This is to certify that the

thesis entitled

Seeking Professional Help: The Experiences of Three Wives of Elderly Alcohol Abusers

presented by

Sheila Hamilton Livingston

has been accepted towards fulfillment of the requirements for

Master of Science degree in Nursing

Barbara Given

Major professor

Date 11/6/90

SEEKING PROFESSIONAL HELP: THE EXPERIENCES OF THREE WIVES OF ELDERLY ALCOHOL ABUSERS

By

Sheila Hamilton Livingston

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN NURSING

Department of Nursing

1990

ABSTRACT

SEEKING PROFESSIONAL HELP: THE EXPERIENCES OF THREE WIVES OF ELDERLY ALCOHOL ABUSERS

By

Sheila Hamilton Livingston

This study was undertaken to explore the life experience of three wives of elderly alcohol abusers who sought professional help for the first time. The aim of this study was to describe the interactions, thoughts and feelings that led up to the choice to seek help. Additionally, the life experience after the first help-seeking attempt was described. From the words of the three women common themes were isolated. Using these common themes, a core pattern of experience was described representing the meaning of life for the three women.

The methodology for this study was based on grounded theory. The three wives were volunteers who had been married for at least 25 years to men whom they perceived to be alcohol abusers. The husbands had to be at least 55 years old in order to represent the aging population. Interviews were held with open ended questions which explored the wives' perceptions.

DEDICATION

This thesis is dedicated to all wives

of alcohol abusers, especially those I have known and loved.

ACKNOWLEDGMENTS

I offer my deepest gratitude to my husband, P.J. and my sons Brian, Michael, John, and James. Thanks for all of your love, understanding, and support. I know that I spent many family time hours on this project and you were behind me the whole way. I love you all.

Special thanks to my colleagues and dear friends, Mary Beth Sommers, RN, MSN, and Linda Keilman, RN, MSN. I couldn't have made it without you!

Thank you to my committee:

Barbara Given, RN, Ph.D.

Andrea Bostrum, RN, MSN

Clare Collins, RN, Ph.D.

Sharon King, RN, Ph.D.

Thanks also to Jill Adams, my typist!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER I
THE PROBLEM

INTRODUCTION

"Eleven years ago, I started therapy with a psychologist after my husband was arrested for driving under the influence of alcohol. The psychologist introduced me to Al-Anon and within the year I began to learn to handle my life differently. For the first time in my life, I began to see I had a choice. What a miraculous concept. I was building myself into a whole person even though my husband's alcoholism progressed rapidly for the next six years.

My husband has now had five years of sobriety. We learned this is a family illness and there can be family recovery if at least one family member tries to find alternatives. I am finally doing it differently, and for me it is a better way. At least, finally, I had a choice."

Cindy
(Black, 1982, pg 151)

Reaching out and making that first contact with a helping resource is a big step. The act of picking up the phone, dialing the number and asking to speak to someone who can help only takes seconds. The processes which lead up to making that call for help--the debates with oneself, the mood changes experienced, telling yourself you can handle the problems alone, the never-ending continuous cycle of depression, anger, hope, guilt--all have taken their psychological and physical toll on you and your family. So, for many wives of alcohol abusers, it may be months or possibly even years before help is sought. For the wife of

an elderly alcohol abuser professional help may have been sought once, many times, or not at all. At some point the wife who has been in an alcohol abused marriage for any length of time may choose to seek help for the first time. The choice to seek help is seen as a problem-solving approach to change a problematic life experience.

The focus of this study will be to investigate the life experience of three wives of elderly alcohol abusers that led to the choice of seeking professional help for the first time. Experiences, which consist of alcohol abusive interactions that led to the first attempt at help-seeking will be explored. This exploration will be done in an attempt to understand the common areas of experience of alcohol abuse in three marriages. The alcohol abuse will have evolved to the point where the wife makes the choice to change her marriage by seeking help in an attempt to improve the quality of the life experience. The quality of the life experience since that help-seeking choice was made will also be explored to see the change if any in the alcohol abuse in the marriage. Comparisons of the similarities will be done to look for a unique pattern of interaction that describes the phenomena of this experience for these three women.

Nursing's role in the discovery of the lived experience is most appropriate. The Social Policy Statement of the American Nurse's Association (1980) specifies that the phenomena of concern to nurses are those human responses to

actual or potential problems. It is in understanding the patterns and rhythms of a life experience that a nurse can facilitate a client toward health and well-being. Promoting overall health and well-being, is that not where nursing's essence belongs?

Health is an active interaction with the environment to pattern a reality that creates a sense of well-being with a future view (Rogers, 1982). The meaning of health and well-being however is as different as the many individual clients and their experiences. Understanding and promoting health and well-being then can only come from understanding the human life experience. Perhaps the ongoing challenge to nursing can be met through the development of nursing theory through qualitative and descriptive research. The major goal of this study then will be to explore, compare and describe the experiences of three women married to elderly alcohol abusers that led to the choice to seek help, and how that choice has affected their life experience today.

Background

One of the greatest scientific achievements of this century is the increasing life expectancy of Americans. In 1900, only 4% of the population were 65 years or older, as predicted to the year 2000 that 12.2% will be 65 and older (Zimering & Domeischel, 1982). In the past five years there

has been a 28% increase in the number of people in the United States aged 65 and over (Christopherson, Escher & Bainton, 1984). Demographers predict that by the year 2000 the number will have increased from the present 25.5 million to more than 30 million (Christopherson, Escher & Bainton, 1984).

In recent years there has been a growing number of elderly and their special health needs. This growing number of elderly citizens are expecting to lead their remaining years in a state of positive well-being. Therefore, there is a growing concern with the process and problems of aging in general. With this concern there is a great deal more attention being turned to the use and misuse of drugs and alcohol by older persons (Petersen & Whittington, 1981). It is estimated that 2% to 10% of persons over the age of 60, and up to 20% of some nursing home populations, suffer from alcoholism (Zimering & Domeischel, 1982).

Alcohol abuse is a matter of increasing concern in the nation today. Barnes (1982) reviewed a number of studies for existing data on prevalence of alcohol abuse and found as many as 20% of the sample populations were heavy drinkers. Warheit and Auth (1983) found that 5.7% to 9.8% of the population are at risk for alcohol-related problems. In an article by Zimering and Domeischel (1982), it was estimated that the cost of alcoholism yearly to the national economy was $31.7 billion, including lost production, health

care, motor vehicle accidents, criminal justice system expenses, alcohol research and training, and social service costs. Alcoholism is ranked as the 4th major fatal illness in the nation.

In a typical American community, one out of six families in your neighborhood is affected by alcoholism (Black, 1982). Alcoholism is a disease that knows no boundaries. Alcoholism can affect children, teens, adults, blue collar workers, professional people, clergy, and the elderly. Only 3% to 5% of the alcoholic people in the United States are the stereotyped skid row drinkers (Black, 1982). The average alcoholic is a man or woman with family, job and responsibilities.

As many as 10% of the elderly are classified as heavy drinkers (Peterson & Whittington, 1981). Whereas Warheit and Auth (1983) categorized only 2.4% of those over 50 years old as having alcohol related problems, Barnes (1982) found 6%-9% prevalence of alcohol abuse in the elderly. In a study by LeGreca, Akers and Dwyer (1988) on alcohol consumption behavior of older adults, 1 out of five reported drinking alcohol daily, 3.5% had experienced drinking related problems in the past year, and 6.3% scored as heavy drinkers. A household survey carried out in Western New York by the Division of Alcoholism and Alcohol Abuse (1979) reported that approximately 1/4 or men in their 50s are heavy drinkers, and even larger proportions, 41% of men 50

to 59 are heavy drinkers. So not only was there a considerable population of elderly in 1979 with drinking problems, these figures could suggest that this trend will increase in the future as that 41% of heavy drinkers in the 50-59 year old group age.

Alcoholics are unable, with any predictability, to control their drinking and/or whose drinking causes problems in major areas of their lives (Black, 1982). Alcoholism is defined as a chronic, primary, hereditary disease process which progresses from an early physiological susceptibility into an addiction characterized by tolerance changes, physiological and psychological dependence, and loss of control over drinking (Milam & Ketcham, 1981).

As people develop the disease of alcoholism, it is most normal for the spouse to become increasingly preoccupied with the behavior of the alcoholic. This preoccupation has been referred to as co-alcoholism (Black, 1982). Abnormal family dynamics frequently occur as a consequence of the alcoholism and co-alcoholism. Family members respond to the behavior of the alcoholic by developing responses that cause the least amount of personal stress to themselves (Wegscheider, 1983). These responses often unwittingly function to promote or enable the progression of the alcoholism.

The enabling responses of the family members, especially the spouses, often supply the means or

opportunity to the alcoholic to continue with the progression of the disease (Steinglass, 1981). Some of these responses might be covering up, making excuses, ignoring, cleaning up after, lying, and suppressing feelings. The result of these enabling responses is that the alcoholic does not see or address the consequences of the drinking behavior (Black, 1982).

Researchers (Jackson, 1954, 1956, 1959, 1962; Orford & Guthrie, 1968; James & Goldman, 1971; Moos, Finney & Gamble, 1982) have found that the responses exhibited by the wife of an alcoholic are a manner of coping in response to the husband's alcoholism. This coping or enabling behavior, can be considered to be dysfunctional. Although these enabling coping behaviors may offer an immediate protection for the alcoholic crisis in the marriage, they in fact allow the alcoholism in the husband to progress.

A person does not make a conscious choice about becoming alcoholic or co-alcoholic and without the evolution of alcoholism in an individual's life he or she may have made other choices. As the problems surrounding alcohol abuse cause more and more inconsistency and unpredictability in the marriage and home, the behavior of the spouse's non-alcoholic family members typically becomes an attempt to restabilize the marriage and family (Black, 1982). Members of an alcoholic marriage and family then choose to respond in manners which make life easier and less painful for them.

At what point does the wife of an alcohol abuser first seek to change the enabling responses, and seek to change the quality of the life experience and progression of the alcoholic patterns in the marriage? Often, spouses and families become caught in the alcoholism and co-alcoholism cycle and cannot see that their responses are dysfunctional.

This study therefore was designed to explore the past life experiences of three women married to elderly alcohol abusers that led to the evolution of the first professional help-seeking attempt. Additionally, this study was designed to see if that help-seeking attempt changed the patterns of alcohol abuse in the marriage. Finally a comparison will be done to observe for the similarities in the three life experiences. A common pattern of response among these three women will be described.

Purpose

The purpose of this study will be to examine the first professional help-seeking attempt of three women who are married to elderly alcohol abusers. The past life experiences which evolved to the point where the choice to seek professional help will be explored. Additionally any changes in the quality of that life experience since the first help-seeking attempt occurred will be explored. A comparison of the three life experiences will be done to

describe the similarities that occurred. The common pattern of response which best describes these three women will be suggested.

A qualitative descriptive approach was chosen for this study. The reason this approach was selected was because the perception of the lived experience is what gives life meaning. It is in mutually discovering the meaning of life with a client that a nurse can facilitate the goal of health and well-being.

