions of social support from their friends.

Attribution Questionnaire (AQ)

There were a total of twelve items designed to measure three dimensions of causality for four specified events. The three

Table 6. Means, Standard Deviations, and t Values for the Comparison of Wives of Alcoholics and Two Student Populations: Perceived Social Support

	Undergraduates		Wives of Alcoholics		
Variable	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>t</u> Value
(Procidano & Heller, 1983) (<u>n</u> = 66)					
PSS-fr	15.15	5.08	11.63	5.33	-4.29**
PSS-fa	13.40	4.83	11.30	6.18	-2.44*
(McKenzie, 1986) (<u>n</u> = 116 ^a)					
PSS-fr	14.85	3.86	11.63	5.33	-4.97**
PSS-fa	13.59	5.83	11.30	6.18	-2.77*

^aFemale respondents

* $p < .01$

** $p < .0001$

attribution dimensions were: internal/external, stable/transient, and global/specific. These attributions were assessed for each of four events: the most negative event marked on the LES (AQ-A), the second most negative event marked on the LES (AQ-B), the most negative event directly related to the husband's drinking (AQ-C), and the second most negative event directly related to the husband's drinking (AQ-D).

Thirty-one respondents did not answer at least one of the twelve items on the AQ. Sample sizes for each of the items are presented in Table 7. Of the 31 women who did not answer the AQ completely, only two women provided no responses at all. Attribution scores for the remaining 29 respondents were derived by calculating averages of the completed items. For example, if a woman responded to the internal/external questions for all four events, her total score would be divided by four. If for the stability/transient dimension she only responded to questions about the two negative events marked on the LES, her stability score would be the sum of those two responses divided by two.

Two possible reasons for failing to complete these questionnaires are immediately evident. First, one respondent indicated that no negative events occurred which were related to her husband's drinking during the three months prior to his admission into treatment, the time frame specified on the questionnaire. It is possible that other respondents also had not experienced a negative event in that time. Second, a number of respondents ($n = 18$) wrote down the same event for AQ-A and AQ-C. It is possible that other women also perceived the most negative event on the LES to be the same

Table 7. Sample Sizes for Completed Items on the Attribution Questionnaires

	Internal- External	Stable- Transient	Global- Specific
AQ-A (most negative event marked on the LES)	94	91	95
AQ-B (second most negative event marked on the LES)	87	88	89
AQ-C (most negative event related to husband's drinking)	86	85	86
AQ-D (second most negative event related to husband's drinking)	74	74	75

as the most negative event related to the drinking, and chose not to duplicate their responses.

It should be noted that the high degree of overlap between AQ-A and AQ-C may lead to spurious correlations between attributions for those events. It was expected that by using average scores the risk of distorting relationships between attributions and other variables was minimal.

Descriptive information about the attribution scores is presented in Table 8. Statistics for all four events as well as for averages across the events are included.

Internal-external dimension. The first dimension was how responsible the respondent perceived herself to be for an event. Response items were reverse codes so that within the range of possible responses, 1 to 7, lower scores reflected greater externality ("something about the situation or other persons"), and higher scores reflected greater perceptions of internality ("something about me"). Further examination of the frequency distribution indicated that while the mean was between 2 and 3 for all four events, both the median and the mode were 1. Additionally, at least 85% of the scores for each of the events was 4 or less. Thus, scores for this attribution dimension were highly skewed toward the external endpoint. Scores on the internal-external dimensions for all four events were found to be correlated at the .001 level.

Stable-transient dimensions. The second dimension concerned how stable or transient the causes of the event were perceived to be.

Table 8. Descriptive Information of the Attribution Questionnaire

	Average Across the 4 Events	AQ-A	AQ-B	AQ-C	AQ-D
<u>Internal-external^a</u>					
mean	2.36	2.49	2.53	2.14	2.49
mode	1 (32%)	1 (48%)	1 (49%)	1 (62%)	1 (50%)
standard deviation	1.5	1.8	1.9	1.8	1.8
<u>Stable-transient^b</u>					
mean	4.33	4.21	4.28	4.13	4.32
mode	7 (7%)	7 (26%)	7 (34%)	7 (26%)	7 (28%)
standard deviation	1.9	2.3	2.4	2.3	2.3
<u>Global-specific^c</u>					
mean	5.74	5.79	5.69	5.87	5.92
mode	7 (29%)	7 (50%)	7 (48%)	7 (58%)	7 (56%)
standard deviation	1.3	1.5	1.7	1.6	1.5

^aScores ranged from 1 = external to 7 = internal.

^bScores ranged from 1 = transient to 7 = stable.

^cScores ranged from 1 = specific to 7 = global.

High scores indicated attributions to "something unchanging" (stable); low scores indicated the event was attributed to "something that changes" (transient). Scores for the stable/transient dimension were much more evenly distributed than for the internal/external dimension. Both the mean and median scores were 4. Additionally, although the mode was 7 for each event, respondents were almost as likely to select either 1 or 4. For example, for AQ-A, 22% of the respondents circled 1 and 15% circled 4. This pattern was similar for the other three events. Scores for the four events were correlated at the .01 level.

Global-specific dimension. The third dimension measured how global the causes of negative events were believed to be. That is, respondents rated to what extent they believed the cause of each event also affected other areas of their lives. A high score on this dimension was indicative of the belief that the cause of each event had a great deal of influence on other areas, whereas a low score rated the cause as specifically affecting this event and having little additional impact. Scores for the global/specific dimension were also highly skewed. Both the median and mode scores were 7, with at least 89% of the respondents marking 4 or higher for each event. Correlations between each of the four events was at the .0001 level of significance.

Comparisons with other populations. As with the perceived social support scales, there are no data from carefully matched samples available for comparisons of attribution patterns. Information is available from female undergraduates ($n = 116$)

(McKenzie, 1986). Respondents were asked to think about the most negative event that had happened to them in the recent past and then complete the AQ. Results of t -tests indicate that women married to alcoholics are more likely to make internal and global attributions than undergraduate females. Table 9 presents the findings.

Military vs. civilian. Univariate analyses revealed that women married to military personnel were more likely than women married to civilians to believe that causes of the most negative events in their lives also affected other parts of their lives ($F(1,92) = 5.23, p < .05$). That is, the attributions of military women tended to be more global than the attributions of civilian women. These two groups did not differ in their perceptions of either how internal or external a cause was, or of how stable or transient a cause was.

Symptom Checklist-90 (SCL-90)

Seven respondents failed to complete all 90 items on the SCL. After examination of the data it was assumed that the missing variables were random. This assumption of randomness is considered an appropriate criterion for replacing missing values with means of other observed values (i.e., the remaining values within a subscale which were not missing) (Cohen & Cohen, 1975).

To handle the missing data, the following procedure was conducted for each respondent. First, it was determined which of the nine SCL subscales had missing values. For each subscale with missing values, the mean of the remaining values within that subscale was

Table 9. Means, Standard Deviations, and t Values for the Comparison of Wives of Alcoholics and Female Undergraduates: Causal Attributions

Variable	Undergraduates ($n = 116$)		Wives of Alcoholics ($n = 97$)		t Value
	$\bar{M}$	SD	$\bar{M}$	SD	
Internal attributions	4.39	2.23	5.51	1.81	3.89*
Stable attributions	3.93	2.13	4.21	2.29	.867
Global attributions	4.74	1.84	5.79	1.52	4.40*

* $p < .0001$

calculated. The mean value was then substituted for this missing value.

Scores on the SCL-90 ranged from 99 to 356 ($M = 210.30$, $sd = 62.65$). Complete descriptions of the nine subscales are presented in Table 10. All of the subscales were correlated at the .0001 level with the total SCL-90 score and with each subscale.

Comparisons with other populations. In presenting their preliminary report on the SCL-90, Derogatis et al. (1973) presented descriptive data from three different populations: general clinical outpatients, emergency service clinical outpatients, and obese normal females. t -tests were conducted to determine if any of these populations differed significantly from the women of these studies in their reporting of psychiatric symptomology. Results indicated that respondents of the present study had higher symptomology scores than the obese females ($t = 5.30$, $p < .0001$), lower scores than the emergency outpatients ($t = -2.125$, $p < .05$), and similar scores to the general outpatients ($t = .10$, NS). Descriptive information is presented in Table 11.

Military vs. civilian. A one-way ANOVA was performed to determine if there was any difference in the level of psychiatric symptomology reported by women married to military personnel and women married to civilians. There was no significant difference between the two groups ($F(1,92) = .71$, NS).

Table 10. Descriptive Information of the SCL and Subscales

Scale	mean	<u>sd</u>	min	max
Symptom Checklist-90 (SCL-90)	210.30	62.65	99	356
Somatization (SOM)	24.02	8.66	12	46
Obsessive-compulsive (OBS)	24.67	8.69	10	45
Interpersonal sensitivity (INS)	20.66	7.73	9	41
Depression (DEP)	38.53	12.16	15	63
Anxiety (ANX)	24.38	8.30	10	43
Hostility (HOS)	14.95	6.01	6	30
Phobic anxiety (PHO)	11.24	4.72	7	26
Paranoid ideation (PAR)	13.67	5.41	6	27
Psychoticism (PSY)	20.39	7.36	10	46

Table 11. Means, Standard Deviations, and t Values for the Comparison of Wives of Alcoholics and Three Populations: SCL-90

Populations	Descriptive Information	Wives of Alcoholics ($n = 98$)	
		$M = 1.34$	$SD = .70$
		t Value	
Obese Normal Females ($n = 48$)	$M = .81$		
	$SD = .52$		-5.30**
Emergency Service Outpatients ($n = 26$)	$M = 1.60$		
	$SD = .69$		2.13*
General Outpatients ($n = 100$)	$M = 1.35$		
	$SD = .82$		-.10

* $p < .05$

** $p < .0001$

Research Questions

Correlational Analyses

Pearson product moment correlation coefficients were calculated to determine whether relationships existed among the variables of interest. Table 12 presents the simple intercorrelations among these variables. As noted above, the nine SCL-90 subscales were highly correlated; thus, only one score representing a general symptom index (i.e., SCL-90) is presented here. Detailed correlational information regarding the SCL subscales and each of the variables of interest are presented for each of the proposed research questions.

Question 1. It was hypothesized that negative life events are associated with psychological dysfunction in wives of alcoholics.

Women reporting higher LES-neg scores tended to have higher SCL-90 scores than those women reporting lower LES-neg scores ($r = .42$, $p < .0001$). All nine subscales of the SCL-90 were also negatively correlated with LES-neg. Scores ranged from $r = .48$ ($p < .0001$) for both the anxiety and psychoticism subscales to $r = .25$ ($p < .05$) for the somatization subscale (see Table 13). The hypothesis posed in question 1 was thus supported.

Question 2. It was predicted that wives reporting higher levels of perceived social support from family tend to have lower levels of psychological dysfunction than wives reporting low levels of perceived support. Likewise, it was predicted that perceived social

Table 12. Intercorrelation Matrix for the Predictor and Criterion Variables

	Psy dys	Neg l e	Total l e	PSS Fa	PSS Fr	I-E	S-T
Psychological dysfunction							
Negative life events	.42****						
Total life events	.36***	.79****					
Perceived social support/ family	-.25*	-.01	.07				
Perceived social support/ friends	-.31**	-.13	-.11	.41****			
Internal- external	.12	.09	.20	-.23*	-.25*		
Stable- transient	-.05	-.06	-.06	.01	.13	-.23*	
Global- specific	.34***	.38****	.30**	-.12	.02	-.02	-.09

* $p < .05$

** $p < .01$

*** $p < .001$

**** $p < .0001$

Table 13. Pearson Product-Moment Correlations for the LES Scales and the SCL-90

Scales	<u>LES-neg</u> <u>n = 98</u>	<u>LES-total</u> <u>n = 98</u>	<u>LES-pos</u> <u>n = 98</u>
Symptom Checklist-90	.42****	.35***	.06
Somatization	.25*	.17	-.04
Obsessive-compulsive	.34***	.27**	.03
Interpersonal sensitivity	.27**	.29**	.13
Depression	.40****	.33***	.01
Anxiety	.48****	.35***	-.03
Hostility	.28**	.22*	.01
Phobic anxiety	.28**	.27**	.12
Paranoid ideation	.31**	.37****	.22*
Psychoticism	.48****	.48****	.19

* $p < .05$

** $p < .01$

*** $p < .001$

**** $p < .0001$

support from friends is negatively correlated with psychological dysfunction.

PSS-fa scores were obtained from 97 respondents. Results indicated a negative correlation between SCL-90 scores and PSS-fa scores ($r = -.25$, $p < .05$). Five of the nine subscales of the SCL-90 were significantly correlated with PSS-fa (hostility, paranoid ideation, interpersonal sensitivity, depression, and psychoticism). Table 14 presents detailed information.

Scores of perceived social support from friends were also derived ($n = 97$). Correlational analyses revealed significant relationships between SCL-90 scores and PSS-fr scores ($r = -.31$, $p < .01$). All but the somatization subscale were correlated with the PSS-fr, with scores ranging from $r = .39$ ($p < .0001$) for interpersonal sensitivity to $r = .21$ ($p < .05$) for hostility (see Table 14). Thus, this analysis supported the predictions that women perceiving high levels of social support from friends and from family experience greater psychological health.

Question 3a. Does social support have a buffering effect? For those women reporting high levels of negative life events, does the existence of social support influence the degree of psychological distress?

To test this, the score representing negative life events was dichotomized around the mean. For those women reporting high negative life event scores, t -tests were conducted to determine whether perceptions of social support would be associated with symptomology,

Table 14. Pearson Product-Moment Correlations for the PSS Scales and the SCL-90

Scales	<u>PSS-fa</u> <u>n = 97</u>	<u>PSS-fr</u> <u>n = 97</u>
Symptom Checklist-90	-.25*	-.30**
Somatization	-.18	-.15
Obsessive-compulsive	-.10	-.23*
Interpersonal sensitivity	-.27**	-.39****
Depression	-.23*	-.27**
Anxiety	-.17	-.26**
Hostility	-.33***	-.21*
Phobic anxiety	-.18	-.32**
Paranoid ideation	-.32**	-.36***
Psychoticism	-.21*	-.25*

*
p < .05

**
p < .01

p < .001

p < .0001

thus buffering the impact of the life events. Analysis for this question revealed no significant difference between level of psychiatric symptomology for PSS-fa ($t(40) = 1.14$). Higher levels of PSS-fr were marginally associated with lower SCL-90 scores ($t(40) = 1.84$, $p < .07$). Thus, it appears that perceptions of support from friends are somewhat likely to mediate the impact of high degrees of life stress.

Question 3b. Does social support have a direct protective effect? That is, do high levels of perceived support protect wives of alcoholic men from experiencing high levels of symptomology regardless of level of life stress?

In order to test this, scores representing PSS-fr and PSS-fa were dichotomized around their means. Scores from respondents reporting high levels of perceived support were then compared. If perceived support provided protection, these women would be more likely to report low levels of symptomology regardless of high LES-neg scores. This was not the case. Results from t -test analyses indicated that SCL-90 scores differed significantly between low negative life events scores and high negative life events scores despite high levels of either PSS-fr ($t(50) = -3.03$, $p < .01$) or PSS-fa ($t(48) = -3.17$, $p < .01$).

Question 4a. It was hypothesized that internal attributions are associated with greater psychological distress among wives of alcoholics.

There was no significant relationship between the SCL-90 score

and the average attribution score for the internal-external dimension ($n = 96$). Two subscales were positively correlated with high internal scores: phobic anxiety and psychoticism (see Table 15). Additionally, the SCL-90 was not significantly correlated with internal attributions for AQ-A ($n = 94$), AQ-B ($n = 87$), AQ-C ($n = 86$), or AQ-D ($n = 74$) events. Thus, there is no support for the hypothesis posed in Question 4a.

Question 4b. It was hypothesized that stable attributions are associated with greater psychological distress among wives of alcoholics.

There were no significant associations between the SCL-90 scales and stable attributions ($n = 95$) (see Table 15). Nor was the SCL-90 correlated with any of the four specific events: AQ-A ($n = 91$), AQ-B ($n = 88$), AQ-C ($n = 85$), and AQ-D ($n = 74$). According to this analysis, neither stable nor variable attributions appear to be associated with psychological distress.

Question 4c. It was hypothesized that global attributions are associated with greater psychological distress among wives of alcoholics.

Positive correlations were found between the SCL-90 score and the average global attribution score ($n = 96$, $r = .34$, $p < .001$). Further analysis indicated that global attributions of three of the four events were related to psychological dysfunction: AQ-A ($n = 95$, $r = .21$, $p < .05$); AQ-C ($n = 86$, $r = .37$, $p < .001$); and AQ-D ($n = 75$,

Table 15. Pearson Product-Moment Correlations for Internal and Stable Attributions and the SCL-90 Scales

Scales	Average Internal <u>n</u> = 96	Average Stable <u>n</u> = 95
Symptom Checklist-90	.12	-.05
Somatization	.08	.03
Obsessive-compulsive	.04	-.10
Interpersonal sensitivity	.12	-.07
Depression	.04	.004
Anxiety	.08	-.05
Hostility	.08	-.01
Phobic anxiety	.22*	-.02
Paranoid ideation	.18	-.08
Psychoticism	.23*	-.15

* $p < .05$

$r = .47$, $p < .0001$) events. The fourth event, AQ-B, approached significance ($n = 89$, $r = .20$, $p = .062$). Table 16 presents detailed information regarding the SCL-90 subscales and global attributions. The hostility subscale is the only one correlated with global attributions for AQ-B (second most negative event marked on the LES). Within each of the other three events depression is the most highly correlated subscale.

The prediction posed in Question 4c is supported. That is, the greater a respondent's level of psychological distress, the more likely she is to perceive that causes of negative events are not just affecting those events, but other aspects of her life as well.

Question 5. It was an open question as to whether the degrees of internality, stability, and/or globality for either negative life events in general or husbands' alcoholism in particular are associated with perceptions of social support from family members.

The relationship between perceived social support from family and internal attributions was significant ($n = 95$, $r = -.23$, $p < .05$). Further examination of the data revealed that respondents reporting lower scores on the PSS-fa tended to have higher internal attributions for both AQ-A ($n = 93$, $r = -.22$, $p < .05$) and AQ-C ($n = 85$, $r = -.26$, $p < .05$). That is, women who perceived little support from their family were more likely to attribute causes of the most negative events in their lives to things about themselves than were women perceiving high levels of support. There were no associations between internal attributions and the PSS-fa for either the AQ-B or

Table 16. Pearson Product-Moment Correlations for the Global Attribution Scores and the SCL-90 Scales

Scales	Average $\bar{n} = 96$	AQ-A $\bar{n} = 95$	AQ-B $\bar{n} = 89$	AQ-C $\bar{n} = 86$	AQ-D $\bar{n} = 75$
Symptom Checklist-90	.34**	.21*	.20	.37***	.47****
Somaticization	.16	.03	.17	.18	.37**
Obsessive-compulsive	.29**	.24*	.13	.34**	.30**
Interpersonal sensitivity	.17	.07	.07	.30**	.29*
Depression	.38****	.27**	.19	.42****	.49****
Anxiety	.36***	.25*	.19	.37***	.45****
Hostility	.35***	.23*	.21*	.38***	.45****
Phobic anxiety	.17	.05	.13	.14	.33**
Paranoid ideation	.28**	.13	.17	.31**	.42****
Psychoticism	.28**	.18	.17	.26*	.37***

* $p < .05$

** $p < .01$

*** $p < .001$

**** $p < .0001$

the AQ-D. There were also no relationships between stable or global attributions of any of the events and the PSS-fa.

Question 6. It was also an open question as to whether internality, stability, and/or globality are associated with perceptions of social support from friends.

The association between perceived social support from friends and internal attributions was also significant ($n = 95$, $r = -.25$, $p < .05$). Scores on the PSS-fr were negatively correlated with internal attributions of three events: AQ-A ($n = 93$, $r = -.20$, $p = .057$); AQ-B ($n = 86$, $r = -.25$, $p < .05$); AQ-C ($n = 85$, $r = -.22$, $p < .05$). The relationship between internal attributions for the AQ-D and PSS-fr was not significant. Thus, respondents reporting low perceptions of social support from friends tended to hold internal attributions for negative events in their lives.

Multiple Regression Analysis

To achieve a clearer understanding of the unique relationship of each of the variables of interest to wives' psychological functioning, a multiple regression analysis was conducted (see Table 17). All the variables representing main effects were put into the regression model. Predictor variables included negative life events, positive life events, perceptions of social support from friends, perceptions of social support from family, internal-external attributions, stable-transient attributions, and global-specific attributions. A forward selection procedure identified five factors which met the .50 level of significance for inclusion in the final

Table 17. Hierarchical Regression Analysis of Psychological Dysfunction on Negative Life Events, Perceived Social Support from Friends, Perceived Social Support from Family, and Global Attributions

Predictor Variable	Standardized B Value	Standardized SE	Partial R ²	Partial F Value
Negative Life Events	.24	.10	.15	16.63***
Perceived Social Support--Friends	-.18	.09	.07	7.58**
Global Attributions	.28	.10	.06	7.10**
Perceived Social Support--Family	-.22	.10	.04	4.8*
Positive Life Events	.08	.09	.006	.81
Standardized B Value for Intercept Term				.03
Model R ²				.3187
F Value				9.80**
d f				(5,88)

* $p < .05$

** $p < .01$

*** $p < .0001$

model. The positive life events score, while not significant at the .05 level, was retained in the model.

Using this procedure the variance of SCL-90 across all observations was found to be 32%. Of this, 15% of the variance was explained by negative life events, 7% by social support from friends, 6% by global attributions, and 4% by social support from family.

Additional Findings

Negative Life Events and Other Variables of Interest

No predictions were made regarding the relationships between the negative life event score and either the perceived social support from friends and from family scores or causal attribution scores. Pearson product moment correlations revealed no significant associations between LES-neg and PSS-fa or PSS-fr. There were also no relationships found between LES-neg and attributions for either the internal-external dimension or the stable-transient dimension. However, it is interesting to note that there were positive correlations between LES-neg and global attributions ($n = 96$, $r = .38$, $p < .0001$). That is, those women reporting higher life stress scores were more likely than women with lower life stress scores to believe the causes of negative events in their lives had a global impact and were not limited to specified events.

Positive Life Events and Total Life Events

No predictions were made regarding either the positive life events score or the total life events score; however, it is

interesting to note significant findings. The positive life events score was correlated with only one variable, the internal attribution score ($n = 96$, $r = .22$, $p < .05$). This suggests that wives reporting a high degree of positive life events were more likely to believe they were responsible for negative events in their lives. There were no other significant relationships with this variable.

The total life events score was found to be significantly correlated with psychological dysfunction ($n = 98$, $r = .36$, $p < .001$). Additionally, the relationship between total life events and global attributions was significant ($n = 96$, $r = .30$, $p < .01$). That is, women perceiving greater degrees of both positive and negative life changes tended to believe that the causes of the most negative events also affected other parts of their lives.

Attribution Scores

While it was expected that wives reporting high levels of psychological distress would tend to make internal, stable, and global attributions, no predictions were made regarding the correlational relationships among the three attribution variables. A correlational analysis revealed a negative correlation between internal and stable scores ($n = 95$, $r = -.23$, $p < .05$). This finding would suggest that the more likely women were to blame themselves for a negative event, the less likely they were to perceive the causes of the event as long-standing and stable. Global scores were not significantly related to either internal or stable scores.

Sociodemographic Variables

Family history. Sixty-three respondents indicated that at least one family member related to them by blood also had a drinking problem. Although no predictions were made regarding this variable, analyses were conducted to determine whether knowing about and/or living with another family member with a drinking problem would influence respondents' perceptions.

Analysis of variance procedures were utilized to evaluate whether respondent scores for the SCL-90, LES-neg, PSS-fr, PSS-fa, and the three attribution dimensions--internal, stable, and global--differed. Comparisons were made between respondents on four measures of family drinking history. The four measures: 1) father having a drinking problem; 2) mother having a drinking problem; 3) father and/or mother having a drinking problem; and 4) number of all blood relatives having a drinking problem.

Only one significant finding emerged. The more family members a woman reported as having a drinking problem, the more likely she was to attribute negative events to long-standing and stable causes ($F(1,84) = 3.90, p = .051$).

Al-Anon attendance. Whether attendance at Al-Anon meetings had an impact on respondents' perceptions was also assessed. Two sets of t-tests were conducted to determine whether SCL-90, LES-neg, PSS-fr, PSS-fa, and internal, stable, and global scores differed. The first set compared differences between women who had never attended Al-Anon (0 months) and those who had been to at least one meeting. There were

no differences. For the second set of tests, women who had attended Al-Anon were divided into those who had attended for less than three months (1-2 months) and those who had attended for three or more months (3+). Three sets of means were compared: 0 months vs. 1-2 months; 1-2 months vs. 3+ months; 0 months vs. 3+ months. Again, no significant differences between any of the variables was evident.

Other variables. The influence of the sociodemographic variables on negative life events, perceived social support, internal, stable, and global attributions, and psychological dysfunction was also investigated. MANOVAs were conducted to determine whether these variables were affected by respondent age, employment status, length of marriage, or combined income with husband. Two other variables tested were how long husband had had a drinking problem and number of days husband drank before entering treatment. Analyses revealed no significant differences for any of the measures.

CHAPTER VIII

DISCUSSION

This dissertation was designed to identify perceptions and experiences which influence psychological functioning of women married to alcoholics. Results of this study indicated that psychological distress among these women appears to be largely a function of negative life events, levels of social support from both friends and family, and global attributions. Negative life events are most often characterized by references to other family members, particularly focusing on behavioral changes. The causes of these events were perceived to be also affecting other areas of the women's lives; that is, women made global attributions regarding the causes of the events. High levels of both life stress and global beliefs were associated with more psychological symptoms of distress. The experience of psychological problems, however, was somewhat mitigated by perceptions of social support from both friends and family.

It was predicted that greater negative life events scores would be correlated with greater scores of psychological distress, as suggested by numerous studies reporting this association (e.g., Cohen et al., 1987; Dohrenwend & Dohrenwend, 1974). Results indicate that the experience of wives of alcoholics parallels the experience of many other populations.

Negative Life Events

An examination of the events selected most frequently as having

a negative impact demonstrates the prominence of both family interactions and effects of alcohol on these women's lives. Nine events were selected by at least 24% of the women as being stressful. Of these, five referred specifically to family members; three events mentioned husbands. In addition, six events characterizing the family situation have been listed by others as behavioral and psychological criteria for the diagnosis of alcoholism (i.e., arguing, changes in financial status, changes in social activities, changes in family closeness, children experiencing difficulties, and husband being held in jail) (Seixas, 1982). Sexual difficulties with husband, cited by 52% of the respondents as having a negative impact, is also often associated with problem drinking (Grisham & Estes, 1982).

Use of this life experiences survey allowed respondents to add events which were not included among the structured items. Some women also chose to elaborate on items already listed. While this technique provides detailed information not tapped by the more general and sometimes ambiguous items, care must be taken to recognize any duplication of responses. Although several women did duplicate items in this study, results indicated that the life events score was not artificially inflated to a degree sufficient to affect overall findings.

Finally, it is important to remember that the participants in this study were in a crisis situation. Their husbands had just been admitted into an alcoholism treatment facility, which alone is potentially quite stressful. The status quo of the family, no matter

how negative, has been disrupted. Additionally, some women may have been denying that their spouses had a drinking problem. Becoming aware that husbands had been diagnosed by professionals as alcoholic, coupled with interruptions in family routine, may have affected recollections of recent events.

Perceived Social Support

The findings of the relationships between perceived social support and psychological functioning are also consistent with previous studies. It has been found that individuals reporting greater levels of social support are less likely to experience psychological distress (Cohen & Wills, 1985; Heller & Swindle, 1983). The results of this study likewise indicated that when a wife of an alcoholic believed she had emotional support available through either family members (other than her husband) or friends, she had lower symptomatic scores.

The relationship between social support and life events, however, is not clear. Simply having high levels of social support does not appear to provide psychological protection. On the other hand, for women experiencing high negative life stress, perceptions of support from friends does appear to buffer the impact somewhat. It is possible that friends outside of the immediate alcoholic situation may be able to provide perspective to these women. That the statistical relationship is marginally significant may reflect the fact that friends are not necessarily likely to be either well-versed in the literature on alcoholism or therapeutically trained. Consequently,

determining whether support groups (such as Al-Anon) or therapy groups provide increased buffering could be beneficial to the development of such programs.