Importance

This study will be meaningful in several ways. First, although work has been done dealing with the wife of an alcohol abuser in general (Lewis, 1937; Futterman, 1953; Jackson, 1954, 1956, 1959, 1962; Orford & Guthrie, 1968; James & Goldman, 1971; Steinglass, 1981; Moos, Finney & Gamble, 1982; Jacob & Leonard, 1988) there has been little research done on the wife of an elderly alcohol abuser in particular. Secondly, this author can contribute to the study of alcohol abuse by viewing the elderly as being a unique group, with unique patterns of alcoholism, and co-alcoholism, possibly requiring special approaches. Third, this author may contribute to the study of gerontology by increasing the understanding that alcohol abuse is a problem faced by the elderly. Fourth, contributions to

nursing will be made in the area of qualitative research. There appears to be a small amount of qualitative research done by nurses in the literature. Yet qualitative research may support nursing as being unique in health care. Fifth, health care providers can benefit from understanding the meaning of any lived experience in order to mutually develop goals and design interventions.

Study Questions

1.) What past life experiences were perceived to lead to the evolution of the first professional help-seeking attempt on the part of the wife who believes her elderly husband to be an alcohol abuser?

2.) According to the wife, how did that first attempt at help-seeking change the life experience?

Definition of Major Concepts

Help-Seeking

Help-seeking will be viewed as a strategy that is directed at managing or altering a problem causing distress. Help-seeking is a problem-solving strategy in which the wife of an alcohol abuser seeks out information and support to reappraise the problematic alcohol abused marriage, and/or

learns new behaviors and skills by which to better manage or to change the alcohol abuse problems. This definition is based on stress and coping work done by Lazarus and Folkman (1984).

Since alcohol abuse in a marriage can span periods of many years, wives can engage in a series of successful or unsuccessful attempts to obtain professional assistance. The help-seeking strategies to be described in this study will be the first time professional help was sought.

Help-seeking can also be considered to be both professional and nonprofessional. Professional help-seeking approaches would include seeking help from professional counselors, family physicians, nurses, alcohol and drug rehabilitation centers, any community based resources in which a fee for service is given, and any nationally recognized organizations which deal in alcohol abuse such as Al-Anon. Nonprofessional approaches might include seeking help and support from family and friends. Although a wife of an elderly alcohol abuser might gain a great deal of support from informal sources, this study is designed to describe professional help-seeking.

Alcohol Abuse

Alcohol abuse has been, and still is tragically and fundamentally misunderstood. Confusion stems back from

myths and misconceptions from thousands of years ago (Milan & Ketcham, 1981). Milam and Ketcham describe a common myth of an alcoholic as a

> "...moral degenerate who choose a life of abasement and through lack of will power and maturity allows himself to lose his job, his family and his self respect...the typical alcoholic would rather be drunk than sober, who lacks confidence and maturity, who is riddled with guilt and shame over past sins and misdeeds, yet lacks the strength of character to change his ways and has no guiding purpose or motivation in life." (1981, pg. 9)

Even today in health care and other helping professions, the term alcoholic takes on a variety of different meanings. Miller and Mastria (1977) have defined the different schools of thought; 1). those that claim alcoholism is a physical disease related to such factors as nutritional deficiencies or hereditary influences, 2). those that claim that alcoholism is mainly a function of socio-cultural variables, 3). and others that claim abusive drinking is caused by personality defects, such as self-destructive impulses, "oral" dependency needs, or an extreme need for power and autonomy. Other reasons for confusion in defining alcohol abuse stem from the wide variety of drinking patterns and behaviors of the person who abuses alcohol and to the many different drinking styles. Some drink daily, some in episodes, and others stay dry for long periods of time between binges (Miller & Mastria, 1977). Alcohol abusers use a wide variety of alcohol (beer, wine whiskey, and others) to achieve the same effects.

In order to fully understand alcohol abuse, it is necessary to examine several definitions. An individual may have "one too many" on an occasional basis, but not habitually abuse alcohol. One out of every 10 alcohol users, however does become an alcohol abuser (Miller & Mastria, 1977) who drinks too much too often. Experts and laymen alike try to classify the alcohol abuser in terms of their various symptoms. The difference between a heavy drinker, a problem drinker and an alcoholic, all who abuse alcohol to different degrees, is often questioned.

A heavy drinker can be defined as anyone who drinks frequently or in large amounts. A heavy drinker may be a problem drinker, an alcoholic, or a normal drinker with a high tolerance for alcohol (Milam & Ketcham, 1981).

A problem drinker can be described as a person who is not an alcoholic but whose alcohol use creates psychological and social problems for him or herself, and/or others (Milam & Ketcham, 1981). The problem drinker may be one who drinks in response to a problem situation.

Alcoholism is defined as a chronic, primary, hereditary disease process which progresses from an early physiological susceptibility into an addiction characterized by tolerance changes, physiological and psychological dependence, and loss of control over drinking (Milam & Ketcham, 1981). The alcoholic, then, is the person who has alcoholism regardless of whether he is initially a heavy drinker, a problem

drinker, or a light to moderate drinker. The alcoholic's increasing problems and heavy drinking stem from the physical addiction and should not be confused with problem drinking, or heavy drinking in the non-alcoholic (Milam & Ketcham, 1981).

The main differences between heavy and problem drinkers, and true alcoholics are that: 1). the true alcoholic has an increased tissue tolerance to the alcohol, 2). a physical dependence on the alcohol with physical symptoms, and 3). an irresistible need for the alcohol when it is withdrawn. Tolerance refers to the fact that a person gradually needs more and more alcohol to attain the same "high" that he/she once received from lower doses (Miller & Mastria, 1977). Thus, alcohol itself forces the alcoholic to become more and more dependent on its use. The eventual result is physical addiction. Once an individual becomes physically addicted, he/she must continue to drink or else experience unpleasant withdrawal symptoms.

The progression of alcoholism can begin with the individual drinking socially to relax, or after a quarrel or disappointment. The alcoholic becomes more and more dependent on this pattern, imbibing larger quantities to get the same effect while concealing his or her actions (Milam & Ketcham, 1981). As alcoholism progresses, drinkers enter a second phase where they sometimes experience blackouts, morning tremulousness, remorseful hangovers, and job and

family difficulties. In spite of changing drinking habits, homes, and even jobs, they are unable to control their drinking. In the final stages, alcoholics cannot tolerate liquor as they used to, nor does it give them the same feeling of euphoria (Milam & Ketcham, 1981).

Where is the point where an individual crosses over from social drinking to alcoholism? There is no specific point, but rather a continuum. The continuum may be considered to range from negative susceptibility at one end to positive susceptibility at the other end. Between are the areas of lower to higher susceptibilities. Low susceptibilities describe those who abstain altogether from drinking, have no tolerance for alcohol, do not use drinking as a problem-solving approach, have little hereditary background for alcoholism, and have healthy liver functioning. Those with high susceptibilities have increasing amounts of tolerance to alcohol, have used alcohol in response to problems, have a strong hereditary background, and have a defect in the liver metabolism for alcohol. Therefore, an individual could start socially drinking at age 21, and with high susceptibility become a true alcoholic by 22. Those with lower susceptibility could start drinking at 21, and have a slow increase in tolerance and dependence, and not present symptoms until age 50. Also, those who have fluctuating drinking patterns can effect this point by drinking and abstaining periodically

while the tolerance and dependence builds.

For the purposes of this study, the broader definition of alcohol abuse will be utilized. Therefore, the elderly alcohol abuser by definition could be either a heavy drinker, a problem drinker or a true alcoholic. The elderly alcohol abuser will be identified through the perceptions of the wife. The rationale for use of this broad definition is associated with the fact that any instance of alcohol abuse can be perceived to be problematic, and therefore warrants study.

The wife will be asked to describe the characteristics and patterns of the husband's alcohol abuse which occurred prior to the first help-seeking attempt and how they may have since changed. The characteristics of alcohol abuse include any predisposing factors that might exist such as abnormal metabolism or family history. The characteristics or alcohol abuse will also include any behavioral, physical, psychological and social factors as perceived to be problematic by the wife. Additionally any characteristics specific to alcohol abuse in the elderly as determined from the literature will be explored. Appendix A contains many of the characteristics of alcohol abuse as described by Milam and Ketcham (1981) from their framework on stages of alcohol abuse.

Patterns of alcohol abuse are the actual drinking behavior that are repeated over time in a continuous

fashion. As the drinking behavior develops, changes occur which grow out of multiple previous experiences.

The life long drinking pattern of the alcohol abusing husband will be described by the perceptions of the wife. Since help-seeking is seen as a problem-solving strategy, description of the life long drinking pattern will be important to see if the first help-seeking attempt facilitated any change in the of drinking behaviors.

The Life Experience of the Wife of an Elderly Alcohol Abuser

The lived experience of the wife of an elderly alcohol abuser is considered to be a phenomenon. The interactions of the alcohol abusing husband and wife over time give the marriage a unique identity. The experience of the wife is inseparable from the alcohol abusive experience of the elderly husband because of the constant interactions in the marriage. The part of the whole life experience which is related to the alcohol abuse in the marriage may be perceived to be problematic by the wife. As the experience moves onward in life the mutual interactions in the marriage may give rise to change. This change might come from the choice of seeking professional help for the alcohol abuse in the marriage.

The lived experience of being the wife on an elderly alcohol abuser consists of both past and present interactions. The past experience consists of the actual living through the interactions which contain the wife's responses, thoughts and emotions. Through the wife actually living these responses, thoughts and emotions come knowledge and skills gained. This knowledge and skills can give rise to choices as the life experience proceeds forward. These choices can give rise to change. The present life experience of the wife of an elderly alcohol abuser has developed from the continuous mutual interactions, thoughts and feelings from the past experience. The mutual interactions have given rise to changes from the past. Choices were made by the wife which caused a change in life experience.

The identity of the life experience in the present is different from that of the past. The responses, thoughts and emotions of the wife today have developed through time. This constant change of the life experience for the wife of an elderly alcohol abuser is an ongoing evolutionary process. Even though there may be some responses, thoughts and emotions that are similar to those of the past they are not exactly the same. Changes in the interaction of the wife and the alcohol abusing husband have occurred. Some of these changes evolved from choices the wife made.

Past work by researchers on wives of alcohol abusers has viewed wives from a variety of different perspectives. No research has been identified that has viewed the wife of an alcohol abuser from the perception of her lived experience. Much of the early research was based on clinical observation alone (Lewis, 1937; Price, 1945; Whalen, 1959). Wives were initially described as aggressive domineering women who wished to control their marriages (Lewis, 1937; Price, 1945). Some researchers felt that wives of alcohol abusers had a certain personality type (Whalen, 1959; Kalashian, 1959; Deniker, deSaugy, & Ropert, 1965). Other researchers believed that wives would fall apart if their husbands became abstinent (Futterman, 1953; Macdonald, 1956).

The picture of these wives has gradually changed over the last 50 years. In opposition to the previous theories, Jackson (1954, 1956, 1959, 1962) felt that the personalities of the wives of alcohol abusers fluctuated relative to their husbands' involvement with alcohol. Jackson's work has not only received support (Bailey, Haberman, & Alksne, 1962; Baily, 1963, 1965, 1967; Kogan & Jackson, 1965; Moos, Finney & Gamble, 1982; Finney, Moos, Cronkite & Gamble, 1983), but her work was one of the first that examined the actual responses of the wife.