While support from friends appears to have some buffering qualities, support from family members seems to have no impact on the relationship between negative life events and symptomology. This finding is not surprising in light of the fact that many of the frequently listed life events involved changes in family behavior. Thus, while women may report high levels of support from other family members, this support is not strong enough to offset the impact of family changes due to alcoholic behavior.

Attributions

Internal/External

There were two important findings regarding the internal/external dimension of causal attributions. First, it was predicted that greater levels of psychological distress among women married to alcoholic men would be associated with internal attributions for negative events. The results did not support this hypothesis. Relative to student populations, the majority of women in this population made highly external attributions, regardless of their symptomatic level. They tended to indicate that causes of negative events were due to "something about the situation or other people." In order to understand possible reasons as to why this pattern may

have emerged, it is appropriate to evaluate the body of research upon which the original hypothesis was based.

It has been repeatedly found that both clinical and nonclinical populations reporting high levels of depressive symptomology attributed the causes of negative events to something about themselves (Sweeney et al., 1986). This same tendency has been noted for individuals with high anxiety scores and high general symptom scores (Nezu et al., 1986). An assumption was made for this dissertation that similar cognitive dynamics would be operating for wives of alcoholic men, and that those women showing greater symptomology would also tend to blame themselves for stressful life events. This was not the case. Perhaps the difference was due to the fact that the wives of alcoholic men reported as stressful a number of very specific events which were directly related to their husbands' drinking. Individuals within populations cited in the above research tended to not have the same experience of forces clearly outside of the individual operating.

The second finding of note involved social support. While internal attributions were not associated with either psychological dysfunction or stressful life events, degree of internality was found to be associated with perceptions of social support. Women who reported lower internal attributions--that is, who tended to say negative events were due to something about the situation or other persons--perceived having greater support from both family and friends. Thus it appears that women who believe they have opportunities to talk and share problems with others they feel close

to are less likely to take responsibility for the consequences of their husbands' drinking.

It is important to remember that causality cannot be inferred from these analyses. On the one hand, it is possible that supportive behaviors from others lead women married to alcoholics to not blame themselves for negative events. On the other hand, it is possible that those women who tend to believe negative events occur because of something about themselves may be less likely to seek out and develop supportive relationships with others.

Stable/Transient

Despite the prediction based on other populations that greater stability scores would be associated with greater symptomology (e.g., Sweeney et al., 1986), there were no significant findings regarding this dimension. Although the measure was found to be psychometrically sound for other populations in other research situations (Gong-Guy & Hammen, 1980), it is possible that it was not adequate for this study.

In light of the fact that many reported negative events are directly or indirectly related to problem drinking of the husband, it is appropriate to interpret causes of many of the events to mean alcohol problems. Therefore, on the one hand, some wives may have adopted the perspective presented in both the professional and lay literature that alcoholism is an ongoing, lifelong, and thus stable problem. On the other hand, other wives may have responded with unstable attributions because of the oftentimes erratic and unpredictable behavior of alcohol abusing husbands.

It is possible that as a group the wives are making several interpretations of the stability question. Until further research clarifies these conceptual problems, it is difficult to know whether stability is a useful concept for understanding the psychological functioning of women married to alcoholic men.

Global/Specific

It was predicted that wives experiencing greater psychological distress would perceive causes of particular negative events as also affecting other areas of their lives. This hypothesis was supported.

Other research has also noted a tendency for individuals experiencing distress to make global attributions for problems in their lives (Sweeney et al., 1986). Because no clear, observable factor appears to be causing numerous negative events in these individuals' lives, researchers have conceptualized the pattern of making global attributions as a cognitive error (Abramson et al., 1978). It should be noted that women married to alcoholic men are not a directly comparable population. These women frequently confront problems caused by the readily identifiable factor of their husbands' abusive drinking. Thus it is not surprising that these women made highly global attributions. While this trend is understandable, it also raises the question of whether wives of alcoholics might begin to blame all problems, whether justified or not, on their husbands' drinking. This cognitive overgeneralizing could impede a woman's efforts to deal with particular problems she faces. Further investigation is needed to determine specific cognitive tendencies.

An exploratory analysis also revealed that the more negative events a woman reported, the more likely she was to state that causes were not responsible for just a specific stressful event, but also had an impact on other parts of her life. It is easy to surmise that in this study women tended to blame husbands' drinking for stressful events, and that this abusive drinking also caused other comparably negative things to occur. To more fully understand why this finding might have emerged, it is necessary to examine attributional patterns of other populations. It is possible that other individuals with high life stress scores but no relationship with alcoholics or alcoholism also tend to make global attributions.

Measurement

There are also several measurement issues regarding the causal attributions which should be noted. First, due to the skewed distributions of scores for both the internal/external dimension and the global/specific dimension, the question is raised as to how well the AQ assesses these constructs. Respondents may have interpreted possible answers as being dichotomous rather than falling along a continuum.

On the other hand, these women may have been accurately representing their perceptions of causes as being completely external and global. This possibility is quite likely in view of the stable/transient scores. Instead of circling either endpoint number (i.e., 1: "something that changes" or 7: "something unchanging"), the women were more likely to select other numbers within the range. For

example, for all four events at least 14% of the women marked the midpoint number (i.e., 4). This suggests that the women may not be simply viewing their answer choices as dichotomous. Rather, in terms of external and global attributions, these women may hold quite homogenous beliefs.

Additional Findings

One other interesting finding emerged in the analysis of the causal attributions. No predictions were specifically made about the relationships between internal, stable, and global scores. The hypothesis that these attributions would all be associated with psychological dysfunction, however, holds an implicit assumption that all three attribution variables would be related.

As noted, only global attributions were correlated with psychological functioning. Global scores were not associated with either internal or stable scores. Interestingly, the internal and stable scores were correlated with each other, but not in the expected direction. Women blaming another person or a situation for negative events were more likely to perceive causes of negative events as stable and enduring.

This finding may be explained by exposure to certain philosophies. For example, the premises on which Al-Anon is based are consistent with this attributional pattern. One principle of Al-Anon states that other family members are not responsible for the alcoholic's behavior. A second theme is that alcoholism is an ongoing, life-long disease. Thus, a woman married to an alcoholic who

subscribes to these beliefs would tend to make external (i.e., due to something about the situation or other people) and stable (i.e., due to something unchanging) attributions about negative events in their lives.

Psychological Symptomology

In addition to the above discussion, two important limitations regarding the use of the Symptom Checklist-90 need to be mentioned. First, the SCL-90 was designed to measure how much certain problems have affected an individual within a specified period of time. All 90 items were given equal weight regardless of clinical severity, so that for example, responses of "a little bit" to both #15 "thoughts of ending your life" and #29 "feeling lonely" were considered equal. Thus, it is important to be cautious in interpreting the meaning of the SCL-90 score.

Additionally, there are several items on the SCL-90 which overlap with the Life Experiences Survey. It would not be surprising if psychological symptoms respondents experienced were also perceived as stressful events. Obvious duplication of some items can be avoided (e.g., LES #7 "eating much more or much less than usual" and SCL-90 #19 "poor appetite" and #60 "overeating"). There are, however, other symptoms which may or may not be represented in the life stress items. For example, LES #31 "arguing a lot more or a lot less with husband" may or may not be duplicated by SCL-90 #5 "feeling critical of others" or #11 "feeling easily annoyed or irritated." Due to the possibility

of spurious correlations between these measures, care must be taken when interpreting the findings.

Sociodemographics

Only one sociodemographic variable appeared to differentiate the respondents. There were significant differences between women married to military men and women married to civilian men for perceptions of social support from family, internal attributions, and age.

It was found that women married to civilian husbands perceived more social support from their family members than women married to military personnel. This finding is not surprising in light of the fact that military families are usually limited in their geographical choices, and consequently living near other family members may not occur frequently. Women married to civilians, on the other hand, may have increased opportunities to live near or visit their families.

The second finding is less easy to interpret. While not strong, the evidence points to a tendency of women who are married to military husbands to blame themselves for bad situations. This finding is particularly interesting when one considers that individuals associated with the military often do not have much control over such external events as job and geographical changes. It would seem that wives of military husbands would thus be more likely to make external attributions. Further investigation could be valuable in determining the extent and impact of this attributional

tendency among military wives, whether their husbands are alcoholic or not.

There was one other significant difference between these two groups. The mean age of women married to civilians is older, reflecting the fact that men tend to both enter and leave the military at relatively young ages.

What is perhaps more interesting in the comparisons between military wives and civilian wives is that there are so few differences. No predictions were made regarding these two groups of women because the focus of the study was not on the impact of a military lifestyle. One might expect the nature of the military (e.g., frequent transfers, assignment uncertainty, the possibility of combat) (Martin, 1984) to result in higher negative life events scores for military wives than for civilians. There were, however, no significant differences between the two groups. Additionally, the more transient nature of the military might lead one to expect less perceived social support from friends. This also was not the case.

Limitations of the Study

The primary limitation of this study is that all the respondents were recruited by staff of inpatient alcoholism treatment facilities where their husbands were in treatment. This methodological procedure provides important information about women whose husbands' problem drinking has been recognized and is being dealt with. Collecting data from these individuals does not, however, address questions about wives whose alcoholic husbands have not

entered treatment, nor about wives who have not acknowledged that their husbands' drinking is a problem.

While all of the respondents were women whose husbands were currently in treatment for alcoholism, there were a number of procedural differences which may have affected the results. One major factor was that 64 of the respondents were recruited while they were participating in inpatient treatment for spouses of alcoholics, while the other 34 women were involved in their husbands' treatment as outpatients only. It is possible that this difference may have led to varying levels of commitment and motivation in completing the questionnaires. It is questionable whether these variations were very influential, however. The 64 inpatient respondents were the women married to military personnel and, as noted above, there were few differences between wives of civilians and them.

Another factor which may have affected responses was the actual distribution and collection of the questionnaires to the outpatients. Due to the small sample sizes from each of the participating civilian facilities, it is difficult to assess how each of the practices may have influenced responses.

It should also be noted that the order of questionnaires within the packet may have had an impact on perceptions of the respondents. The first thing women were asked to do was to remember stressful life events. It is possible that thinking about these events may have exacerbated symptomology or lowered perceptions of support. As all the questionnaires were collated in the same order, it is expected

that any effects of ordering would be consistent across the sample.

Finally, there were a number of women whose husbands were in treatment who did not participate in the study. The measures involved an ability to read and understand English, thus precluding both illiterate and non-English speaking women. Other women took questionnaires but did not return them. One can only speculate what factors contributed to noncompliance. These issues must be considered when generalizing from the findings.

Implications for Future Research

The present study of wives of alcoholics replicates previously found relationships between stressful life events and psychological functioning, and the mediating impact of social support (e.g., Cohen & Wills, 1985). As has been noted, an appropriate next step is to determine causality. One valuable extension of this research would be an evaluation of intervention programs designed to provide opportunities for social support from others.

The attributional analyses yielded less clear-cut results. It was evident from this study that women whose husbands are currently undergoing treatment tend to make highly external and global attributions about the negative events in their lives. In order to determine whether these attributional patterns are meaningful it is necessary to examine a control population matched in age and marital status. This would determine whether married women in general tend to make external and global attributions, or whether these women are exhibiting particular tendencies.

Additionally, future research could investigate which attributional patterns provide the most realistic assessment of living with an alcoholic husband, and then determine what factors influence these attributions. It would also be interesting to assess the perceptions of other women married to alcoholic men: those whose husbands are not in treatment; those whose husbands have been abstinent for a period of time; those who did not remain in the marriage because of the problem drinking. Should these patterns vary markedly these results could be helpful in developing effective treatment strategies for wives of alcoholics.

This study was concerned with negative events chosen and specified by the respondents themselves. While many of the events were related to the husbands' problem drinking, the women were not asked their beliefs about the causes of the alcoholism itself. It would be interesting to examine whether wives of alcoholics make similar attributions about their husbands' alcoholism. This information could be beneficial to practitioners working with these women.

Finally, as alcoholism among women has become increasingly visible, the need for comparable research on husbands of alcoholic women is strongly apparent. In order to enhance theoretical understanding and practical implications, it is necessary to examine both similarities and differences between women and men married to alcoholics.

Conclusion

Social psychological research about perceptions of ambiguous entities such as negative life stress and social support continues to be conceptually problematic. Cohen (1977) notes that while operationalization of constructs becomes more refined, subtlety of the issues and subjective interpretations frequently create measurement difficulties. Additionally, research strategies are not yet sophisticated enough to predict much variance in dependent variables. In light of these problems, it is not surprising that effect size--that is, the extent to which a phenomenon exists in the population--tends to be smaller than that found in such fields as experimental or physiological psychology.

In assessing effect size (ES) of correlational research, Cohen (1977) suggests utilizing the following conventions: $r = .10$, small ES; $r = .30$, medium ES; $r = .50$, large ES. As he points out, these conventions are arbitrary but not unreasonable considering the above mentioned difficulties. Thus, based on these guidelines, results of this study fall between small-medium and medium-large ES.

These findings are important both practically and theoretically. On a practical level there are two immediately identifiable findings which may provide useful guidelines for individuals interacting with women married to alcoholics. The first finding is the recognition that perceived social support is associated with overall better psychological functioning. Practitioners and other concerned individuals may find development of these perceptions

to be beneficial. This may be done in several ways. One is through offering social skills and assertiveness training. A second is to help with the logistics of attending groups where friendship development is possible (e.g., church, service clubs). A third is through simply encouraging women to spend time working on already existing relationships with friends and family.

The second finding which may prove useful is the awareness that women married to alcoholics tend to make external and global attributions. Practitioners need to be sensitive to these tendencies to help wives remain focused on their own particular problems.

From a theoretical perspective, this research has contributed to the knowledge base of three related areas. First, the results of this study extend the generalizability of the life events/social support model. While it may be intuitively compelling to apply this model to all individuals experiencing psychological distress, one must recognize that differing life circumstances may create unforeseen consequences. This study determined that the specific life situation of being married to an alcoholic did not lead to unique relationships among life stress, social support, and psychological symptomology.

Second, it was found that the causal attribution model for symptomology is not appropriate for this population. The original model suggests that individuals experiencing psychological distress hold internal, stable, and global attributions about their life situations (Sweeney et al., 1986). The women in this study shared a similar externally-based life situation. Those experiencing high symptomology also shared the tendency to make global attributions.

They did not, however, make internal or stable attributions. Thus, it appears that introduction of specific circumstances may lead to different attribution patterns. This research clearly identifies limitations of the existing causal attribution model and suggests further investigation of the impact of external variables.