Researchers have shown that wives' methods of coping with change when their husbands' alcohol abuse changes

(Orford & Guthrie, 1968; James & Goldman, 1972; Moos, Finney & Gamble, 1982). Additionally researchers have indicated that the level of disturbance of wives from an alcoholic marriage is not different from that of wives from problem marriages (Deniker, deSaugy & Ropert, 1964; Bailey, 1965). Wives of alcohol abusers can be considered to have basically normal personalities of different types. They may suffer personality disturbance when their husbands are actively drinking. Along with the personality fluctuations are changes in the wives' methods of coping.

As the focus in research changed from viewing wives of alcohol abusers separately to one of focusing on the alcohol abusive marriage as a unit, a more interactive approach, the concept of roles evolved. The belief is that each person in an alcohol abusive family plays a role (Steinglass, 1978, 1981; Black, 1982). The players of these roles seek to maintain the homeostasis of the family unit.

Different interactional patterns have also been identified for alcohol abusive marriages depending on the alcohol abusing husbands' drinking pattern and place (Jacob & Leonard, 1988). Wives married to episodic and/or binge drinkers experiences less problem-solving and had more negative attitudes than wives whose husbands were steady drinkers at home (Jacob, Dunn & Leonard, 1983; Dunn, Jacob, Humman & Seihamer, 1987).

This researcher however will define the wife of an

alcohol abusing husband for this study based on her life experience as previously described. This will give the results of this study a much more humanistic qualitative appearance. The life experience of the wife of an elderly alcohol abuser will be considered to consist of both past and present interactions, which contain responses, thoughts and emotions. These constant interactions have given rise to change. Often this change has come about from the choices that the wife has made. These choices lead to change in the life experience.

The three wives involved in this study will have been married to alcohol abusing husbands for at least five years. This will allow for change of the life experience. The wife must have sought professional help for either herself, her husband or both at least once. The husband must be at least 55 years old in order to show those alcohol abusers progressing into older age.

Assumptions

1). The life experience a wife of an elderly alcohol abuser is a phenomenon which is shared by other wives of elderly alcohol abusers.

2). Alcohol abuse progresses and changes over time.

3). The wife's life experience cannot be separated from the husband's alcohol abuse.

4). The wife has developed responses, thoughts and emotions to the alcohol abusive interactions which give rise to the development of knowledge and skills.

5). The knowledge and skills derived from the past life experience give rise to choices.

6). Choices can give rise to change and the repatterning of the life experience.

7). The life experience constantly moves forward, never repeating itself.

8). The health and well-being of the wife can only be truly defined by the wife.

Limitations

1). The sample of women will be three in number with no attempt at random selection.

2). The marriage of the alcohol abuser and the wife will be

at least of 5 years duration. The wife may be separated, but not divorced.

3). The age of the alcohol abuser must be at least 55, and not less. The purpose of this limitation is to be sure that only the elderly population will be studied. The age of 55 was chosen as the limitation in order to allow for those alcohol abusers who would be entering their elderly years.

4). The identification of the husband as an alcohol abuser will be left up to the perceptions of the wife, and will not be verified or validated by any other means.

5). The method of data collection will be a onetime interview format with the wife only.

6). There is a potential for interviewer bias as there will only be one interviewer.

7). All data collected will depend on the wife's recall, and are not verifiable.

8). Human beings are complex. Factors such as personality, environment, mental capabilities, values, and lifestyle are acknowledged to be important but are beyond the scope of this study.

9). Subjects are a volunteer sample. Those individuals who do not volunteer may be in some way systematically different from those who do, thus limiting the generalizability of the findings.

Overview of Chapters

This study is presented in six chapters. In chapter I, the introduction, the purpose and importance of the study, the research questions, definitions of variables, assumptions and limitations of the study, and this overview of the following chapters is presented. In Chapter II a conceptual framework in which the main concepts will be developed within the chosen nursing theory will be presented. A review of the relevant literature will be presented in Chapter III. The research design and methodology are included in Chapter IV. Data analysis and results are contained in Chapter V. In Chapter VI the study findings, conclusions, recommendations and nursing implications are presented.

CHAPTER II

CONCEPTUAL FRAMEWORK

Introduction

The conceptual framework for this study has been developed to provide a systematic way to understand the wife of an elderly alcohol abusing husband. This conceptual framework utilized is based on Martha Rogers' theory for nursing (1970). Concepts discussed will include alcohol abuse in the elderly, and the response of the wife of an elderly alcohol abusing husband, which includes help-seeking. In this chapter, implications for nursing will be presented based on Rogers' theory and the nursing process.

Rogers' Theory

Rogers considers her theoretical basis for nursing as a conceptual system of theories that are both humanistic and optimistic. The focus of Rogers' conceptual system is that of Unitary Man, which provides a broad perspective of man and environment and the person's response to various life events (Rogers uses the term "man" when referring to person.) Nursing is the science that studies Unitary Man.

Rogers' (1970) theory of nursing provides a method of organizing abstract concepts and demonstrating their

relationships. There are four major concepts that compose Rogers' conceptual system; 1) energy fields, 2) open systems, 3) pattern and organization, and 4) four dimensionality.

According to Rogers, energy fields are the fundamental units which constitute both man and environment. Energy fields are both dynamic and unifying. There are two energy fields; the human energy field and the environmental energy field. The energy field is always greater than the sum of its parts and cannot be viewed in terms of parts because parts do not exist. Unitary Man is viewed as a dynamic, unified energy field; rather than a being that has an energy field.

The human and environmental energy fields flow through each other and are open. Therefore, if the fields are open then they extend to infinity and cannot be separated from each other. Man and environment cannot be separated. Rogers (1980) stated that the relationship between the human field and the environmental field is one of mutual interactions and mutual change. Man and environment are not to be separated but perceived simultaneously.

Pattern and organization give identity to the energy fields. The nature of the pattern and organization continuously changes and are increasingly unique, more diverse, and complex. Change proceeds by continuous repatterning of both human and environmental fields and

reflects mutual, simultaneous interaction between the two fields at any given point in space and time. Rogers (1980) indicates that the existence of organization and patterning is a phenomenon and that the nature of life's pattern and organization is a constant process of evolution.

Four dimensionality is described as a nonlinear domain. Unitary man is a four dimensional being in a four dimensional environment. A "point in time" that is present for one human interacting with the environment, is not necessarily present for another human. This concept can be thought of as the "relative present" or the "infinite now".

To summarize, Unitary Man is defined as (1970, 1980) an irreducible, four dimensional energy field identified by pattern and organization and manifesting characteristics different from those of the parts, which cannot be predicted from knowledge of parts. Interaction between the human energy field and environmental energy field is such that both are repatterned mutually, continuously, simultaneously, and with increasing complexity in a four dimensional time matrix along a space-time continuum.

Rogers has several main principles from her conceptual system called the Principles of Homeodynamics. These principles postulate a way of perceiving Unitary Man. The Principle of Resonancy refers to the nature of change occurring between human and environmental fields. Both are identified by wave pattern and organization manifesting

continuous change, accelerating, and decelerating, from lower frequency wave patterns to higher frequency wave patterns.

The Principle of Helicy postulates the direction of the change. The nature and direction of the human and environmental change is unidirectionally forward, continuously innovative, accelerating and decelerating, probablistic and characterized by increasing diversity. Though there may be many similarities in experiences and reactions in life, they are never the same, and are non-repeating.

The Principle of Complementarity refers to the inseparableness of the human and environmental fields. Man and environment have continuous and mutual interactions. This mutual process is a contradiction to the notion of causality. In a universe of open systems, mutuality is explicit, human and environmental fields change together (Rogers, 1980, 1982).

Rogers nursing theoretical system is based upon five basic assumptions of man which are nursing's main concern (1970). The five assumptions are: 1) wholeness, 2) openness, 3) pattern and organization, 4) unidirectionality, and 5) sentience and thought. Whelton (1979) summarized these basic assumptions:

(1) Wholeness - there exists an individual integrity, and individual physical and psychological uniqueness, that is the person.

(2) Openness - there is a constant interaction between the person and his/her environment. This exchange is ultimately affected by and effects all other interaction in the universe.

(3) Pattern and Organization - as the person develops, he/she increases in complexity, his/her life-style and habits grow out of multiple previous human/environment interactions.

(4) Unidirectionality - events in a person's life are unique, they do not come again or repeat themselves.

(5) Sentience and Thought - a person has the ability to understand his/her world and his/her experiences in the world.

In summary, the Principles of Homeodynamics postulate the nature and direction of unitary human development. The Principle of Resonancy refers to the nature of the change, the Principle of Helicy to the direction of change, and the Principle of Complementary to the inseparability of the human and environmental fields.

Additionally, Rogers nursing theoretical system is based upon five assumptions of man. These assumptions are:

1) wholeness, 2) openness, 3) pattern and organization, 4) unidirectionality, and 5) sentience and thought. These assumptions about human beings are the basis for a conceptual system which guides the nurse in practice.

The abstractness of this theoretical perspective is what enhances its applicability to nursing practice. The major concepts of the theory explore what man is, his relationships to the environment, and the life process itself. These concepts are fundamental to the understanding of the wife and the elderly alcohol abusing husband. Rogers (1970) clearly believed in the growth process of man throughout the life process in addition to visualizing man as being able to effect change in his future rather than adapting to environmental influences. These beliefs of Rogers have implications for the wife of the elderly alcohol abuser. According to Rogers' theoretical basis, the wife has the potential to repattern her responses to the elderly husband's alcohol abuse, and seek help to grow, and to enhance the quality of her life process. The relationships of Rogers' theoretical concepts to the elderly alcohol abusing husband, and to the responses of the wife will be explored in the next two sections. These relationships will further substantiate the use of Rogers' theory for this study.

Alcohol Abuse in the Elderly Husband

The abstract concepts of Rogers' theory can be utilized to explain alcohol abuse in the elderly. As man ages, he accelerates, and decelerates unidirectionally along time and space becoming more complex. Additionally, the elderly man's interaction with the environment is constantly being patterned and repatterned. Events in the elderly man's life never repeat themselves, so the elderly become more unique. Therefore, to define alcohol abuse in the elderly, this researcher proposes the need to look at the elderly and their problems as being increasingly unique and complex.

The elderly husband who abuses alcohol is a dynamic unified energy field. This elderly man is greater than the sum of his parts. Therefore, this man's life experience is greater than just the alcohol abuse. Many other factors will contribute to the total life experience.

The energy field that is the elderly husband who abuses alcohol is open, an flows through other energy fields such as those of his wife, family members, and the environment. Therefore, the elderly husband's life experience cannot be separated from his wife, or from the environment. The experiences of the husband and wife consist of mutual interactions and must be perceived simultaneously.

Pattern and organization give identity to the elderly alcohol abuser. Part of this man's identity then is the individual pattern or habit of drinking alcohol. The nature and pattern of this organization continuously change, and become increasingly more unique, diverse nd complex. Therefore the drinking habits of the elderly man will change over time, and become more diverse, and unique. This change in drinking habits reflects mutual,simultaneous interaction with the wife, family, and environment. The drinking patterns or habits evolve over time.