Finally, this study extends the understanding of women married to alcoholics. Four previously untested factors which significantly affect wives' psychological functioning were identified. By knowing that negative life stress, perceived social support from both friends and family, and global attributions are influential, researchers can begin to investigate specific features of these variables to further characterize the experience of wives of alcoholics.

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LIST OF REFERENCES

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APPENDIXES

APPENDIX A

LETTERS TO FACILITIES REQUESTING VOLUNTEER RESPONDENTS

Department of Psychology
Box 3452
New Mexico State University
Las Cruces, NM 88003
July 7, 1987

To whom it may concern:

My name is Becky McKenzie. I am a doctoral candidate in the community psychology program at the University of Tennessee, Knoxville. For my dissertation research I am conducting a descriptive study of wives of alcoholics. I am particularly interested in the relationship of causal attributions, life changes, and perceived social support from family and friends to wives' psychological well-being.

Currently, I am employed as a visiting assistant professor of social psychology at New Mexico State University. I am using subjects from a treatment facility in nearby El Paso, TX. However, I am also interested in obtaining subjects from other facilities throughout the country. I am writing to request permission to obtain information from women whose husbands are currently in treatment for alcoholism at your facility.

I have put together questionnaire packets consisting of four instruments currently in use by researchers in the field (the Attribution Questionnaire, the Life Events Survey, the Perceived Social Support surveys, and the Symptom Checklist-90). A demographic survey is also included, as well as two copies of the informed consent sheet. It is expected that subjects can complete the packet within an hour. Subjects are instructed to not put their names on any of the questionnaires. Therefore, all data will be anonymous and confidential. Only group data will be reported.

I will be responsible for any financial costs incurred by your facility. I will copy the questionnaires here and send them to you. I will also reimburse the facility for the cost of returning the questionnaires to me.

I realize the difficulties in conducting research with this population. At this time I am interested in using as many as 20 subjects from your facility. However, I recognize that many women are reluctant to participate in this type of research for any number of reasons. Therefore, I will be happy with data from however many subjects you are able to provide. At this time I have no deadline for obtaining data.

Thank you for any help you might be able to provide. Please contact me for any additional information regarding my research. I can be reached at either (505) 646-6207 (office) or (505) 525-1175. You can also leave a message for me at (505) 646-2502.

Again, thank you.

Yours,

Becky J. McKenzie

APPENDIX B

APPROVED REQUESTS FOR HUMAN SUBJECTS FROM
THE UNIVERSITY OF TENNESSEE AND
NEW MEXICO STATE UNIVERSITY

FORM B

CRP # _____

Date received in ORA _____

THE UNIVERSITY OF TENNESSEE, KNOXVILLE

Application for Review of Research Involving Human Subjects

I. IDENTIFICATION OF PROJECT

Date May 14, 1986

Project Director and Co-Director:

Becky J. McKenzie (doctoral candidate) and Cheryl B. Travis
(advisor)

Address and Phone number of PD:

Department of Psychology
Box 3452
New Mexico State University
Las Cruces, NM 88003
(505) 646-5473

Title of Project:

An Analysis of Stress Reactions in Wives of Alcoholics

Department:

Psychology

Estimated starting date:

Upon CRP approval

Completion date:

April 1, 1987

II. OBJECTIVE OF PROJECT

The objective of this dissertation is to conduct a descriptive analysis of wives of men diagnosed as alcoholic and currently undergoing treatment. Variables which are speculated to be important antecedents for psychological well-being of these women are life events, causal attributions for these events, and perceived social support from friends and family.

III. DESCRIPTION OF SUBJECTS

100 subjects will be recruited. Subjects will be wives of men

who have been diagnosed as alcoholic and are undergoing inpatient treatment at two different types of alcoholism treatment facilities. The first facility from which permission to obtain respondents has been granted is the Residential Treatment Facility in El Paso, Texas. Wives are actively involved in their husbands' treatment by being admitted into the residential program for weeks five and six of their husbands' stay. The second facility from which permission is pending for obtaining subjects is the Alcoholism Treatment Unit in Knoxville, Tennessee. Wives typically participate in their husbands' treatment by attending appropriate programs.

The only criterion for subjects in this study is that they be women married to men who are identified as alcoholic and are undergoing treatment.

IV. METHODS OF PROCEDURE

Subjects will provide demographic information on the following: age, ethnicity, number of children and their ages, length of marriage, periods of marital separation if any, employment status of wife, joint income, history of alcoholism in the wife's family of origin, perceived length of time the husband's alcoholism has been a problem, nature and style of the alcohol abuse, and incidence of battering or physical abuse. In addition each subject will complete four questionnaires: The Life Experiences Survey, Attribution Questionnaire, Perceived Social Support, and SCL-90 (see attached). At the El Paso facility, staff will discuss the project with potential respondents and will set aside a time during the first week of residence for subjects to complete the instruments if they wish. At the Knoxville facility, staff will discuss the project during an education program geared toward spouses. For those women wishing to participate, time and space will be made available for them to complete the instruments.

V. SPECIFIC RISKS AND PROTECTION MEASURES

The anticipated risk to the participants is minimal. That is, anticipated risk of harm is not greater than the risks encountered in daily activity or during the performance of routine psychological tests. Participants are asked to report on the following: major changes in their lives which may or may not have been perceived negatively; causal beliefs about those changes in their lives; perceived social support from friends and family; and symptoms of psychological distress. Should thinking about any of these cause the participant to feel uncomfortable, two strategies for coping are available. One, the participant may call the PD collect at the provided phone number for further discussion of the research. Two, the participant may talk with the staff of the alcoholism treatment facility where her husband is in treatment.

Participants will be anonymous. They will be directed to not

put their names on their questionnaires. Subject identity will not be recorded by the PD or staff of either treatment facility. All data analysis will be based on pooled group scores.

VI. BENEFITS VS. RISKS

Both anticipated benefits and risks to the participants are minimal. It is possible that filling out the questionnaires may lead the participant to become concerned about events in her life, and she may seek additional discussion with the PD or facility staff to deal with feelings about her responses. Ultimately, it is expected that this additional contact would be beneficial.

VII. METHOD OF OBTAINING "INFORMED CONSENT" FROM SUBJECTS

Two informed consent forms (see attached) will be distributed to interested participants just prior to administration of the questionnaires. Participants will be asked to sign one form and return it to an envelope addressed to the PD. They will be told that the other form is for their information. Staff will reiterate verbally that:

1. Participants are under no obligation to fill out the questionnaires.
2. Participants may discontinue involvement in the project at any time without penalty.
3. Participants are not to put their names on the questionnaires.
4. Should the participants wish to discuss anything about the research, they are free to call the PD collect at the listed telephone number.

The PD will keep in her possession the signed consent forms for three years following completion of the research.

VIII. RESPONSIBILITY OF PROJECT DIRECTOR

By the compliance with the policies established by The University of Tennessee, Knoxville, Committee on Research Participation, the project director 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.

Project Director _____ Date _____
Becky J. McKenzie, Doctoral Candidate

Co-Director _____ Date _____
Cheryl B. Travis, Ph.D.

IX. DEPARTMENTAL REVIEW

COMMENTS/RECOMMENDATIONS:

The application described above has been subjected to departmental review and has been approved.

Department Head _____ Date _____

Chair, Departmental
Review Committee _____ Date _____

THE UNIVERSITY OF TENNESSEE
KNOXVILLE



Office of
Research
Compliances

July 25, 1986

Ms. Becky J. McKenzie ✓
Dept. of Psychology, Box 3452
New Mexico State University
Las Cruces, NM 88003

Dr. Cheryl B. Travis
303C Austin Peay Bldg.
UT CAMPUS

Dear Ms. McKenzie and Dr. Travis:

As Chairperson of the Committee on Research Participation I have reviewed your project, "An Analysis of Stress Reactions in Wives of Alcoholics," CRP #2155. The project qualified for expedited review and is approved.

This approval is for a period ending July 25, 1987. 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. Obtain prior approval from the Committee before institution any changes in the project.
2. Retain signed consent forms from subjects for at least three years following completion of the project.
3. Submit a Form D to report termination, to renew approval, or to report changes in the project at 12-month or less intervals.

The Committee wishes you every success in your research endeavor.

Sincerely,

A handwritten signature in dark ink, appearing to read "L. B. Cebik".

L. B. Cebik, Chair
Committee on Research Participation

cc: Dr. Thomas C. Collins, Vice Provost for Research
Dr. R. R. Shrader
Dr. W. H. Calhoun

404 Andy Holt Tower / Knoxville, Tennessee 37996-0140 / (615) 974-7697

NEW MEXICO STATE UNIVERSITY

Dept. Head

College Dean

Committee

OG&C DIST:8/29/86

B. McKenzie-3452

D. Martin-3452

D. Darnall-RC

(see reverse side for description)

APPLICATION FOR PERMISSION TO USE HUMAN SUBJECTS IN RESEARCH

Principal Investigator

BECKY J MCKENZIE

Date

8-15-86

Faculty Member



Student

Department

PSYCHOLOGY

Title of Research Project

AN ANALYSIS OF STRESS REACTIONS IN
WIVES OF ALCOHOLICS

If Principal Investigator is a student, check purpose of project:



Master's Thesis



Doctor's Dissertation



Other (Explain)

Sponsor

Where work will be done

WM BEAUMONT HOSP
RESIDENTIAL TREATMENT
FACILITY, EL PASO, TX

Protocol of Research Project: Brief description of methods, number of subjects you expect to use, number of experimental sessions for each subject. Specify whether male, female, or both are to be used, and age range. Where questionnaires are to be used, a copy must be submitted. (Use back of this page).

CHECK LIST FOR RESEARCHER

Please check the appropriate square.

- | | Yes | No | |
|----|-------------------------------------|--------------------------|--|
| 1. | ☒ | ☐ | Federal funds are involved |
| 2. | ☒ | ☐ | The subjects will be fully informed |
| 3. | ☒ | ☐ | The consent of each subject will be received in writing prior to the experimental session. |
| 4. | ☒ | ☐ | The subjects will be fully protected from undue harassment and unreasonable risk. Their physical and psychological well being will be protected. |
| 5. | ☒ | ☐ | The subjects' personal privacy will be protected. |
| 6. | ☒ | ☐ | The subjects' participation will be entirely voluntary. |
| 7. | ☒ | ☐ | The subjects' time will not be unduly invaded and the integrity of the subjects' instructional time will not be compounded. |

Prior approval from the Committee must be obtained if Item 1 is checked YES and/or Item 6 is checked NO.

I have read the section in the Policies and Procedures Manual (pages 78-82) on the use of Humans in Research, and I certify that my proposed research is in conformity with the university policy.

Signature of Researcher

DISPOSITION BY: Committee on Participation of Human Beings as Subjects for Research.

Action Taken:



Approved



Disapproved

Date

for the Committee

Approval is valid for one year from date approved.



PROTOCOL OF RESEARCH PROJECT

Brief Description of Methods

S's: WIVES OF MILITARY PERSONNEL ADMITTED
TO RTF FOR ALCOHOL PROBLEMS. THESE WOMEN
ARE ALSO IN RESIDENTIAL TREATMENT WEEKS 5+6
OF THEIR HUSBANDS' STAY. THE WOMEN WILL BE
GIVEN 5 QUESTIONNAIRES TO COMPLETE (SEE
ATTACHED). PERMISSION HAS BEEN OBTAINED
FROM RTF FOR THIS STUDY

Subjects

Number of Subjects 100 Age Range 18 - 60

Sex of Subjects ☐ Male ☒ Female ☐ Male and Female

*LEVEL 1 - RESEARCH

All research which is not described in the Administrative Policy and Procedures Manual, pages 78-79 (Section IV, A-3).

APPENDIX C

INFORMATION ABOUT THE SPOUSE TREATMENT PROGRAM AT THE RESIDENTIAL
TREATMENT FACILITY, WILLIAM BEAUMONT HOSPITAL
EL PASO, TX

The Residential Treatment Facility (RTF) located at William Beaumont Hospital in El Paso, TX, is an alcohol and drug treatment unit operated by the U.S. Army. Patients include both enlisted and commissioned Army personnel and their spouses.

Patients are sent to RTF from their assigned military post when their alcohol or drug problem is identified. Possible ways this may happen include an arrest for driving while intoxicated, domestic disturbance, a job-related incident, or a spouse seeking assistance. Residential treatment is the third option should neither education nor education plus counseling prove appropriate. Individuals identified as having chemical dependency problems may choose not to participate in treatment; however, if they are discovered intoxicated once more they are discharged from the Army.

Residential treatment lasts for six weeks. During the fifth and sixth weeks of a patient's stay, his/her spouse is also admitted into RTF for treatment.

Wives who were admitted into the spouse treatment program between August 1986 and December 1987 were told of the need for volunteer research participants on the second day of their two week treatment. Interested women then obtained the questionnaire packets from counselor Major Ludwig, completed them in their hospital rooms, and returned them to Major Ludwig.

Note: This information was obtained from Major Ralph Ludwig, U.S. Army Chaplain, therapist for spouses at RTF.

"SPOUSES GROUP" SCHEDULE (1ST WEEK)

Monday 7 Jul - Friday 18 Jul 1986

Monday 7 Jul	0830-0900	In Processing (1st Floor)	Mrs. Hill
	0915-1115	Orientation (3rd floor group room)	CH Ludwig
	1130-1300	Lunch	
	1300-1445	Group Counseling	CH Ludwig Mrs. Brewer
	1630-1730	Supper	
	1800-2000	MMPI Testing (3rd floor testing room)	Medic
Tuesday 8 Jul	0900-0915	Community Meeting (3rd floor)	
	0915-1005	"If you Loved Me"	
	1020-1115	"Guidelines"	
	1130-1300	Lunch	
	1300-1545	Group Counseling MMPI Feedback	CH Ludwig Dr. Gold
Wednesday 9 Jul	0900-0915	Community Meeting	
	0915-1115	T-A Personality Development	Mr. Mullen
	1130-1300	Lunch	
	1300-1445	Group Counseling	CH Ludwig Mrs. Brewer
	1500-1615	Dynamics of Forgiveness (with spouses)	Mr. Mullen
	1930-2130	Adult Children of Alcoholics (Optional for interested spouses)	Mrs Ludwig
Thursday 10 Jul	0900-0915	Community Meeting	
	0915-1115	Viable Leisure Activities (First Floor Community Room)	LT Heissenbuttel
	1130-1300	Lunch	
	1300-1445	Group Counseling	CH Ludwig Mrs. Brewer
	1500-1600	"Feelings"	
	2000-2100	AI-Anon Meeting (3rd floor group room)	
Friday 11 Jul	0900-0915	Community Meeting	
	0915-1115	T-A Basic Life Positions	Mr. Mullen
	1130-1300	Lunch	
	1300-1445	Group Counseling	CH Ludwig Mrs. Brewer
	1500-1550	"12 Steps of A-A"	
	2000-2100	AI-Anon Meeting (Alano Club, Bus leaves at 1930)	
Saturday 12 Jul	0900-1130	Couples Group	CH Ludwig

Breakfast, lunch, and evening meals, will be served in the hospital dining facility. The bus will leave from in front of the RTF at 1130 for lunch and at 1630 for supper.