As the life experience patterns and repatterns over time, the alcohol abuse itself will become more complex and diverse. The dependency and tolerance to alcohol will change and become a more unique experience than that of younger alcohol abusers. The symptoms and stages of alcohol abuse as known to the general alcohol abuser may not be totally accurate criteria to define the problem of alcohol abuse in the elderly. The elderly's experience with alcohol has probably evolved past the average person's experience. The main criteria used to define the stages of alcohol abuse fail to take into consideration the changing physiology and life styles of the elderly.

The elderly man who abuses alcohol is a four dimensional being in a four dimensional environment. The point in time that is present for this man who is

interacting with the environment, is not necessarily present for another. The wife of this elderly alcohol abuser may not perceive an interaction in the same way. The wife may attempt to stop the alcohol abuse that the husband is seeking to maintain.

Rogers' Principles of Homeodynamics can be applied to the elderly alcohol abuser. The Principle of Resonancy, which refers to the nature of change, describes the elderly alcohol abuser and the environment as being identified by pattern and organization. Interactions between man and environment are always changing, accelerating, and decelerating, from lower to higher frequency patterns. The elderly alcohol abuser is always changing from interactions with the environment. His alcohol abuse will affect the life experience and environment at different degrees as it evolves. The elderly husband's susceptibility changes from an increased tolerance to a lower tolerance with the increased complexity of the aging process. The alcohol abuse will become more complex, unique, and diverse as time goes forward.

The Principle of Helicy which postulates the direction of change, suggests that the nature and direction of change is unidirectional, continuously forward. The elderly alcohol abuser may have life experiences that are similar to previous experiences, but they will never be the same.

Therefore alcohol abuse will evolve in sequential stages with increased complexity.

The Principle of Complementarity refer to the inseparableness of the human environmental fields. Therefore, as the life process of the elderly alcohol abuser evolves it is continuously interacting with human and environmental fields. This mutual process is a contradiction to causality. So alcohol abuse may not be caused by one specific factor with specific symptoms but rather is evolved out of repatterning of personal, human, and environmental interactions. With increased complexity, uniqueness, and diversity of the aging process, the usually recognized symptoms associated with alcohol abuse may not be present, and symptoms patterned from the general health process of the individual may be more suggestive of the evolution of alcohol abuse.

Rogers' basic nursing assumptions can be applied to describe the elderly alcohol abuser. The concept of wholeness refers to the individual uniqueness and integrity that is the person (see Figure 1). Openness refers to the potential extent of human and environmental interactions (this is indicated by broken lines in Figure 1). Pattern and organization refer to that which gives the person identity (name, past occupation, drinking patterns, stage of alcohol abuse). The pattern and organization is derived from multiple human and environmental interactions over

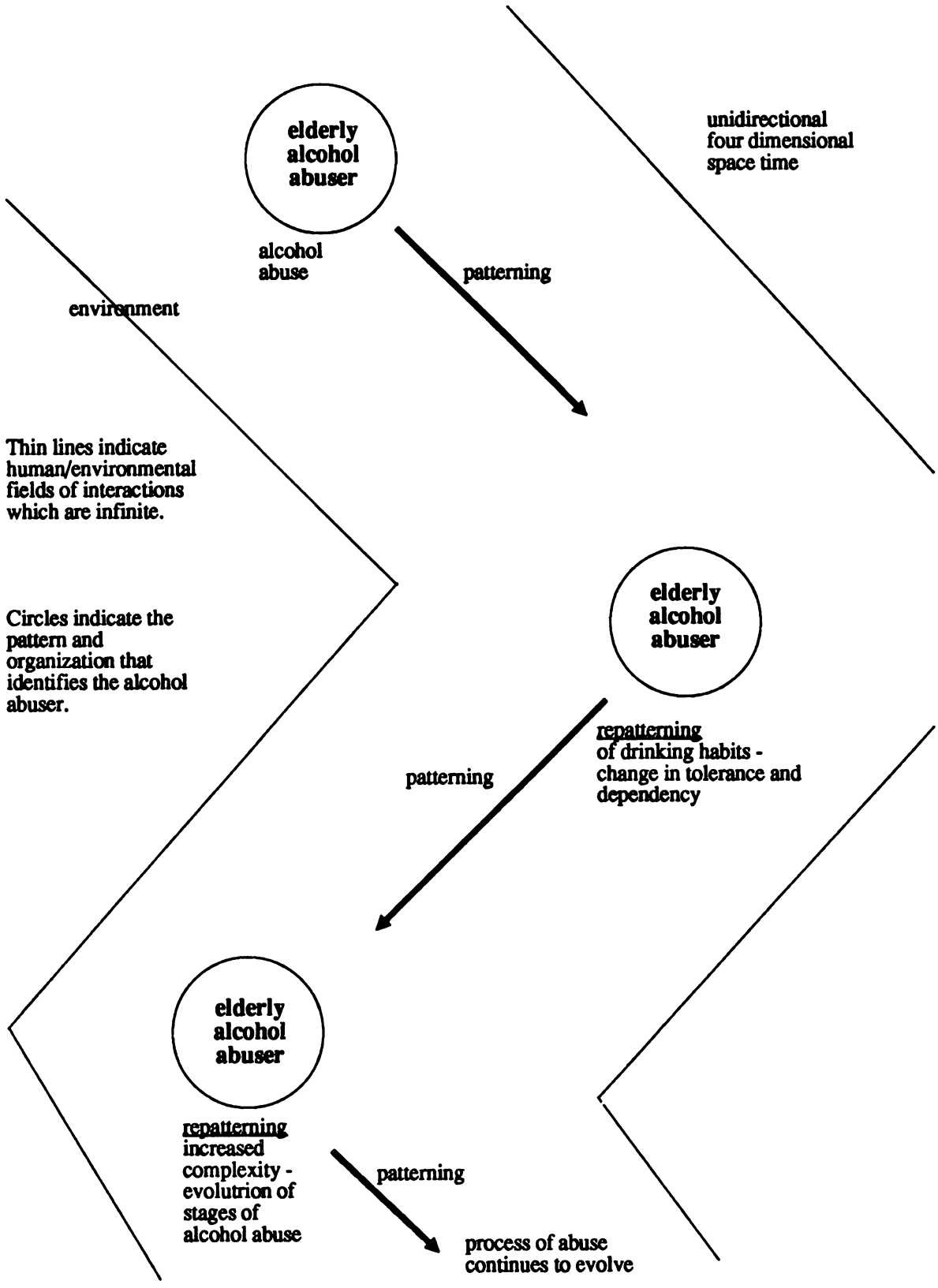


Figure 1: Application of Rogers' Theory to an Elderly Alcohol Abuser

time. Unidirectionality refers to events encountered by the person that are not repeated. Sentience and thought refer to the capacity of the person to think, to understand, to experience, and to perceive his world.

Sentience and thought is an important assumption to consider. The elderly alcohol abuser has the capacity to think about and understand his alcohol abuse. This assumption gives the person the ability to learn about alcohol abuse and to make choices. The past experiences regarding the alcohol abuse can lead towards continued abuse or cure, depending on how these experiences are perceived. Additionally, with these past abusive experiences, feelings such as guilt, depression, remorse, and denial can evolve. These feelings and any choices made will contribute toward future human and environmental interactions.

To summarize, the elderly man who abuses alcohol can be defined as an irreducible, four dimensional energy field identified by pattern and organization. Pattern and organization, which include drinking patterns and stages of alcohol abuse give identity to this man. Interaction between human and environmental energy fields gives rise to mutual change or repatterning that is simultaneous and continuous. The elderly man who abuses alcohol will evolve along a space-time continuum becoming more complex, diverse, and unique. The life experience of an elderly alcohol abuser may have evolved past that of most alcohol abusers,

and is therefore more difficult to define and identify.

Based on Roger's Principles of Homeodynamics, the basic assumptions, the elderly alcohol abusing man is conceptualized to be a unique individual, who has multiple human and environmental interactions that are never repeated. These mutual interactions give rise to change, or repatterning of the life experience. The elderly alcohol abuser has the ability to understand and perceive his world. Therefore he will have feelings and be able to make choices about this life experience.

The next section will be an application of Rogers' theory to the responses of wives of elderly alcohol abusing husbands. Rogers' principles and basic assumptions will be reviewed with respect to the wife's response.

The Wife's Response to Alcohol Abuse

Even though many researchers and authors focus on the drinker, wives of alcohol abusers have also been the subject of many clinical reports and experimental studies (Edwards, Harvey & Whitehead, 1973). Intense marital conflict, marital separation, and divorce are frequent concomitants of alcohol abuse (Miller, 1976). Research has demonstrated divorce rates of chronic alcohol abusers range from 49% to 79% (Miller, 1976). The majority of those divorces reported

excessive drinking as the major cause of the marital conflict (Miller, 1976).

The interrelationship between marital difficulties and alcohol abuse is so close that it seems hard to determine which came first, marital tension or excessive drinking. Marital tension and alcohol abuse seem to feed each other. In any event, most clinicians agree that a change in the relationship between the alcohol abuser and the spouse can be conducive to sobriety.

The picture of the wife seems to be changing from that of an aggressive woman who married an alcohol abuser to fulfill her need to dominate, through that of one whose personality fluctuated with the stresses involved in marriage to an alcohol abuser, to that of a woman who may or may not react to the stress of her marriage with personality dysfunction (Edwards, Harvey & Whitehead, 1973). Wives of alcohol abusers are now considered to have basically normal personalities of different types, rather than one particular type. They may suffer personality dysfunction when their husbands are active alcohol abusers. However, these personality disturbances lessen when the alcohol abuse of their husbands decreases or becomes abstinent. Along with the personality fluctuations are changes in the wives' behaviors in response to their husbands' drinking and with their roles in the family. Responses of the wife to alcohol

abuse are very much like the responses to most any life crises (Moos, Finney & Gamble, 1982).

Consistent with Rogers' conceptual system, the concepts of the elderly alcohol abuser, and his wife who interacts with the alcohol abuse cannot be separated (see Figure 2). As previously stated, alcohol abuse is seen as a unidirectional process that progresses by patterning and repatterning through space and time. As the alcohol abuser's susceptibility changes to an increase in tolerance and physical and psychological dependency to alcohol, he will pattern and repattern the drinking behaviors to support this process through space and time.

The wife of the alcohol abuser cannot be segregated because, according to Rogers, she would be considered an integral part of the environment. The alcohol abuser and his wife are continuously interacting in a unidirectional way. The wife's responses are seen as a continual interaction with the alcohol abuser to protect the wife from the crisis of the alcohol abuse in the marriage. The wife's responses are continuously patterned and repatterned based on the husband's unidirectional progress of the alcohol abuse. Help-seeking is seen as an attempt at repatterning the life experience.