SPouses Group" Schedule (2ND WEEK)

Monday	0900-0915	Community Meeting	
14 Jul	0915-1000	"Romance to Recovery"	
	1010-1115	Family Research	LTC Kruzich
	1130-1300	Lunch	
	1300-1445	Group Counseling	CH Ludwig Mrs. Brewer
	1500-1600	"Symptoms of Sobriety"	
Tuesday	0900-0915	Community Meeting	
15 Jul	0900-1115	T-A Analyzing Transactions	Mr. Mullenr
	1130-1300	Lunch	
	1300-1450	Group Counseling	CH Ludwig Mrs. Brewer
	1500-1615	"The Family Trap" (with spouses)	
Wednesday	0900-0915	Community Meeting	
16 Jul	0915-1015	Optional Films	
	1015-1045	Field Trip Briefing (1st floor Community Room)	Mr Mullen
	1100-1630	Lunch & Field Trip To Juarez.	
	1930-2130	Adult Children of Alcoholics (Optional for Interested spouses)	Mrs Ludwig
Thursday	0900-0915	Community Meeting	
17 Jul	0915-1115	Human Sexuality Awareness	Mr. Fischer
	1130-1300	Lunch	
	1300-1445	Group Counseling	CH Ludwig Mrs. Brewer
	2000-2100	Al-Anon Meeting (3rd floor group room)	
Friday	0830-0930	EL PASO GRANDE	GOODBY
18 Jul			

GOD GRANT ME THE SERENITY

TO ACCEPT THE THINGS I CANNOT CHANGE;
THE COURAGE TO CHANGE THE THINGS I CAN
AND THE WISDOM TO KNOW THE DIFFERENCE.

**GOALS AND OBJECTIVES FOR
SPOUSES GROUP PROGRAM OF THE RTF**

- 1. ACQUIRE FACTUAL KNOWLEDGE ABOUT ALCOHOL, ALCOHOLISM AND THE ALCOHOLIC.**
- 2. LEARN ABOUT THE NATURE OF ADDICTION.**
- 3. DEVELOP AN AWARENESS OF HOW ALCOHOLISM, AND THE ALCOHOLIC, AFFECTS AND INFECTS THE WHOLE FAMILY SYSTEM.**
- 4. LEARN HOW TO MAKE THE ALCOHOLIC MORE RESPONSIBLE FOR THEIR OWN BEHAVIOR AND LEARN HOW TO BECOME MORE RESPONSIBLE FOR OUR OWN BEHAVIOR.**
- 5. BECOME ACQUAINTED WITH THE KEY TREATMENT RESOURCES WITHIN OUR COMMUNITIES.**
- 6. BECOME INTRODUCED TO ALANON THROUGH ACTIVE PARTICIPATION IN LOCAL ALANON MEETINGS.**
- 7. PARTICIPATE IN GROUP COUNSELING WITH OTHER SPOUSES OF ALCOHOLICS.**
- 8. LEARN SOME WAYS TO IMPROVE COMMUNICATIONS AND RESOLVE CONFLICTS WITHIN OUR MARRIAGES.**
- 9. DEVELOP AND IMPROVE OUR OWN SELF ESTEEM, AND OUR SELF AWARENESS.**
- 10. INCORPORATE ANY SPECIFIC INDIVIDUAL GOALS OR OBJECTIVES INTO THIS TWO WEEK EXPERIENCE AS THEY ARE EXPRESSED TO THE GROUP OR STAFF.**

APPENDIX D

INFORMATION ABOUT THE FAMILY TREATMENT PROGRAM,
CHEMICAL DEPENDENCY UNIT, HOTEL DIEU MEDICAL
CENTER, EL PASO, TX

Hotel Dieu
Medical
Center

October 22, 1987

Becky Mc Kenzie
New Mexico State University
Department of Psychology
Box 3425/Las Cruces New Mexico 88003

Dear Becky:

I hope all goes well with you.

We've been busy here-very exciting too. New owners, new programs and lots of new community interaction.

I'm sorry to say we haven't gathered much in the way of demographics, particularly on family members. I am enclosing a copy of my latest report and a description of the family weeks process, which is 75% didactic, 25% structured group interaction/and communication exercises within a multiple family edu-therapy modality.

The above information, I hope, is of some assistance for your methods section. The only question I can answer is that approximately one wife in four has attended Al-anon and 90% have attended fewer than 10 meetings.

At this moment, there are no forms to return, I will remind Fernando about them for the rest of October.

Sincerely,


Carol Gray

CG/ag



National Health Service
111 Queen's Road, London
W1R 3BH

FAMILY PROGRAM STATUS REPORT *CG*
January 17, 1987 to August 16, 1987

In the past seven months, Family Week has been attended by 57 patients and 139 family members. Due to new staffing patterns, the incoming Family Therapist and one C.D. intern were the only professional observers. Only four patients had no family attendance.

During this period, the Family Week program was cut from a 4½ day program to 3½ days. Due to this, the completion/coverage of Steps One through Three by family members has been dropped. An anonymous survey form is completed by all family members; they continue to validate the pertinence and quality of program components. Many suggest a longer program, stating that they need time for some conjoint work, for example. (Approximately half of all couples in Family Week are referred to specific marital therapists for follow-up.)

Patients and alumni consistently report that Family Week was the highlight of their program. Some tell us that they chose Hotel Dieu because of Family Week, knowing that their chances for recovery will improve significantly with family healing.

Although a small percentage of participants complain at first about the program taking place during work/school hours, nearly all report later that they were glad that they were able to give their undivided energy to this very intensive program.

Carol Gray

Carol Gray, M.A.

vrj

ORIENTATION TO THE FAMILY WEEK PROCESS

On behalf of the entire staff of Hotel Dieu Treatment Center, we would like to welcome you to our Family Therapy Program. We find your participation in the treatment process essential to both you and the patient. In fact, we cannot provide the best possible therapy without your help. It is our experience that the involvement of the family forces the patient to look at the reality of the addictive behavior and its effects on others. You, too, need the process to look at how the patient's behavior has caused your entire family to respond in ways that are not healthy. It is the purpose of our Family Program to help your entire family.

Chemical Dependency (alcoholism and other drug dependencies) is an illness which is characterized by denial and self-delusion. Because of the strong delusory process, (denial, minimizing, blackouts, memory defects and suppression of painful feelings) it is essential that the patient be helped to see just how bad the drinking or drug use has been.

The objectives of the Family Week Program at Hotel Dieu Treatment Center are:

1. To provide the family with knowledge and understanding of the illness.
2. To have the family provide data to enable the patient to become aware of the effects of his/her drinking or using on himself and those around him.
3. To help family members become aware of their own feelings and the unhealthy defenses they use to cope.
4. To aid the family in expressing these feelings to the patient.
5. To help the family to understand the ways in which they enable the patient to continue in his/her illness.
6. To help the family re-establish some form of healthy communication among themselves.
7. To provide an atmosphere of care and support, in a group setting, for the family.
8. To provide a setting in which the family can identify with and gain support from other families with similar problems.
9. To develop an awareness and appreciation of the AA program for the addict and the importance of the Al-Anon, Alateen groups for the family.
10. To develop an awareness of the need for the continued support of the Aftercare program at Hotel Dieu Treatment Center.

PARTICIPATION AND ABSENCES

Because of the importance of family week for recovery from the illness of chemical dependency, we have made it a requirement that family members be involved in the full four days of activities in order to be admitted for participation in the family week process. Only those family members who are willing to participate for the full process should come to family week. A little knowledge is often more harmful than helpful.

Absences from any of the family week processes without prior arrangement with counseling staff will result in termination from the Family Week Program for that particular individual. We urge you to "clear" your week to be involved in the program. Should you have an unavoidable conflict with the family week process, talk with the family counseling staff to make possible other arrangements for involvement in the patient's treatment program. Exceptions to this family week structure are made at the discretion of the Family Counseling Supervisor.

Family members coming in and out of the family week process break the cohesiveness of the group which slows down or causes a deterioration in the group process. We have a short time frame to work in and a lot of work to do. We elect, therefore, to work with those individuals who do make a commitment to the full week involvement. In dealing with a disease, half measures result in incomplete recovery. As part of a recovery process, we ask you to commit one hundred percent. This is a life or death issue.

TIMES FOR FAMILY WEEK

The time frame for family week is as follows:

Tuesday	-	9:00 a.m. - 3:30 p.m.	
Wednesday	-	9:00 a.m. - 3:30 p.m.	6:00 p.m. (S.O.P. night)
Thursday	-	9:00 a.m. - 3:30 p.m.	
Friday	-	9:00 a.m. - 2:30 p.m.	

You will receive a detailed overview at the Family Week Orientation. Please be prompt for meetings and scheduled events! The process will be much smoother for everyone.

NAME TAGS

Everyone receives a name tag at orientation time. Fill it out with your name (only) in large letters. We ask that you wear it throughout the family week process. It helps everyone to get acquainted and it helps the staff to learn who you are. If you lose your name tag or leave it at home, just ask for or pick up another one.

SMOKING - BEVERAGES

Smoking is not allowed in any of the groups or lectures. This is necessary in order to have everyone involved. Many people cannot tolerate cigarette smoke because of their physical health. We need to make family participation accessible to them also. You may smoke on breaks, in certain areas of the hospital. In all the Family Program Groups and Lectures, we do not permit family members or patients to have coffee, other beverages or food.

MEDICATIONS

We ask you to let the family counseling staff be aware of any medications or medical conditions that you currently have. We will ask you to note this on the back of the information card prior to beginning the Family Week Process.

We ask that family members not bring medications with them to family week unless absolutely necessary. If it is necessary that you have to take medication during the week, advise the family counseling staff.

MEALS

You will have approximately one and one-half hours for lunch. There is a cafeteria in the hospital, nearby restaurants, or you can bring your lunch.

CLEAN-UP

We ask that family members be responsible to clean up and pick-up after themselves following the lectures and group activities. Our attitudes are affected by our physical surroundings!

ALANON - AA - NARANON - NA - ALATEEN

You will be receiving information throughout the family week process about these support groups for individuals involved with chemical dependency. You will also receive a schedule of meeting times and places for the community. We urge you to attend either Alanon meetings or open AA meetings in the evenings this week as a part of your treatment.

MANIPULATION AND THERAPY OUT OF GROUP

In family systems where chemical dependency exists, family members and patients learn to meet their needs or attempt to meet their needs through manipulation of someone else, usually another family member. This can take place in a number of ways: threatening, guilt, promising, etc. We urge you to deal with these issues in the course of the family process. These methods of fulfilling needs are not healthy and are part of the disease process. If a family unit allows this type of non-functional behavior to continue through the course of the treatment process, the prognosis for recovery for the chemically dependent person and/or the family unit is extremely poor. It is very important to take the risks to recover.

CONFIDENTIALITY

The need for confidentiality is basic to a program of this nature. You are going to be involved with other patients and family members at a very personal level in the process of family therapy. No one is free to share outside the groups what has been said or what has taken place with someone else. If you want to share what happened with you, you may do that. Violations of group or personal confidentiality by either a patient or a family member will be dealt with as a serious issue by the Chemical Dependency Treatment Unit staff.

PASSES

Passes are given at the end of the family week process for therapeutic reasons only. If it is determined by staff that a pass and/or passes are therapeutically indicated for either the patient and/or the family members, the inpatient counselor and the patient will schedule them. The standard pass time on Friday afternoon is from 12:30 p.m. to 4:30 p.m. for a four-hour supper pass.

BEHAVIOR LIST FOR FAMILY GROUP

In the letter you received from the family program, you were advised to begin a list of the behaviors of the patient that you are aware of or that you have seen related to the use of alcohol or other chemicals. It is imperative that you make a list and use it to share with the patient. The purpose is that your sharing specific behaviors and feelings you've had can serve as a mirror to the patient.

If chemically dependent person is to recover, the delusion that exists about the use of alcohol/drugs and the subsequent behavior must be broken through you. Your mirroring the truth can help the individual to see themselves as they have become.

You must make a list to work in the family group. We will not work with those people who do not have a list. The family staff will be giving you a sheet to aid you in making your list, please use it. If you have questions, please ask them.

PATIENT REQUESTS

Your patient may ask you to bring in various items. Please call the nursing staff to see if items are on the accepted list before bringing them in.

APPROPRIATE DRESS

Shorts, low cut dresses and/or blouses or any other clothing which may be sexually provocative on adults or teenagers are not considered to be appropriate for wear in family week. Inappropriate dress will be confronted by staff and that person will be asked to change or leave the program.

TAKE CARE OF YOURSELF

The weeks process in Family Group is a very stressful week. We encourage you to take care of yourself. Eat right, get 6-8 hours sleep, and relax after groups. You are here for yourselves as well as the patient. Take care of #1 - YOU!!!

APPENDIX E

INFORMATION ABOUT THE FAMILY TREATMENT PROGRAM, CHEMICAL
DEPENDENCY UNIT, ST. VINCENT'S STRESS
CENTER, INDIANAPOLIS, IN

St. Vincent Stress Center
8401 Harcourt Road
Indianapolis, IN 46260
November 18, 1987

Dear Becky:

. . . (E)nclosed is a brochure describing the unit. Wednesday is family day and the way I gathered volunteer S's was to make an announcement at 9:00 a.m. about the study each Wed. Interested women would take the questionnaires home after I met with them briefly to explain the questionnaires. They would turn the completed questionnaire in to unit staff who would put it in my mailbox on the unit. I am a consulting clinical psychologist to the C(hemical) D(ependency) unit at the St. Vincent Stress Center. . . .

Robin (Shallcross, Ph.D.)

Note: transcribed from handwritten copy

The Stress Center follows the philosophy of The Daughters of Charity to provide physical, mental, emotional and spiritual support for those persons in need regardless of race, sex, color or creed.

If you or someone you know would like additional information, contact:
The St. Vincent Stress Center
Chemical Dependency Program
8401 Harcourt Road
Indianapolis, Indiana
(317) 875-4710

JCAH approved.



*St. Vincent
Stress Center*

8401 Harcourt Road • P.O. Box 80180
Indianapolis, IN 46280-0180



Inpatient Chemical Dependency Program



**St. Vincent
Stress Center**

The road to recovery

The use of alcohol or other mood-altering drugs usually begins in a search for simple pleasure. This may evolve into an easy means of dealing with the stress of everyday living.

Tragically for some, however, it develops into a chronic and severely disabling illness. The result — chemically dependent people ultimately suffer losses in virtually every aspect of life — their physical, spiritual and emotional well-being, their families, and their jobs.

But at the same time it is often very difficult for persons to admit their alcohol or chemical misuse is the real source of the problem. Treatment helps with the denial.

The St. Vincent Stress Center's goal is to start an individual on the road to recovery and abstinence through a comprehensive treatment and education program. It is conducive to increased self-awareness, understanding of interpersonal relationships and an understanding of the disease of alcoholism or chemical dependency. The Stress Center relies heavily on the proven principles of Alcoholics Anonymous to provide a foundation from which a person may be restored to a meaningful and useful life.

The program functions with a multi-disciplinary staff. Each patient is under the care of a physician, and treatment includes medical examinations, intake evaluation, group counseling, self-help techniques, individualized plans and aftercare.



Families play a key role in recovery

An important part of the treatment is participation by the patient's family. The program consists of a weekly family day, which begins at 9 a.m. and includes lectures and group therapy. Families are also welcome at the noon meal at no cost. The Stress Center cooperates with Al-Anon. Family members are introduced to this program and encouraged to participate.

Referrals to the Chemical Dependency Unit may be made by a variety of professionals, family members, or the patient. Admissions usually are scheduled in advance, and the typical stay is 4 weeks. However, each stay may differ, depending on the individual. For those in need, detoxification is part of the rehabilitative program. Treatment costs are often covered by insurance.

APPENDIX F

INFORMATION ABOUT THE FAMILY TREATMENT PROGRAM,
ALCOHOL AND DRUG REHABILITATION CENTER,
UNIVERSITY OF TENNESSEE HOSPITAL,
KNOXVILLE, TN



Alcohol and Drug Recovery Center
1924 Alcoa Highway
Knoxville, TN 37920-6999
(615) 544-9600

November 16, 1987

Becky J. McKenzie
New Mexico State University
Dept. of Psychology
Box 3452
Las Cruces, New Mexico 88003

Dear Becky,

I have enclosed all of the brochures that we have on the program. I trust these are helpful. You will note that I have also included a program schedule noting the meetings that the minor would be involved in also.

Functioning as a Family Therapist, I have had direct contact with the spouses in our couples group that meets once a week. I usually give the spouses the questionnaires on the night they attend couples group and ask them to return it to the staff on their return visit to the medical center. This system appears to be working very well at this point. I will have several questionnaires in the mail to you by 20 November, 1987.

Thanks for giving me the opportunity of working with you and feel free to contact me if there are questions or if the information submitted is not complete.

Again thanks,

A handwritten signature in cursive script that reads 'M. Douglas Henley'.

M. Douglas Henley, MSW
Counselor

MDH/mb

UNIV. OF TENN. Alcohol + Drug Recovery etc.

INPATIENT PROGRAM SCHEDULE

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
6:45am	Wakeup	Wakeup	Wakeup	Wakeup	Wakeup	Wakeup	Wakeup
7:45am	Vital Signs	Vital Signs	Vital Signs	Vital Signs	Vital Signs	Vital Signs	Vital Signs
8:00am	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast
8:30am	Thought for The Day	Thought for The Day	12 Step Study (8:30-9:30)	Thought for The Day	Thought for The Day	Thought for The Day	
9:00am	Exercise	Exercise		Exercise	Exercise	Family Group	Thought for the Day
10:15am	Coin Ceremony	Coin Ceremony	Coin Ceremony	Coin Ceremony	Coin Ceremony	*Visiting (10-11:30)	
10:30am							AA Inside
10:45am	Group Therapy	Medical Lecture	Stress Management	Mental Health Education	Mental Health Education		
12:00	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
1:00pm	Chemical Dependency Film	Group Therapy	Chemical Dependency Film	Group Therapy	Group Therapy	Study Time	Recreation and Study Time
2:30pm	Mens' Group & Women's Group	Assertive-ness	Special Group 3:00	Spirituality Lecture (3:30)	Chemical Dependency Video		
4:00pm			Community Meeting 4:15				
5:00pm	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
6:00pm	Family Group & Childrens' Group	*Visiting (6-7)	Extended Aftercare	Couples' Group *			Visiting (6-8:30)
7:00pm	Family Orientation * *Family Visiting 7-7:30	AlAnon and Alateen * Inside	Womens' AA Inside	*Visiting (7-8)			
7:30pm	AA Outside				AA Outside		
8:00pm		AA in Executive Dining Room	Introduction to AA Inside or NA Outside	AA Inside	NA on ADRC	NA in Auditorium	
9:30pm	Relaxation Training						
11:30pm	Quiet Time in Room	Quiet Time in Room	Quiet Time in Room	Quiet Time in Room			Quiet Time in Room
12:00	Bedtime	Bedtime	Bedtime	Bedtime	Bedtime (1:00 am)	Bedtime (1:00 am)	Bedtime

* Family members must attend the scheduled treatment activity in order to visit.

2/18/87

M E M O R A N D U M

TO: Curtis Curley, Director
Office of Health Affairs
Andrea Bowditch, Auditor

FROM: Worley Fain, Director
Denny Dukes, Associate Director
Alcohol and Drug Recovery Center

DATE: August 11, 1987

SUBJECT: ADRC PATIENT DATA FOR JULY, 1987

I. ADMISSION DATA

A.	Admissions	22	B. Average Daily Census	14.9
	Readmissions	0	Percent Occupancy	93%
	TOTAL	<u>22</u>		
C.	Admission Problems		D. Sex	
	Alcohol	7 (32%)	Male	18 (82%)
	Drugs	0 (0%)	Female	4 (18%)
	Both	15 (68%)		
E.	Marital Status			
	Single	10 (45%)		
	Married	8 (37%)		
	Divorced	4 (18%)		

II. DISCHARGES DATA

A.	Discharges	22	B. Average Length of Stay	19 Days
C.	Number with previous inpatient treatment	12 (55%)		
D.	Method of Payment at Discharge:		E. Type of Discharge:	
	Insurance	9 (41%)	Regular	14 (64%)
	Medicare/Medicaid	5 (23%)	Admin	2 (9%)
	Private Pay	3 (14%)	Transfer	0 (0%)
	DRI	5 (22%)	AMA	2 (9%)
			DRI	4 (18%)

MEMORANDUM

TO: Curtis Curley, Director
Office of Health Affairs
Andrea Bowditch, Auditor

FROM: Worley Fain, Director
Denny Dukes, Associate Director
Alcohol and Drug Recovery Center

DATE: September 3, 1987

SUBJECT: ADRC PATIENT DATA FOR AUGUST, 1987

I. ADMISSION DATA

A.	Admissions	22	B.	Average Daily Census	14.1
	Readmissions	0		Percent Occupancy	88%
	TOTAL	22			
C.	Admission Problems		D.	Sex	
	Alcohol	9 (41%)		Male	16 (73%)
	Drugs	0 (0%)		Female	6 (27%)
	Both	13 (59%)			
E.	Marital Status				
	Single	6 (27%)			
	Married	12 (55%)			
	Divorced	4 (18%)			

II. DISCHARGES DATA

A.	Discharges	23	B.	Average Length of Stay	21 Days
C.	Number with previous inpatient treatment	8 (35%)			
D.	Method of Payment at Discharge:		E.	Type of Discharge:	
	Insurance	12 (52%)		Regular	13 (57%)
	Medicare/Medicaid	6 (26%)		Admin	3 (13%)
	Private Pay	2 (9%)		Transfer	1 (4%)
	DRI	3 (13%)		AMA	4 (17%)
				DRI	2 (9%)

M E M O R A N D U M

TO: Curtis Curley, Director
Office of Health Affairs
Andrea Bowditch, Auditor

FROM: Worley Fain, Director
Denny Dukes, Associate Director
Alcohol and Drug Recovery Center

DATE: October 14, 1987

SUBJECT: ADRC PATIENT DATA FOR SEPTEMBER, 1987

I. ADMISSION DATA

A. Admissions	22	B. Average Daily Census	13.7
		Percent Occupancy	86%
C. Admission Problems		D. Sex	
Alcohol	12 (55%)	Male	13 (59%)
Drugs	0 (0%)	Female	9 (41%)
Both	10 (45%)		
E. Marital Status			
Single	11 (50%)		
Married	3 (14%)		
Divorced	8 (36%)		

II. DISCHARGES DATA

A. Discharges	24	B. Average Length of Stay	17 Days
C. Number with previous inpatient treatment	11 (50%)		
D. Method of Payment at Discharge:		E. Type of Discharge:	
Insurance	13 (54%)	Regular	15 (63%)
Medicare/Medicaid	7 (30%)	Admin	1 (4%)
Private Pay	2 (8%)	Transfer	2 (8%)
DRI	2 (8%)	AMA	4 (17%)
		DRI	2 (8%)

APPENDIX G

INFORMATION ABOUT THE FAMILY TREATMENT PROGRAM,
ADDICTION TREATMENT UNIT, ST. MARY'S MEDICAL
CENTER, KNOXVILLE, TN

ST. MARY'S MEDICAL CENTER

Oak Hill Avenue
Knoxville, Tennessee 37917 (615) 971-6011

November 5, 1987

Becky J. McKenzie
College of Arts & Sciences
Dept. of Psychology
Box 3452
Los Cruces, New Mexico 88003

Dear Becky:

Enclosed please find the initial information we give to family members. In addition to what's described in there we also have available a Spouse's Therapy Group, Couples' Therapy Group (which includes the patient), Parents Therapy Group, and Children's Therapy Group. We refer family members into these groups following their participation in family week. These groups are available on an open ended basis. We of course refer to Alanon and Naranon.

The procedure we used for filling out the forms varied to some degree. The majority were filled out while informant met with us. We found if we gave them out to be returned later, we got only a small percentage back.

We do not have a collection of demographic information already compiled. I'm sorry I can't help you with that one.

My job title is Director of Family Therapy, Addiction Treatment Unit. Ron Emrich is a Family Therapist and he also worked with some of the women who responded. You didn't ask, but perhaps it would help to know that I am an LCSW and Ron is a Vocational Rehabilitation Counselor.

I wish you continued success in your graduate program and I regret we were not able to provide you with more responses.

Sincerely,

Sally Ostermeier
Sally Ostermeier, LCSW
Director of Family Therapy
Addiction Treatment Unit

SO:clb

**Caring
For You.**

Member of the Mercy Health Care System - Province of Cincinnati

ST. MARY'S MEDICAL CENTER

Oak Hill Avenue
Knoxville, Tennessee 37917 (615) 971-6011

ALCOHOLISM TREATMENT UNIT

Tower 5
Oak Hill Avenue
Knoxville, TN
971-6761

WELCOME!

Chemical Dependency is a chronic disease; an illness which has interfered with your patient's daily life, work, and health. It has affected family members as well, causing bewilderment, confusion, anger, hurt and often stress-related physical illness. Chemical Dependency is a family illness, and that's why we treat all members of a dependent's family, in addition to the patient who is hospitalized. Our treatment objectives are to arrest the patient's disease, and to aid in the recovery of that person and each member of the family.

During inpatient treatment your patient will be safely withdrawn from all chemicals, treated for the immediate symptoms of his/her illness, and will initiate personal recovery. The family will be involved in the patient's and their own recovery process.

Upon discharge from the hospital, the patient and family members will continue treatment on an outpatient basis in the Aftercare Program. This extended care is extremely important to assure full recovery of your patient, yourself and family.

You will find the staff and atmosphere at the Alcoholism Treatment Unit friendly, supportive, and understanding. A Family Therapist is assigned to each patient and will be meeting with you shortly after admission. Your participation in the treatment process not only addresses your needs and concerns, but also contributes greatly to the recovery of your patient.

**Caring
For You.**

Member of the Mercy Health Care System - Province of Cincinnati

INFORMATION AND GUIDELINES

Length of Stay

St. Mary's Alcoholism Treatment Unit program lasts 4-6 weeks. It is impossible to identify a specific discharge date early in the program, due to differing needs of the patient population. If you have specific concerns about length of stay, please contact your family therapist.

Special Care

Patients are assigned to special care when they are first admitted to ATU. This is so nursing staff can closely monitor patients' health as they go through detoxification (or detox). This process of withdrawing from alcohol or drugs may cause physical or psychological discomfort. Staff and fellow patients spend time with them to help them in adjusting and orienting to the unit.

Patients are not permitted to have visitors or to talk on the telephone while they are in special care. If someone needs to relay a message to you during this period, a staff member will contact you. If you need to get a message to the patient, you can contact the staff. We will be happy to assist with getting your message to the patient. Our telephone number is 971-6761.

Patients leave special care when they are medically stable, thinking clearly, able to interact with others, and participating in the program (lectures, groups, etc.). You may then visit them during scheduled times outlined under Visiting. Please refer to the sheet on visiting for additional information.

Packages

Cigarettes are not sold in the hospital. Patients will be asking you to bring cigarettes, clothing and other personal items. Patients wear street clothes while here. When you bring packages or suitcases for a patient, please bring them to the Nurses' Station (front desk). It is our policy to inspect all packages and suitcases delivered to patients. Medicines will be reviewed by the doctor. Items containing alcohol will not be given to the patients. If you wish to bring a package to the patient during non-visiting hours, you may, but you will not be permitted to visit with the patient at those times.

Patient Requests for Alcohol and Drugs

Patients are sometimes nervous and a little uncomfortable in treatment. The first solution that occurs to them is to take a pill or a drink. They may call you and ask you to bring them alcohol or pills. However, you can be certain that the patients are given proper medical supervision and all the medication that they need. If the patient asks you to bring them pills or alcohol, it is best to encourage them to keep trying to manage without taking anything. Reassure them that they will feel better soon. Suggest that they talk to staff members about how they are feeling, etc. It would also be helpful if you would notify the staff about the patient's request for pills or alcohol. If a patient obtains alcohol or any other drug from outside the unit, he or she may be discharged from treatment.