The marriage relationships of an elderly alcohol abusing husband and the wife can be considered a system or "group field" (Rogers, 1982). A group field is a separate

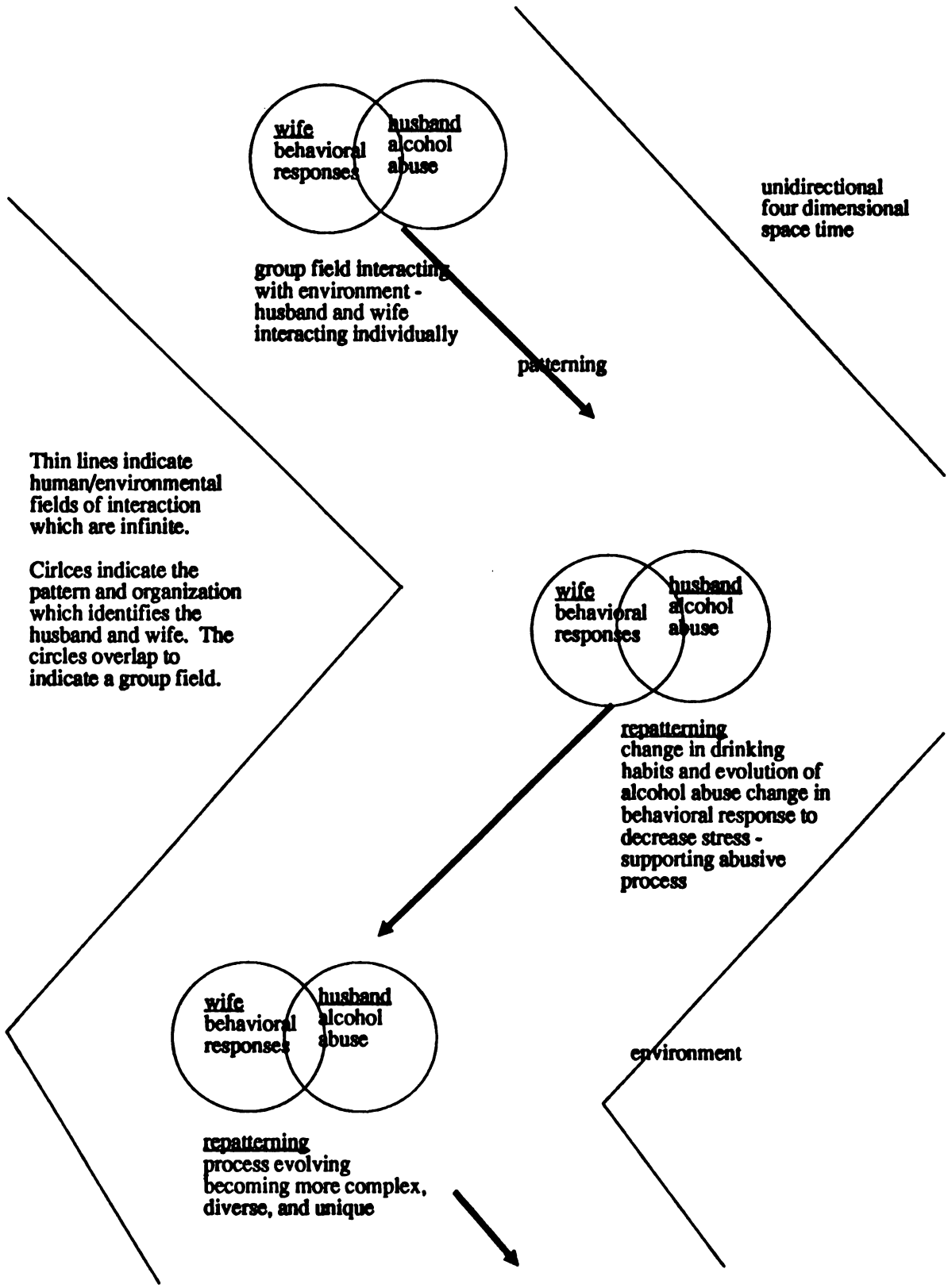


Figure 2: Application of Rogers' Theory to an Alcohol Abused Marriage

unique energy field which is made up of two or more individual energy fields. The group field can interact with the environment mutually and simultaneously as an individual unique system with its own identifiable pattern and organization, manifesting characteristics different from the sum of the parts.

The husband and wife are also each a separate field. Environment is defined as an irreducible, four-dimensional energy field identified by pattern and organization, manifesting characteristics different from those of the parts, and encompassing all that outside any given human field. The husband and the wife then can be considered to be the environment to each other, as well as the environment being all outside of the marriage group field.

Repatterning of human/environment interactions within the marriage can be expected to occur as the husband and wife interact with each other and the environment. The marriage partners seek to accomplish developmental tasks associated with marriage, family, and individual life cycles which are necessary for maximum health. As the marriage changes over time, accelerating and declining, the husband and wife may have common life experiences and reactions but the exact situation never recurs. Therefore, the alcohol abused marriage system is patterned and repatterned by human and environmental interactions that occur over time.

Rogers' basic nursing assumptions can be applied to describe the alcohol abused marriage, or group field. The concept of wholeness refers to the marriage as an open unit with members, the husband, and the wife (see Figure 2). The concept of openness refers to the extent of interaction within or outside the marriage (this is indicated by broken lines in Figure 2). Pattern and organization refers to that which gives the marriage identity (surnames, habits, drinking patterns, responses to drinking patterns). The pattern and organization are derived from multiple human and environmental interactions over time. Unidirectionality refers to events encountered by the marriage, within and outside, that are not repeatable. Sentience and thought refer to the capacity of the husband and wife to think, to understand, to experience each other, and to perceive each other. The relationship between the husband and the wife in the alcohol abused marriage at any given point in time and space is irreversible, non-repeatable, rhythmical, and characterized by pattern and organization and by increasing complexity.

Within the context of the marriage, the elderly wife has perceptions, judgments, and reacts to her husband with certain responses, and his alcohol abuse in a way that is familiar (patterning) and has evolved over time (repatterning). Because the wife has the ability to think and perceive her environment, she is able to make choices

about the direction her own life experience leads. The wife of an alcohol abuser has the ability to decide to repattern her interactions, and responses. Therefore the wife of an elderly alcohol abusing husband can decide to seek professional help for herself and for her husband.

Based on Rogers' Principle of Helicy, change within the marriage evolves in sequential stages and increases in diversity. Repatterning of the wife's responses can be expected to occur as the husband who abuses alcohol seeks to continue his alcohol abuse. Because of the complexity of the interactions in the alcohol abused marriage system, some of the responses of the wife will in fact actually support the drinking behaviors of the husband. The wife's responses will be characterized by patterning and repatterning to protect and to cause the least amount of stress within the marriage. The decision to seek help occurs as the interactions with the alcohol abusing husband become more complex. The husband's alcohol abuse will have evolved to a particular stage, with individualized drinking habits or patterns. Help-seeking behavior is an attempt by the wife to repattern her life experience. That is why responses of wives of elderly husbands who abuse alcohol can be identified and described by nursing professionals and will change over time.

Rogers' Principle of Complimentarity refers to the inseparability of the human and environmental fields. The

marriage of the elderly alcohol abusing husband and his wife is considered a group field with each member, the husband and the wife, being an individual field. Therefore, the wife can be thought of as a part of the environment to the husband. Rogers emphasizes the continual mutual process between the human and environmental fields; human and environmental fields changing together. Keeping in mind Rogers' concept, if the wife has a change in her behavioral responses toward the husband's alcohol abuse, then as a mutual dynamic interactive part of the husband's environment, these response changes will impact the husband and his alcohol abusive behaviors.

In summary, Martha Rogers' theoretical basis for nursing is utilized to conceptually describe the responses of the wife of an elderly alcohol abusing husband. The wife is considered to be a woman, who may have any type of personality, who is responding to the alcohol abuse of the husband like any other family crises, with responses. The purpose of these responses is to alleviate stress from the marriage system. Help-seeking is seen as an attempt to repattern the life experience.

Based on Rogers' conceptual system and Principles of Homeodynamics, the partners in a marriage of an elderly husband who abuses alcohol and the wife are conceptualized to be a group field. This group field is made up of two separate fields. There are multiple human/environment

interactions, one which is the interaction with each other as a husband with alcohol abuse and his wife. The help-seeking behavior of the elderly wife interacting with the alcohol abusive husband is considered to be one pattern of human and environmental interaction, and as such, identifiable and describable for nursing. Responses of the wife will change over time as the alcohol abuse of the husband continues, and increases in complexity.

This researcher's results will contribute to nursing knowledge by assisting nurses to identify, describe, possibly explain and make predictions about patterns of human/environmental interactions. An understanding of help-seeking and responses of the wife of an elderly alcohol abuser is necessary to design nursing interventions that facilitate the health of the wife and consequently the potential health of the husband.

In the next chapter the review of literature relevant to this study is presented. Included will be a review of wives of alcohol abusers, and alcohol abuse.

CHAPTER III

REVIEW OF THE LITERATURE

Introduction

The purpose of this chapter is to report on the literature that is pertinent to this study. The areas of literature to be reviewed are alcohol abuse in the elderly, and wives of alcohol abusers. An additional discussion will be presented for both areas to review the implications from current studies and their relationship to the present study. The topics covered under alcohol abuse in the elderly are the prevalence, criteria for identification, stages and patterns, and predictors.

ALCOHOL ABUSE IN THE ELDERLY

Alcohol abuse in the elderly continues to be a neglected area of research in the field of gerontology (Petersen & Whittington, 1981). In the field of nursing there was not any research identified that pertained to alcohol abuse in the elderly. Scholarly literature in the field of drug and alcohol abuse concerning the elderly has been previously overlooked because of the preoccupation with these problems among young and middle-aged people (Petersen & Whittington, 1981).

Existing data on the prevalence of alcohol abuse in the elderly indicated that there was a low rate of problems among this group (Graham, 1986). Graham (1986) suggested that as the generations who are younger continue to age, higher rates of alcohol abuse will occur. There will be more elderly who have liberal views on the use of alcohol (Graham, 1986). Additionally, Graham (1986) suggested that there has been difficulty identifying alcohol abuse in the elderly because they are often isolated, or protected and the symptoms are often confused with those of aging problems. Therefore, the real prevalence of alcohol abuse in the elderly is unknown.

Those working in the health field and related areas have begun to take more seriously the use and misuse of drugs and alcohol by older persons. Petersen and Whittington (1981) noted that the number of writings on this topic from 1975 to 1980 are almost as many as those writings in the three decades prior to 1975.

Prevalence of Alcohol Abuse in the Elderly

Much of the initial research of alcohol abuse in the elderly deals with the prevalence (Bailey, Haberman & Alksne, 1965; Zimberg, 1974). Since the awareness of alcohol abuse in the elderly developed only recently a large

portion of this research has dealt with identifying its magnitude.

Bailey, Haberman, and Alksne (1965) in a household prevalence survey of 3,959 dwelling units in New York City found that there was a second peak prevalence of alcoholism in the 65-74 year old age group which was almost as high as the level of the first peak prevalence they found in the 45-54 year old group. Interestingly, the prevalence among the 55-64 year old group was markedly lower than either of the two adjacent age groups. This decline in the prevalence from the 45-54 age group to the 55-64 age group may account for the belief that alcoholism decreases with age. This would be reinforced by the failure of many surveys to include subjects over 60 years of age.

Zimberg (1974) reviewed studies and found evidence that 23 percent of patients over age 60 in a psychiatric observation ward were clearly alcohol abusers. Other studies reviewed by Zimberg of general medical hospitals produced rates of 15-38 percent for men and 4 percent for women having alcohol problems.

A household study carried out in Western New York by the Division of Alcoholism and Alcohol Abuse (1979) reported that approximately 1/4 of men in their 60s were heavy drinkers, and even larger proportions, 41 percent of men 50-59 were heavy drinkers. These findings were not consistent with Bailey, Haberman and Alksne (1965) who found a markedly

lower prevalence in the 55-64 year old group. Since this Western New York study was done in 1979, perhaps the high rate of prevalence in the 45-54 year old group found in Bailey, Haberman and Alksne has aged and is now reflected in the older group. So not only is there a considerable population of elderly now with drinking problems, these figures suggested that this trend will only increase in the future.