Telephone

Patients have access to the telephone after they move out of the detoxification phase, but they are only allowed to talk on the telephone when they have free time. Their telephone can be used only for outgoing calls. If you wish to talk with the patient, you can call 971-6761 and ask a staff member to give them a message.

Visiting

Visiting is not allowed except at the designated days and times. Visiting is not permitted in any other area of the hospital.

You will not be allowed to start visiting until the specified time. If for some reason you arrive at the hospital before the specified time, please wait down on the first floor of the hospital in a waiting area or in the cafeteria. If you come up to wait at the entrance to the 5th floor, you will be asked to go back downstairs.

You may bring children to the hospital to visit a parent, sibling, or grandparent in treatment. It is necessary however, for you to supervise the children at all times.

You are responsible for concluding all of your visits at the scheduled times. Failure to cooperate with visiting regulations can jeopardize the visiting privileges of the entire patient population. All the rules are intended to protect and maintain the therapeutic environment. Your support and cooperation with the rules will help us provide the best possible treatment.

- | | | |
|--------------|-----------------------|--|
| WEDNESDAYS - | <u>8:00 - 9:00 pm</u> | All visitors must attend Family Support Group and Alanon or Naranon to be eligible for Wednesday visits. |
| SATURDAYS - | <u>10:00-12:00 pm</u> | All visitors must attend Family Education group at 9:00am - 10:00am prior to visiting. |
| SUNDAYS - | <u>6:00 - 7:30 pm</u> | Open Visiting |

Passes

After 14 days in treatment, patients may apply for a therapeutic pass. Passes are for 1 day only, Saturdays. Please contact your family therapist if you have any specific questions concerning passes.

FAMILY SERVICES

Family Support Group
Wednesday Evenings 5:30-6:45 pm
Located in the Shamrock Room, 1st Floor - Tower

Family Support Group is your first opportunity to become involved in the Family Treatment Program at ATU. You are asked to attend these weekly meetings from the time of admission through your patient's discharge. This group will provide you with the opportunity to discuss your feelings and concerns, ask questions, and benefit from the experience and support of the other families.

Alanon and Naranon meet at 7:00 pm. Children's Group (for ages 5-11) meets at the same time for children or siblings of patients. Ask your family therapist for the location of these meetings.

There is a Saturday morning education group offered for families from 9:00 - 10:00 am. Attendance at this group is required for Saturday visiting.

There are groups offered for Couples and Parents which families are referred into following Family Week. Your family therapist will be discussing these groups with you.

THREE STAGES OF TREATMENT

- STAGE ONE - Separate Treatment. For the first few weeks you and your patient will receive separate treatment. You will be involved in Family Support Group and are strongly encouraged to attend Alanon and/or Naranon. Your patient will be involved in the inpatient lectures, groups, and meeting.
- STAGE TWO - Family Week. This is a period of reintegration for the patient and family, as they are involved in family week together. This stage of treatment is timed so that your patient and the family have had sufficient time to begin to understand the disease of Chemical Dependency and the way in which it has affected everyone's lives and relationships.
- STAGE THREE - Aftercare. Groups are held weekly to encourage and support re-integration and family recovery. In no way does Aftercare take the place of Alanon, Naranon, A.A., N.A. or Alateen meetings.

ALCOHOLISM TREATMENT UNIT

Typical Family Week Schedule

Week of _____

MONDAY	9:00 - 9:15	-Orientation
	9:15-10:15	-Chemical Dependency I - The Disease Concept, Glenn Petersen, M.D.
	*10:30 -12:00	-Family Discussion Group
	12:00 - 1:00	-Lunch Break
	1:00 - 1:50	-Psychological Dependency of Family Ann Quammen, CSAC
	* 2:00 - 3:30	-Family Reconstruction Group
	3:45 - 4:30	-Film
TUESDAY	9:00 - 9:15	-Arrival
	9:15 -10:15	-Chemical Dependency II - the Disease Concept, Glenn Petersen, M.D.
	*10:30 -12:00	-Family Discussion Group
	12:00 - 1:00	-Lunch Break
	1:00 - 1:50	-Chemical Dependency Family Roles Mary Hughes, LCSW
	* 2:00 - 3:30	-Family Reconstruction Group
	3:45 - 4:30	-Film
WEDNESDAY	9:15 - 9:30	-Arrival
	*9:30 -11:00	-Feelings Game
	*11:00 -12:00	-Family Discussion Group
	12:00 - 1:00	-Lunch Break
	1:00 - 1:45	-Enabling - Carl Smith
	*2:00 - 3:30	-Family Reconstruction Group
	3:45 - 4:30	-Spirituality
THURSDAY	9:00 - 9:15	-Arrival
	9:15 -10:15	-Co-Dependency - A Family Disease Sally Ostermeier, LCSW
	*10:30 -12:00	-Family Discussion Group
	12:00 - 1:00	-Lunch Break
	1:00 - 1:45	-Relationship Issues - Ron Emrich, M.R.C.
	* 2:00 - 3:30	-Family Reconstruction Group
	3:45 - 4:30	-Family Aftercare
FRIDAY	9:00 - 9:15	-Arrival
	9:15 -10:15	-Alanon & Naranon
	*10:30 -12:00	-Family Discussion Group
	12:00 - 1:00	-Lunch Break
	1:00 - 1:50	-Patient Aftercare - Bob Kassem, Director
	* 2:00 - 3:30	-Family Reconstruction Group
	3:45 - 4:15	-Graduation

*In order to participate in these activities, you must be present the entire week. If that's not possible, you are welcome to attend lectures and films. We appreciate your cooperation.

FAMILY WEEK REGISTRATION

WEEK OF: _____

PATIENT'S NAME: _____

Family Members Attending

Relationship to Patient

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Plan to attend: ENTIRE WEEK _____ LECTURES ONLY _____ CANNOT ATTEND _____

Please remember, if you wish to participate in the Family Therapy Groups with your patient, it is REQUIRED that you be present for the ENTIRE week. You may attend any or all lectures if you are not able to attend for the entire week.

Please return completed form as soon as possible.

APPENDIX H

INFORMED CONSENT FORM FOR RESPONDENTS

CONSENT FORM

This research project has been developed to find out how you think about your life, including your marriage and the fact that your husband is undergoing treatment for alcohol problems.

There are five questionnaires I would like you to fill out. The first one is concerned with major changes you have experienced in your life in the recent past. There can be both good and bad changes. The second questionnaire asks what you believe to be the causes of the negative events in your life. The third asks questions about your family and friends who give you help. The fourth questionnaire is a list of problems people often experience at different times of their lives. The last one asks for some general information about you.

Filling out the questionnaires should take about an hour. The staff will explain how the forms are to be filled out and will answer any questions you might have about the forms. You may stop and turn in the questionnaires at any time you feel discomfort without any penalty. When you have completed the forms, please return them to the staff. DO NOT PUT YOUR NAME ON ANY OF THE QUESTIONNAIRES.

If you have any questions or concerns about your responses to the questionnaires, you may choose to talk with one of the staff members. Or, if you wish, you may call me collect at (505) 646-5473 during the daytime or (505) 525-1175 after 7 in the evening.

Please sign this form and return it to the staff. You may keep the second copy for your own information. Thank you very much for your help with this project!

Becky J. McKenzie

I have read and understand this consent form.

Signed _____ Date _____

APPENDIX I

LIFE EXPERIENCES SURVEY (LES)

The Life Experiences Survey

Listed below are a number of events which sometimes bring about change in the lives of those who experience them and which require making social readjustments.

1. First, please circle the numbers of those events that you have experienced in the three months BEFORE your husband was accepted for treatment.

2. Then, for each item circled below, please write on the line provided how positive or negative the event was to your life. That is, indicate the type and extent of impact that the event had. A rating of -3 would indicate an extremely negative impact. A rating of 0 suggests no impact either positive or negative. A rating of +3 would indicate an extremely positive impact.

For example:

_____ 1. Death of close friend

_____ 2. New job

extremely negative -3	moderately negative -2	somewhat negative -1	no impact 0	slightly positive +1	moderately positive +2	extremely positive +3
-----------------------------	------------------------------	----------------------------	-------------------	----------------------------	------------------------------	-----------------------------

_____ 1. Marriage

_____ 2. Being held in jail or other similar institution

_____ 3. Husband being held in jail or other similar institution

_____ 4. Death of husband

_____ 5. Sleeping much more or much less than usual

_____ 6. Death of

_____ a. daughter

_____ b. son

_____ c. mother

_____ d. father

_____ e. sister

_____ f. brother

_____ g. other: _____

_____ 7. Eating much more or much less than usual

_____ 8. Foreclosure on mortgage or loan

- _____ 9. Death of a close friend
- _____ 10. Outstanding personal achievement
- _____ 11. Minor law violation like traffic tickets or disturbing the peace
- _____ 12. Pregnancy
 - _____ a. Abortion
 - _____ b. Miscarriage
 - _____ c. Childbirth
 - _____ d. Currently pregnant
- _____ 13. Changed work situation (different work responsibilities, major change in working conditions, working hours, etc.)
- _____ 14. New job
- _____ 15. Physical assault by husband
- _____ 16. Serious illness or injury of husband
- _____ 17. Serious illness or injury of close family member:
 - _____ a. daughter
 - _____ b. son
 - _____ c. mother
 - _____ d. father
 - _____ e. sister
 - _____ f. brother
 - _____ g. other: _____
- _____ 18. Sexual difficulties with husband
- _____ 19. Trouble with your employer (in danger of losing job, being suspended, demoted, etc.)
- _____ 20. Trouble with in-laws
- _____ 21. Major change in financial status (a lot better off or a lot worse off)
- _____ 22. Sexual assault by someone other than husband
- _____ 23. Major change in closeness of family members (increased or decreased closeness)
- _____ 24. Gaining a new family member (through birth, adoption, family member moving in, etc.)
- _____ 25. Physical assault by someone other than husband

- _____ 26. Change of residence
- _____ 27. Marital separation from husband because of personal conflicts
- _____ 28. Increased or decreased attendance at church or other religious activities
- _____ 29. Getting back together with husband after separation due to fighting
- _____ 30. Sexual assault by husband
- _____ 31. Arguing a lot more or a lot less with husband
- _____ 32. Change in husband's work (loss of job, beginning new job, retirement, etc.)
- _____ 33. Major change in usual type and/or amount of recreational activities
- _____ 34. Borrowing more than \$20,000 (buying home, business, etc.)
- _____ 35. Borrowing less than \$10,000 (buying car, TV, etc.)
- _____ 36. Being fired from job
- _____ 37. You experiencing a serious illness or injury
- _____ 38. Major increase or decrease in such social activities as going to parties, going to movies, visiting with friends
- _____ 39. Children experiencing difficulties at school or with the law
- _____ 40. Major change in living conditions of family (building new home, remodeling, deterioration of home, neighborhood, etc.)
- _____ 41. Divorce
- _____ 42. Serious injury or illness of close friend
- _____ 43. Retirement from work
- _____ 44. Son or daughter leaving home because of marriage, college, etc.
- _____ 45. Ending of formal schooling
- _____ 46. Separation from husband because of work, travel, etc.

_____ 47. Leaving home for the first time

Other recent experiences which have had an impact on your life. List and rate.

_____ 48. _____

_____ 49. _____

_____ 50. _____

APPENDIX J

PERCEIVED SOCIAL SUPPORT FROM FRIENDS (PSS-fr)
AND FROM FAMILY (PSS-fr)

Perceived Social Support-Friends

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with friends. For each statement there are three possible answers: Yes, No, Don't know. Please circle the answer you choose for each item.

- | | | | |
|-----|----|------------|---|
| Yes | No | Don't Know | 1. My friends give me the moral support I need. |
| Yes | No | Don't Know | 2. Most other people are closer to their friends than I am. |
| Yes | No | Don't Know | 3. My friends enjoy hearing about what I think. |
| Yes | No | Don't Know | 4. Certain friends come to me when they have problems or need advice. |
| Yes | No | Don't Know | 5. I rely on my friends for emotional support. |
| Yes | No | Don't Know | 6. If I feel that one or more of my friends were upset with me, I'd just keep it to myself. |
| Yes | No | Don't Know | 7. I feel that I'm on the fringe in my circle of friends. |
| Yes | No | Don't Know | 8. There is a friend I could go to if I were just feeling down, without feeling funny about it later. |
| Yes | No | Don't Know | 9. My friends and I are very open about what we think about things. |
| Yes | No | Don't Know | 10. My friends are sensitive to my personal needs. |
| Yes | No | Don't Know | 11. My friends come to me for emotional support. |
| Yes | No | Don't Know | 12. My friends are good at helping me solve problems. |
| Yes | No | Don't Know | 13. I have a deep sharing relationship with a number of friends. |
| Yes | No | Don't Know | 14. My friends get good ideas about how to |

do things or make things from me.

- | | | | | |
|-----|----|------------|-----|---|
| Yes | No | Don't Know | 15. | When I confide in friends, it makes me feel uncomfortable. |
| Yes | No | Don't Know | 16. | My friends seek me out for companionship. |
| Yes | No | Don't Know | 17. | I think that my friends feel that I'm good at helping them solve problems. |
| Yes | No | Don't Know | 18. | I don't have a relationship with a friend that is as intimate as other people's relationships with friends. |
| Yes | No | Don't Know | 19. | I've recently gotten a good idea about how to do something from a friend. |
| Yes | No | Don't Know | 20. | I wish my friends were much different. |

Perceived Social Support-Family

Directions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with their families. For this questionnaire, please think of your family as being anybody you are related to through blood or marriage except your husband. I am interested in how you relate to other family members besides your husband. For each statement there are three possible answers: Yes, No, Don't know. Please circle the answer you choose for each item.