Barnes (1982) reviewed the number of studies (including her own household survey in Western New York State) and found the prevalence of heavy drinking among older people to be approximately 6-9 percent (compared to 20 percent heavy drinkers in the total sample). Similarly, 54 percent of people aged 18-49 had one or more alcohol related problems compared to 30 percent of those aged 50-59 and 9 percent of those 60 and over.

Warheit and Auth (1983) categorized only 2.3 percent of those over 50 years old as being at high risk for alcohol related problems. This was compared to 5.7 percent of those aged 30-49 and 9.8 percent of those aged 18-24 who were at high risk for alcohol-related problems.

In a study on alcohol behavior among older adults, LaGreca, Akers, and Dwyer (1988) found that 1 out of 5 of their respondents reported drinking some kind of alcoholic beverage nearly daily or daily. Also, 3.1 percent of the total sample (4.3 percent of the drinkers) experienced a

drinking related problem in the past year and 6.3 percent scored as heavy consumers in the past year. The typical quantity measure showed that a little over 5 percent drank four or more drinks per day. Retrospective self reports also revealed that most of the respondents continued the pattern of drinking behavior established before they were 60. Most either remained abstainers or maintained the same general level of drinking. Some changes, however, did occur in that 3.9 percent decreased drinking whereas almost 5 percent began drinking, increased drinking, or became heavy drinkers.

The actual prevalence of alcohol abuse in the elderly is really unknown. The previous studies range the numbers from 2-10 percent with estimated prevalences being considerably higher for elderly individuals who are patients of general medical wards and psychiatric patients. Diagnosis of alcohol abuse in the elderly is complicated, as the alcohol problem is likely to be denied and hidden by the elderly and often even by the family members (Petersen & Whittington, 1981). Elderly drinkers may not even be aware that they have an alcohol problem, and they may suffer from symptoms which they do not realize are related to their drinking (Petersen & Whittington, 1981). Physicians are often unwilling or unable to recognize elderly alcohol abuse, and care facilities may not address it as a problem (Zimberg, 1974). Criteria that help professionals identify

alcohol abuse may not be accurate or valid for the elderly. The next section will cover literature reviewed on criteria for identification of alcohol abuse in the elderly.

Criteria for Identification of Alcohol Abuse in the Elderly

A factor in recognizing the problem of alcohol abuse in the elderly is the common criteria used for diagnosing alcohol abuse. The following researchers suggest that different criteria may need to be applied for the elderly.

Clark and Midanik (1980) reviewed studies on alcohol abuse and found the following criteria typically used in operational definitions of alcohol abuse in general population surveys: 1) high levels of alcohol consumption, 2) symptoms of alcohol dependence or withdrawal, and 3) adverse consequences or life problems resulting from alcohol intake. Clark and Midanik (1980) suggest that these criteria fail to take into consideration the changing physiology and life styles of the older population These criteria may not be appropriate to identify elderly alcohol abusers.

Rosin and Glatt (1971) reported on 103 elderly alcoholic patients, with a hypothesis that elderly alcoholics have less frequently observed withdrawal symptoms than the general alcoholic population. They reported only 1

person with delirium tremens out of the 103. Also, Rosin and Glatt found that most elderly alcoholics do not require detoxification. Thus using a criteria of symptoms of alcohol dependence and withdrawal may not be appropriate for the elderly.

Rosin and Glatt (1971) found that health problems rather than social problems were more indicative of alcohol abuse in the elderly. Self neglect, falls, excessive incontinence, and confusion were more often observed than marital and job related problems.

Zimering and Domeischel (1982) recognized that the elderly alcohol abuser consumes less alcohol than the younger alcohol abuser, however they are more likely to drink daily. One of the main reasons for the decrease in alcohol consumption is the liver's inability to metabolize alcohol as it should (Zimering * Domeischel, 1982). Therefore, smaller amounts of alcohol will produce the same effect in the elderly as large amounts will in younger people. This liver change can come from aging as well as from years of alcoholism (Zimering & Domeischel, 1982). Additionally, Zimering and Domeischel (1982) explained that there is less tolerance for alcohol due to the elderly person's lower body water content and less lean body mass which affect the distribution of the alcohol. Therefore in recognizing the problem of alcohol abuse in the elderly, one

must recognize that the elderly may consume lower amounts of alcohol than the younger alcohol abuser.

Graham (1986) reviewed existing instruments for identifying and measuring alcohol abuse in the elderly population. She concluded that these instruments were inappropriate for use with elderly populations because of differences between the elderly and the younger populations on which these measures were standardized. Graham (1986) found five domains commonly used for all ages in measuring alcohol abuse: 1) level of consumption, 2) alcohol related social and legal problems, 3) alcohol related health problems, 4) symptoms of drunkenness or dependence, and 5) self-recognition of the problem. The extent to which these domains, as currently measured, apply to the elderly population may be inappropriate.

The first domain, the level of consumption, has been the most commonly used measure. It may be misleading to interpret proportions consumed without adjusting for age. Four drinks per day may be relatively benign for a robust 30 year old man but very damaging to a 100 pound, 70 year old woman. Graham recommended that valid measures of alcohol abuse for the elderly need to be developed. Studies need to be done to identify problem levels of consumption for different age groups. Using the same cutoff to define alcohol abuse regardless of the age does not give an accurate comparison.

The second domain, alcohol related social or legal problems has focused on the kinds of problem experienced by nonelderly men, including employment and marital problems, drinking and driving, and legal and financial problems. For a retired, widowed, elderly man who has few social contacts and no car, he has fewer opportunities to have problems in these areas. Graham (1986) described more appropriate indicators for the elderly which might include 1) housing problems, 2) falls or accidents, 3) poor nutrition, 4) inadequate care of self, clothing, and living quarters, 5) lack of physical exercise and 6) social isolation.

According to Graham the third domain of health problems related to alcohol abuse, was suggested to be the best way to identify elderly alcohol abusers. However these markers must be standardized for the elderly population. We need to know the probability that certain health problems can be used to identify alcohol abuse in the elderly. Health professionals can be more effective in directing the elderly alcohol abusers toward treatment if there is clear evidence of alcohol related health problems that are separable from age related health problems.

Dependence measures the fourth domain. This measure has been less useful for identifying alcohol abuse among the elderly. Dependence and drunkenness symptoms may be denied, attributed to something else or unrecognized according to Graham (1986).

The fifth domain of identification of alcohol abuse, self recognition of alcohol-related problems, seemed to be much less likely among the elderly. Graham felt this may be because of denial or because alcohol-related problems are mistaken for or confounded with age-related problems.

The previous literature has indicated that the criteria for identifying alcohol abuse in the general population may not be appropriate for the elderly. Health problems have been suggested as more indicative of elderly alcohol abuse (Rosin & Glatt, 1971; Graham, 1986). Tolerance and dependency to alcohol appear to be less. Criteria for assessing alcohol abuse in the elderly population appears to warrant development. Studies need to be done to determine valid and reliable measures. The next section includes a review of literature on the stages and patterns of alcohol abuse in the elderly.

Stages and Patterns of Alcohol Abuse in the Elderly

At present there has not been any literature identified which looks at staging of the alcohol abusive process relative to age. There are however, several studies on patterns or drinking habits of the elderly. One important question which has been raised is whether or not elderly

alcohol abusers developed their alcohol problems during old age or earlier in their lives.

Zimberg (1974) described elderly alcohol abusers as belonging to one of two groups: 1) those who began drinking at an early age (early onset), and 2) those who began drinking later in life (late onset). Those associated with late onset alcohol abuse seemed to use alcohol as a coping mechanism to adapt to the problems of aged individuals (Zimberg, 1974). Problems and stresses of aging include depression, bereavement, retirement, loneliness, marital stress, and physical stress. Elderly persons ccould indeed be alcoholics, but could also be problem drinkers. Those alcohol abusers in the late onset group responded readily to treatments which included anti-depressants, socialization and problem-solving programs (Zimberg, 1974).

Early onset drinkers started early in life. It was commonly believed that by the time this group reached old age, they had many physical and psychological problems from long-term drinking. Part of this group was either in nursing homes or psychiatric hospitals. These long-term drinkers were considered "burned out". Others from the early onset group never made it to old age because they died from physical effects of drinking, accidents, and suicides. However, Zimberg suggested that it is becoming more apparent that there are many long-term elderly drinkers whose health status has not overly deteriorated and who are still

functioning in society as they always have. Zimberg suggested that those elderly alcohol abusers who did not deteriorate had fluctuations in their drinking patterns or simply had the ability to tolerate the long-term drinking.

Rosin and Glatt (1971) found that late onset alcohol abuse was associated with the stresses and problems of aging. Late onset alcohol abusers did not seem to have the deep-rooted psychological problems or the personality characteristics of younger alcohol abusers. Rosin and Glatt (1971) suggested that these late onset drinkers seem to use alcohol as a coping mechanism to adapt to the problems of aged individuals.

Glantz (1981) was particularly interested in the late onset group of alcohol and drug abusers. The late onset group of alcohol abusers constituted about one-third of all alcohol abusers as compared to two-thirds for early onset. Glantz formulated a model to make predictions about the most probable patterns of drug and alcohol abuse in the elderly, and to identify some of the factors which are likely to be antecedent to drug and alcohol abuse among the aged. Glantz specifically hypothesized that elderly drug and alcohol abuse is related to coping problems. He suggested that there are a number of social and psychological factors which contribute to the development by some elderly adults of a reliance on psychoactive substances as a coping mechanism which may then lead to abuse.

Hochhauser (1981) on the other hand, attempted to conceptualize substance abuse problems among the elderly late onset group within a learned helplessness framework. After experiencing a variety of uncontrollable events (death of a significant other, relocation, health problems, retirement) the elderly person may come to believe that he/she is being controlled by environmental events. As helplessness is learned, there may be increased emotional problems (depression and anxiety), cognitive deficits (a belief that thing cannot be changed) and motivational deficits (a tendency to give up). In an effort to cope with learned helplessness and its consequences, the elderly may resort to the use, misuse, or abuse of substances.