- | | | | | |
|-----|----|------------|----|--|
| Yes | No | Don't Know | 1. | My family gives me the moral support I need. |
| Yes | No | Don't Know | 2. | I get good ideas about how to do things or make things from my family. |
| Yes | No | Don't Know | 3. | Most other people are closer to their family than I am. |
| Yes | No | Don't Know | 4. | When I confide in the members of my family who are closest to me, I get the idea that it makes them uncomfortable. |
| Yes | No | Don't Know | 5. | My family enjoys hearing about what I think. |

Yes	No	Don't Know	6. Members of my family share many of my interests.
Yes	No	Don't Know	7. Certain members of my family come to me when they have problems or need advice.
Yes	No	Don't Know	8. I rely on my family for emotional support.
Yes	No	Don't Know	9. There is a member of my family I could go to if I were just feeling down, without feeling funny about it later.
Yes	No	Don't Know	10. My family and I are very open about what we think about things.
Yes	No	Don't Know	11. My family is sensitive to my personal needs.
Yes	No	Don't Know	12. Members of my family come to me for emotional support.
Yes	No	Don't Know	13. Members of my family are good at helping me solve problems.
Yes	No	Don't Know	14. I have a deep sharing relationship with a number of members of my family.
Yes	No	Don't Know	15. Members of my family get good ideas about how to do things or make things from me.
Yes	No	Don't Know	16. When I confide in members of my family, it makes me uncomfortable.
Yes	No	Don't Know	17. Members of my family seek me out for companionship.
Yes	No	Don't Know	18. I think that my family feels that I'm good at helping them solve problems.
Yes	No	Don't Know	19. I don't have a relationship with any member of my family that is as close as other people's relationships with family members.
Yes	No	Don't Know	20. I wish my family were much different.

APPENDIX K

ATTRIBUTION QUESTIONNAIRE (AQ)

Attribution Questionnaire

Section I.

For this section you are asked to answer some questions about the two events which you rated in the last survey as the most extremely negative. Remember, these events took place in the three months BEFORE your husband was accepted into treatment. For each event there is a set of questions. Please write the most negative event in the space provided on this page, and circle the numbers which most clearly match your thoughts about this event. Then do the same on the next page for the second most negative event.

A. most negative event _____

1. How upsetting was the event for you?

1	2	3	4	5	6	7
not at all						extremely

2. How much control over the occurrence of this event did you have?

1	2	3	4	5	6	7
none						a great deal

3. Did this event occur primarily because of something about you (such as your personality or behavior)--or was it primarily due to something about the situation or another person or persons?

1	2	3	4	5	6	7
something about me					something about the	
					situation or other person	

4. Did this event occur because of something that changes readily (such as mood, effort, luck, or fate)--or because of something relatively unchanging (such as ability or unchanging qualities of a situation or person)?

1	2	3	4	5	6	7
something that changes					something unchanging	

5. To what extent do the causes of this event affect other areas of your life?

1	2	3	4	5	6	7
not at all					a great deal	

B. second most negative event

1. How upsetting was the event for you?

1 2 3 4 5 6 7
not at all extremely

2. How much control over the occurrence of this event did you have?

1	2	3	4	5	6	7
none						a great deal

3. Did this event occur primarily because of something about you (such as your personality or behavior)--or was it primarily due to something about the situation or another person or persons?

1	2	3	4	5	6	7
something about me					something about the situation or other person	

4. Did this event occur because of something that changes readily (such as mood, effort, luck, or fate)--or because of something relatively unchanging (such as ability or unchanging qualities of a situation or person)?

```

      1      2      3      4      5      6      7
something that changes                something unchanging

```

5. To what extent do the causes of this event affect other areas of your life?

1	2	3	4	5	6	7
not at all						a great deal

Section 2

For this section you are asked to answer some questions about two events which you believe are directly related to your husband's drinking. Think of the two most negative events which occurred in the three months BEFORE your husband was accepted for treatment.

A. most negative event related to husband's drinking_____

1. How upsetting was the event for you?

1	2	3	4	5	6	7
not at all						extremely

2. How much control over the occurrence of this event did you have?

1	2	3	4	5	6	7
none						a great deal

3. Did this event occur primarily because of something about you (such as your personality or behavior)--or was it primarily due to something about the situation or another person or persons?

1	2	3	4	5	6	7
something about me					something about the	
					situation or other person	

4. Did this event occur because of something that changes readily (such as mood, effort, luck, or fate)--or because of something relatively unchanging (such as ability or unchanging qualities of a situation or person)?

1	2	3	4	5	6	7
something that changes					something unchanging	

5. To what extent do the causes of this event affect other areas of your life?

1	2	3	4	5	6	7
not at all					a great deal	

APPENDIX L

SYMPTOM CHECKLIST-90 (SCL-90)

SCL-90

INSTRUCTIONS

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please circle the numbers to the right of each problem that best describes how much that problem has bothered or distressed you from three months BEFORE your husband was accepted for treatment up to today.

HOW MUCH WERE YOU BOTHERED BY:	not at all	a little bit	moder- ately	quite a bit	ex- treme- ly
1. Headaches	1	2	3	4	5
2. Nervousness or shakiness inside	1	2	3	4	5
3. Unwanted thoughts, words, or ideas that won't leave your mind	1	2	3	4	5
4. Faintness or dizziness	1	2	3	4	5
5. Feeling critical of others	1	2	3	4	5
6. The idea that someone else can control your thoughts	1	2	3	4	5
7. Loss of sexual interest or pleasure	1	2	3	4	5
8. Feeling others are to blame for most of your troubles	1	2	3	4	5
9. Trouble remembering things	1	2	3	4	5
10. Worried about sloppiness or carelessness	1	2	3	4	5
11. Feeling easily annoyed or irritated	1	2	3	4	5
12. Pains in heart or chest	1	2	3	4	5
13. Feeling afraid in open spaces or on the street	1	2	3	4	5

14.	Feeling low in energy or slowed down	1	2	3	4	5
15.	Thoughts of ending your life	1	2	3	4	5
16.	Hearing voices that other people do not hear	1	2	3	4	5
17.	Trembling	1	2	3	4	5
18.	Feeling that most people cannot be trusted	1	2	3	4	5
19.	Poor appetite	1	2	3	4	5
20.	Crying easily	1	2	3	4	5
21.	Feeling shy or uneasy with the opposite sex	1	2	3	4	5
22.	Feeling of being trapped or caught	1	2	3	4	5
23.	Suddenly scared for no reason	1	2	3	4	5
24.	Temper outbursts that you could not control	1	2	3	4	5
25.	Feeling afraid to go out of your house alone	1	2	3	4	5
26.	Blaming yourself for things	1	2	3	4	5
27.	Pains in lower back	1	2	3	4	5
28.	Feeling blocked in getting things done	1	2	3	4	5
29.	Feeling lonely	1	2	3	4	5
30.	Feeling blue	1	2	3	4	5
31.	Worrying too much about things	1	2	3	4	5
32.	Feeling no interest in things	1	2	3	4	5
33.	Feeling fearful	1	2	3	4	5
34.	Your feelings being easily hurt	1	2	3	4	5

35.	Other people being aware of your private thoughts	1	2	3	4	5
36.	Feeling others do not understand you or are unsympathetic	1	2	3	4	5
37.	Feeling that people are unfriendly or dislike you	1	2	3	4	5
38.	Having to do things very slowly to insure correctness	1	2	3	4	5
39.	Heart pounding or racing	1	2	3	4	5
40.	Nausea or upset stomach	1	2	3	4	5
41.	Feeling inferior to others	1	2	3	4	5
42.	Soreness of your muscles	1	2	3	4	5
43.	Feeling that you are watched or talked about by others	1	2	3	4	5
44.	Trouble falling asleep	1	2	3	4	5
45.	Having to check and double check what you do	1	2	3	4	5
46.	Difficulty making decisions	1	2	3	4	5
47.	Feeling afraid to travel on buses, subways, or trains	1	2	3	4	5
48.	Trouble getting your breath	1	2	3	4	5
49.	Hot or cold spells	1	2	3	4	5
50.	Having to avoid certain things, places, or activities because they frighten you	1	2	3	4	5
51.	Your mind going blank	1	2	3	4	5
52.	Numbness or tingling in parts of your body	1	2	3	4	5
53.	A lump in your throat	1	2	3	4	5
54.	Feeling hopeless about the future	1	2	3	4	5

55.	Trouble concentrating	1	2	3	4	5
56.	Feeling weak in parts of your body	1	2	3	4	5
57.	Feeling tense or keyed up	1	2	3	4	5
58.	Heavy feeling in your arms or legs	1	2	3	4	5
59.	Thoughts of death or dying	1	2	3	4	5
60.	Overeating	1	2	3	4	5
61.	Feeling uneasy when people are watching or talking about you	1	2	3	4	5
62.	Having thoughts that are not your own	1	2	3	4	5
63.	Having urges to beat, injure, or harm someone	1	2	3	4	5
64.	Awakening in the early morning	1	2	3	4	5
65.	Having to repeat the same actions such as touching, counting, washing	1	2	3	4	5
66.	Sleep that is restless	1	2	3	4	5
67.	Having urges to break or smash things	1	2	3	4	5
68.	Having ideas or beliefs that others do not share	1	2	3	4	5
69.	Feeling very self-conscious with others	1	2	3	4	5
70.	Feeling uneasy in crowds, such as shopping or at a movie	1	2	3	4	5
71.	Feeling everything is an effort	1	2	3	4	5
72.	Spells of terror or panic	1	2	3	4	5

73.	Feeling uncomfortable about eating or drinking in public	1	2	3	4	5
74.	Getting into frequent arguments	1	2	3	4	5
75.	Feeling nervous when you are left alone	1	2	3	4	5
76.	Others not giving you proper credit for your achievements	1	2	3	4	5
77.	Feeling lonely even when you are with people	1	2	3	4	5
78.	Feeling so restless you couldn't sit still	1	2	3	4	5
79.	Feelings of worthlessness	1	2	3	4	5
80.	Feeling that familiar things are strange or unreal	1	2	3	4	5
81.	Shouting or throwing things	1	2	3	4	5
82.	Feeling afraid you will faint in public	1	2	3	4	5
83.	Feeling that people will take advantage of you if you let them	1	2	3	4	5
84.	Having thoughts about sex that bother you a lot	1	2	3	4	5
85.	The idea that you should be punished for your sins	1	2	3	4	5
86.	Feeling pushed to get things done	1	2	3	4	5
87.	The idea that something serious is wrong with your body	1	2	3	4	5
88.	Never feeling close to another person	1	2	3	4	5
89.	Feelings of guilt	1	2	3	4	5

90. The idea that something is wrong with your mind	1	2	3	4	5
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APPENDIX M

FACT SHEET

FACT SHEET

1. Age: _____
2. Ethnicity: Asian _____ Native American _____
 Black _____ White/Anglo _____
 Hispanic _____ Other _____
3. Are you a paid employee? yes, full time _____
 yes, part time _____
 no _____
4. Combined income of you and your husband:
 under \$10,000 _____ \$20,000-29,999 _____
 \$10,000-14,999 _____ \$30,000-59,999 _____
 \$15,000-19,999 _____ over \$60,000 _____
5. Length of present marriage:
 less than 3 months _____ 2 years to 5 years _____
 3 months to 6 months _____ 5 years to 10 years _____
 6 months to 1 year _____ 10 years to 20 years _____
 1 year to 2 years _____ more than 20 years _____
6. Have you and your present husband ever been separated due to
 marital conflicts? no _____ yes _____
 If yes, how many times? _____
 What was the longest period of time (years and months)? _____
7. How many children do you have? _____
 Please list their ages: _____
8. How long has your husband had a drinking problem? _____
9. How often did your husband drink before being accepted into
 treatment? _____ days each month
10. Have any of your blood relatives ever had a drinking problem?
 yes no don't know
 mother _____
 mother's mother _____
 mother's father _____
 father _____
 father's mother _____
 father's father _____

Please list other relatives related to you by blood that you know to have a drinking problem:

11. Have you ever attended Al-Anon? no _____ yes _____
If yes, for how many months did you attend? _____
How often did you attend? _____ times each month

McKenzie
Research
June, 1986

VITA

Becky Jean McKenzie was born in Watseka, Illinois, on January 28, 1954, during a basketball tournament in which her father was coaching in his lucky red tie. While this did not pretend great things for Ms. McKenzie in the sports arena, she and her brothers did romp around in the big yard of the house on Mulberry Street where they all spent a wonderful and relatively uneventful childhood. During adolescence, Ms. McKenzie divided her time between extensive involvement in extracurricular activities (a perusal of her yearbook finds her showing up on nearly every page) and hanging out at the A&W. Ms. McKenzie graduated from Watseka Community High School in May, 1972.

Ms. McKenzie started her undergraduate work at the University of Illinois. After a somewhat restless period, she ended up at the University of Maryland, from which she graduated in May, 1977, with a B.A. in English linguistics. Perhaps more influential (and more interesting?) than her course work were her two major volunteer involvements. Ms. McKenzie spent two years each as a ward visitor at a federal mental institution and as a telephone crisis counselor.

For a number of vague reasons, Ms. McKenzie moved to Knoxville, Tennessee, in August of 1977, where she eventually spent seven years. In August, 1980, Ms. McKenzie was admitted with a graduate assistantship to the doctoral program in community psychology at The University of Tennessee, Knoxville.

Both before and during her graduate career, Ms. McKenzie worked

and played well. She spent long hours in the various jobs she held: house supervisor at a shelter for people in crisis situations; unit counselor for adolescents at a private psychiatric hospital; mental health worker taking preadolescents on white water raft trips. Ms McKenzie also devoted a fair amount of time to playing. She spent time in the nearby mountains hiking, backpacking, rock climbing, and white water paddling; she got involved with traditional square and contra dancing; she took off on several road-trips around the country. In addition, Ms. McKenzie worked with the Knoxville Rape Crisis Center as a volunteer phone counselor and a board member during her seven years in Knoxville.

In August, 1984, Ms. McKenzie accepted a one-year position at New Mexico State University in Las Cruces. Despite her initial despair at the contrast between the high desert and lush East Tennessee, Ms. McKenzie eventually signed three more one-year contracts with N.M.S.U. While at N.M.S.U., Ms. McKenzie taught a number of popular undergraduate psychology courses. After her fourth year, Ms. McKenzie was nominated by outgoing seniors for a teaching excellence award. By the time these nominations were collected, however, Ms. McKenzie had left N.M.S.U. and thus was not eligible to receive the award. In addition to her teaching, Ms. McKenzie served as a faculty advisor to the Association for Concerns of the Handicapped, was a co-founder of the Southern New Mexico Music and Dance Society, and completed her dissertation research.

Ms. McKenzie returned to humidity when she accepted a position in San Antonio, Texas in August, 1988. Ms. McKenzie is teaching in a

one-year position at Trinity University. While her cats are enjoying the pleasant weather, Ms. McKenzie is gearing her job search to the north and hardwood forests again.

Ms. McKenzie received her Ph.D. from the University of Tennessee in December, 1988.