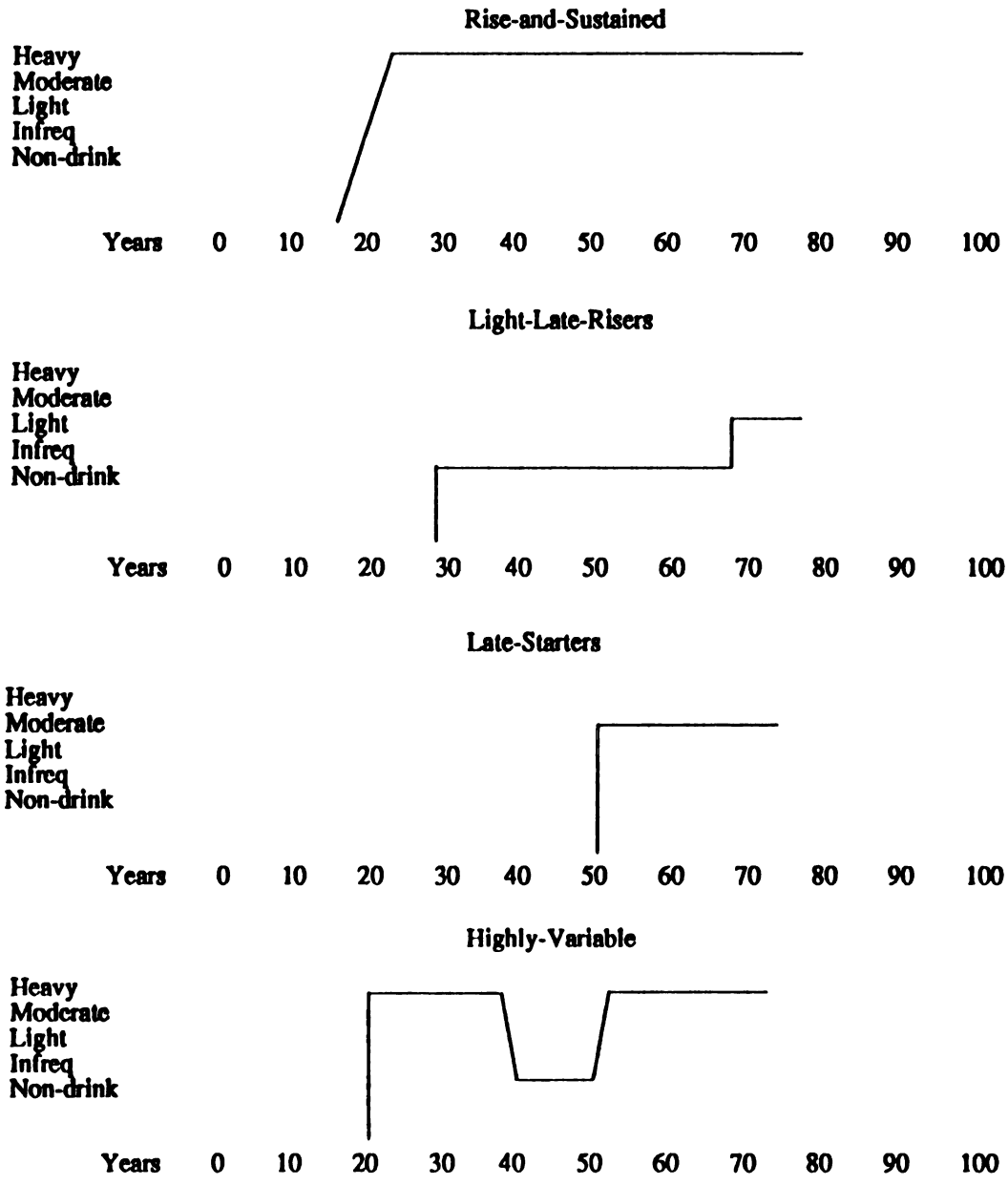
The research of Dunham (1981) reported the inordinate degree of change in drinking patterns associated with aging in a sample of 310 residents of Miami, Florida, who were 50 years of age and older and living independently in congregate housing. The author employed a self-reported retrospective measure of life-drinking behavior that focused on key events in an individual's drinking history and that was general enough to allow reasonably accurate recall of events. The variables of interest were the age at which these middle-aged and older subjects first began to drink regularly (once a month or more often), the ages at which they drank the heaviest, the ages that they drank the least, the ages that their drinking was most typical of their total

drinking years and their current drinking activity. At each point respondents were asked to give a general estimate of the amount and frequency of drinking. Dunham found that there were six distinct patterns of drinking behavior (excluding abstinence) over a lifetime. Although Dunham noted six patterns, only four applied to the elderly alcohol abuser.

Dunham's four patterns of alcohol abuse in the elderly (Table I) include: 1) the "rise-and-sustained" pattern, where the heavy drinker continues into old age, 2) the "light-and-late-riser" pattern, where the drinking is very light throughout one's life and rises when one reaches old age, 3) the "late-starter" pattern, where the person does not drink regularly until later in life when they rise to heavier drinking, and 4) the "highly-variable" pattern, where drinking rises and falls during life. Dunham described the rise-and-sustained pattern and the highly-variable pattern as those most likely fitting into the early onset alcohol abuser as described by Zimberg (1974). Those late-start and light-late-risers were probably in the late onset group.

In summary, the elderly alcohol abuser can be described as belonging to one of two groups. The first group called "early onset" are those who began drinking at an early age. By older age some of these people were either in psychiatric hospitals, nursing homes or had multiple health problems

Table 1: Dunham's Four Patterns of Alcohol Abuse in the Elderly



(Zimberg, 1974). Others from this group have managed to maintain some health and have functioned in society. This may be due to fluctuating drinking patterns and/or protection and help from family members (Zimberg, 1974).

The second group of elderly alcohol abusers are called "late onset", and did not start drinking until later in life. Members of this group are thought to drink in response to the stressors and life problems of aging (Rosin & Glatt, 1971; Glantz, 1981). Another belief is that the elderly drink in response to uncontrollable events such as the death of a loved one, or retirement (Hochhauser, 1981).

Dunham (1981) proposed four groups which describe the drinking patterns or behaviors of the elderly: 1) the "rise-and-sustain" pattern, 2) the "light-and-late riser" patterns, 3) the "late starter" pattern, and 4) the "highly variable" pattern. Dunham described the rise-and-sustained pattern and the highly variable pattern as fitting into the early onset alcohol abuser group. Those late-start and light-late-risers are in the late onset group. The next section will include a review of literature on predictors of alcohol abuse in the elderly.

Predictors of Alcohol Abuse in the Elderly

Over the last 10 years researchers (Smart & Liban, 1981; LaGreca, Akers & Dwyer, 1988) have begun to look for

predictors of alcohol abuse in the elderly. Smart and Liban (1981) reported on the results of a household survey of 993 persons aged 18 and over in an area near Toronto, Canada, regarding the predictors of drinking problems and dependency symptoms at various age levels, including the elderly. The results indicated that far more problem drinking was found in younger than elderly persons, but that elderly problem drinkers were most difficult to predict, probably because of their lower alcohol consumption. The authors' expectation that drinking predictors especially the frequency and volume of consumption, would be different for elderly persons was not supported. Serious dependency symptoms were best predicted by volume and frequency of consumption at all levels of age. The elderly problem drinker was most likely to be male, born outside of Canada, not retired, in the lower socio-economic group and drinking several times a week but not in very large quantities.

Christopherson, Escher, and Bainton (1984) studied reasons for drinking, and past and present drinking patterns among the elderly in rural Arizona. Interviews were conducted with 444 individuals aged 65 plus. Responses to a list of 20 reasons for drinking were divided into six groups: social, mood change, food, health, personal coping and interpersonal coping. Respondents were grouped into categories on the basis of their quantity and frequency of alcohol consumption. These categories were abstainers,

light drinkers, moderate drinkers and heavy drinkers. Approximately 80 percent of the respondents drank for the more acceptable or "right" reasons (social, mood change, food or health). Only 12 percent indicted that they often drank for one or more of the coping reasons. Light, moderate, and heavy drinkers were differentiated according to reasons for drinking, as were the various age groupings. Findings indicated that the rural elderly's alcohol use was generally at an acceptable and nonabusive level and style, that alcohol use diminishes with age, and that drinking patterns and reasons generally remain consistent into old age. Therefore the evidence in this study for either drinking or abstinence as a stable and largely predictable aspect of one's overall lifestyle seemed much more convincing than the notion of an increase in alcohol consumption in response to the crises, frustrations and deprivations of old age.

LaGreca, Akers, and Dwyer (1988) studied the relationship between life events and alcohol behavior. The authors investigated 1,410 persons over the age of 60, in two retirement homes, and two age-heterogeneous communities. The hypothesis that higher frequency, greater quantity, or problem drinking occurs in this age group as a response to significant life events was not supported. Additionally, social support networks were not significant mediators for the impact of life events on alcohol use.

Therefore, researchers (Christopherson, Escher & Bainton, 1984; LaGreca, Akers & Dwyer, 1988) have found that drinking behaviors in the elderly may be a stable and largely predictable aspect of one's overall lifestyle. The hypothesis that problem drinking occurs in response to stressors or significant life events has not been substantiated. The next section will include a summary of all the previously reviewed literature on alcohol abuse in the elderly.

Summary

In summary, researchers have begun to take more seriously the use and misuse of alcohol by older persons. Many initial studies have dealt with identifying the prevalence of alcohol abuse in the elderly, which has ranged form two to ten percent. The actual prevalence is unknown because alcohol abuse in the elderly is complicated, hidden, or unrecognized.

Criteria used to define alcohol abuse may need to be different for the elderly. Levels of consumption may be less. Tolerance and dependency may be a different experience. Adverse consequences resulting from alcohol intake seem to be related to health problems and levels of self care and functioning. Valid measures for alcohol abuse in the elderly need to be developed and standardized to aid

health professionals in being more effective in directing elderly alcohol abusers toward treatment.

Drinking patterns or behaviors in the elderly can be divided into two groups: 1) early onset, and 2) late onset. Those in the early onset group started drinking at an earlier age and have managed to maintain their functioning into their later years. Those in the late onset group were believed to drink in response to the stresses of aging. This however has not been substantiated. Drinking behaviors in the elderly may reflect one's overall lifestyle. The next section includes implications from the recent literature and their relationship to the present study.

Implications from Recent Literature

The previously reviewed literature on alcohol abuse in the elderly relates to this present study in several ways. First because alcohol abuse in the elderly is hidden or unrecognized, identifying appropriate candidates for this study will be more difficult. Some wives may not wish to be interviewed, others may not realize that they actually have been experiencing alcohol abuse in their marriages.

Second, there is not standardized criteria to define alcohol abuse in the elderly. The alcohol abuse of the husband will be determined by the wife's perception. The direction of the questions of the interview in this study

will be mainly based on criteria developed for the general population. Additional criteria will be added based on the previously reviewed literature. This will be only an attempt at identifying alcohol abuse in the elderly, and may not necessarily be completely valid. Research needs to be done to develop valid and reliable measures of alcohol abuse in the elderly not only to improve research, but in order to identify those elderly who are in need of treatment.

Third, although there has been some studies on drinking behaviors or patterns in the elderly, these studies were all cross sectional. Longitudinal research is needed to determine whether or not the late onset group who abuse alcohol is in response to the stressors of aging, or whether drinking is a lifestyle pattern that is carried into old age, and becomes abusive due to the normal changes of aging. Also, longitudinal research is needed to determine exactly what happens to the early onset group who is able to maintain their lifestyle into old age. Although this study will be able to identify the drinking patterns of the husband based on the perception of the wife, explanations as to why these patterns evolved in an abusive way will be merely hypothetical because this is a cross sectional design with a small sample group.

Finally, the state of research for the elderly who abuse alcohol seems to be in more of an exploratory stage. The problem appears to have been identified, but hypotheses

and models to explain and predict alcohol abuse in the elderly need to be generated. Nurses in particular need to address alcohol abuse in the elderly with research in order to develop measures for care. That is why this study is of an exploratory nature.

The next section will be a review of literature on wives of alcohol abusers. This section will include discussions on the Disturbed Personality Theory of wives of alcohol abusers, the Decompensation Theory, the Stress Theory, and the interactional approach of looking at wives of alcohol abusers as part of a family system and through social learning. In addition the topic of codependency will be reviewed. A discussion which will relate the literature findings to the present study will be included.

WIVES OF ALCOHOL ABUSERS

Wives of alcohol abusers have been the subject of many clinical reports and experimental studies (Edwards, Harvey & Whitehead, 1973). In reviewing the literature up to this date, there have been no studies of behaviors of wives of alcohol abusers specifically in the elderly population. Additionally, there have been no studies identified by nurses. Therefore, the studies and literature reviewed do not reflect age as a variable, but simply look at wives of alcohol abusing husbands.

The picture of the wife as depicted in the literature seems to be changing from that of an aggressive woman who married an alcoholic to fulfill her need to dominate (Lewis, 1937), through that of one whose personality fluctuated with the stresses involved in marriage to an alcohol abuser (Jackson, 1954), to that of a woman who may or may not react to the stress of her marriage with personality dysfunction (Kogan & Jackson, 1965a). The emphasis is shifting from focusing on the individual alcohol abusing husband and the individual spouse to that of the marriage as an interactional system in which alcohol is a problem (Steinglass, 1981). The following discussions include reviews of literature on the Disturbed Personality Theory, the Decompensation Theory, the Stress Theory, the Psychosocial Theory, the interactional approaches of family systems and social learning, and codependency.

The Disturbed Personality Theory

The Disturbed Personality Theory was the first postulated to describe wives of alcohol abusers. This Disturbed Personality Theory was based on the psychoanalytical view which characterized women with certain personalities who tended to select alcohol abusers or potential alcohol abusers as their mates. These women drove their husbands to drink to satisfy their own pathological needs. They were often described as hostile, and

controlling women, who would fall apart if their husbands became sober. These theorists were most often social workers or psychiatrists directly involved in the treatment of alcoholics and their wives and as a result, the majority of the studies which back this framework are little more than clinical impressions of wives seen in treatment (Edwards, Harvey & Whitehead, 1973).

Lewis (1937) wrote one of the first articles devoted to describing wives of alcoholics. Such a wife found an outlet for her aggressive impulses in her marriage with a man who was partially dependent and who created situations that forced her to punish him. Lewis believed that the husband often took on a feminine role, and that the therapist's job was to help him become more masculine.

Price (1945) studied 20 wives of alcoholics and described the wife as being a typically dependent person who became hostile or aggressive toward the husband. The wife interpreted the husband's drinking as a rejection of her, or lack of love, or to get even because the wife had been too demanding, or had assumed more responsibility than the husband. The wife then made her husband feel more inadequate, which caused a continual repeat in this process. Price theorized that the alcoholism of the husband was proof of the wife's superiority and the husband's inadequacy. Therefore, the wife would fight treatment for the husband.

Whalen (1959) described wives of alcoholics seen in a

family service agency. She concluded that they had married to fulfill certain personality needs of their own and that their husbands possessed particular psychological characteristics that enabled them to fill these needs.

Whalen placed these wives in four categories: 1)"Suffering Susan," who, to punish herself, chose a husband who would make her life miserable; 2)"Controlling Catherine," who needed to dominate someone and so chose a weak, inept husband; 3)"Wavering Winnifred," who, to be loved, sought a weak husband who needed her desperately; and 4)"Punitive Polly," who needed an emasculated husband to control and punish. Whalen proposed that such women often, but not always, chose an alcoholic.

In an attempt to compare alcoholic's wives with a control group, Deniker, deSaugy, and Ropert (1965) compared 100 alcoholics and their wives to 100 non-alcoholics and their wives. The 100 alcoholics and their wives were divided into two groups,s 50 psychiatric alcoholics (those with chronic disorders chiefly psychiatric in nature) and 50 digestive alcoholics (those with chronic hepatodigestive disorders). Deniker, deSaugy, and ropert concluded that most of the character traits manifested by the alcoholic couples had little specificity and could be observed in any neurotic couple. One significant finding was that the wives of psychiatric alcoholics unconsciously maintained their husbands' alcoholism, and needed treatment themselves.

However, wives of digestive alcoholics, if aided by professionals, could frequently help their husbands to recover. Thus the authors indicated that there might be two types of wives, and that a wife's personality type might be related to her husband's type of alcoholism.

Lemert (1962) looked at dependency in marriages of alcoholics as the variable between two groups: those in which drinking was a problem before or at marriage and those in which the problem developed after marriage. The first had a much higher incidence of dependency attributes, however, dependency was not demonstrated to be a common factor in any of these marriages. This information causes questioning of the idea of dependency of the husband and wife to each other in the disturbed personality theory.

Corder, Hendricks and Corder (1964) attempted to broaden the knowledge about alcoholics' wives by measuring personality characteristics of wives motivated to join Al-Anon. There were 43 volunteers, representing 75 percent of the active membership of two Al-Anon groups and a control group of 30 women married to nonalcoholics, matched in a mean age, educational and economic levels. The group form of the Minnesota Multiphasic Personality Inventory (MMPI) was administered and the mean T- scores were compared on 9 clinical and 4 validating scales. The Al-Anon group scored slightly higher than the controls who were not Al-Anon members on 4 clinical scales, but both groups were within

normal range for each scale. These results, the authors said, seemed to bring into question the characterization of the wives of alcoholics as severely neurotic and disturbed. The most limiting factor in this study was again the use of a small sample and highly motivated women who joined Al-Anon.

In another examination of the disturbed personality theory, Haberman (1964) studied 156 wives from various social agencies. He looked at variations in psychophysiological symptom scores in the wives during their husbands' periods of drinking and periods of abstinence. The women all revealed fewer symptoms when their husbands were abstaining.

These studies share several limitations. First, aside from Deniker, desaugy and Ropert 91965); Lemert (1960); and Haberman (1964), these researchers (Lewis, 1937; Price, 1945; Whalen, 1959; Corder, Hendricks & Corder, 1964) used relatively small numbers of wives. Second, it is not possible to know whether the wives described were representative of the total population of alcohol abusers' wives. Some of these studies (Lewis, 1937; Price, 1945; Whalen, 1959) were actually clinical impressions of wives seen in treatment. Studies such as Lemert (1960) and Corder, Hendricks, and Corder (1964) provided conclusions that did not support the Disturbed Personality Theory. Taken as a whole, studies of the Disturbed Personality

hypothesis do not provide any similar results which would demonstrate a unique personality type for wives of alcoholics. The Disturbed Personality Theory about wives of alcoholics was proposed at a time in which traditional sex roles and role relationships were the norm. No similar theory about husbands of alcoholic women has ever been proposed. It may be that the Disturbed Personality Theory can be seen as a social reaction to women who took on nontraditional roles to maintain their families during the alcoholic crises. This was then interpreted as psychopathology by traditional clinicians. The next section is a review of the literature on the Decompensation Theory.

The Decompensation Theory

The Decompensation Theory is a corollary to the Disturbed Personality Theory. The Decompensation Theory states that, if an alcoholic man is able to successfully stop drinking, then his wife will decompensate. This decompensation is said to occur because marriage to an actively drinking alcoholic was thought to be a defense against unconscious psychological conflict. Removal of this defense was thought to result in a disintegration of the woman's personality integration, with resultant severe psychological problems, such as a major depression or psychosis.

Futterman (1953) concluded that there was much clinical evidence, although he did not describe what it was, that wives of alcoholics, because of their needs, seemed unconsciously to encourage their husbands' alcoholism. The wives tended to identify with their strong dominant mothers. These wives unconsciously felt inadequate and so chose a weak, dependent husband. When this marriage relationship was disturbed by a decrease in the husband's drinking, the wife would fall apart.

Following Futterman's (1953) concept of decompensation, Macdonald (1956) studied 18 women admitted to a state mental hospital who were wives of alcoholics. He found 11 cases of decompensation associated with a decrease in the husband's drinking, one associated with an increase, and six in which there had been no change in the husband's drinking pattern. Macdonald's study was one of the first attempts to investigate empirically a hypothesis suggested by psychoanalytic theorists. It gave some support to Futterman's (1953) theory that personality decompensation in the wife would follow abstinence in the husband.

Kalashian (1959) described wives of alcoholics who were in treatment as needing to play a maternal role. This study was based on women who were still in marriages in spite of being able to manage financially alone. Something other than financial support must make the marriage worthwhile. Because she felt needed, the wife was able to deny herself.

Kalashian also suggested that the wife's defensive response to her husband's drinking made him hostile, which caused her feelings of guilt, so the wife would indulge the husband to reduce guilt. Like Futterman (1953) and Macdonald (1956), Kalashian found that the husband's recovery could present a problem to the wife leading her to anxiety, depression, phobias, and somatic disorders.

Clifford (1960) compared 25 wives of alcoholics unable to maintain a durable remission with 25 wives of alcoholics abstinent for a long period. Clifford found from the results that the wives of abstinent alcoholics had, in many cases, caused their husbands to seek treatment by threatening to abandon them. This group showed concern for the effects of alcoholism on their children, accepted some responsibility for these alcoholic problems, questioned their own adequacy and social worth, and felt indispensable to their husbands. However, this same group seemed disappointed at the changes in their husbands' personality after rehabilitation. The wives of relapsed alcoholics indicated no awareness of possible damage to their children, accepted no responsibility for their husbands' drinking, seemed impervious to feelings of inadequacy and social status, and did not feel indispensable to their husbands. These wives seemed cynical about efforts to help their husbands.

There are two major problems considering the validity of the Decompensation Theory. First, the subjects of the studies have usually been women in treatment or couples in treatment. This could represent an atypical population, and says nothing about the fate of the wives who recover without the wife's getting involved in treatment. The second problem with interpreting such clinical observations is the lack of consideration of alternative explanations. For example, if a spouse has had to overfunction for a number of years, and suddenly again has a mate on whom she can rely, she may then be able to attend to her own needs, conflicts, and problems, with the result looking like decompensation. An alternative explanation is that the readjustment of the roles and role definitions that accompanies recovery is difficult, and may result in a difficult period for both partners. The next section discusses the literature reviewed for the Stress Theory.

The Stress Theory

Jackson (1954, 1956, 1959, 1962) was the first advocate of the Stress Theory. She theorized that in their efforts to handle problems associated with alcohol abuse, family members came to feel guilty, ashamed, inadequate and isolated from social support. Wives were especially

affected because, in their own and in society's eyes, they had failed in their major role.

Jackson (1954) studied wives of alcoholics who belonged to Al-Anon over a three-year period as an empirical test for her theory. She attended and made recordings of each meeting. In addition to the 50 Al-Anon members participating in the study, Jackson interviewed wives whose alcoholic husbands were hospitalized. Jackson's results indicated that the wives and families seemed to pass through stages in reacting to alcoholism in the husbands or fathers. These stages are:

Stage 1 - wives and families attempt to deny the problem.

Stage 2 - they attempt to eliminate it in the face of social isolation, alienation, and the wives' feelings of inadequacy.

Stage 3 - disorganization; few problems met constructively, and the wives accept their husbands drinking problem as permanent.

Stage 4 - attempts to reorganize the family; wives' resentment of husbands' behavior changes to pity, and wives take on many responsibilities of the husbands.

Stage 5 - efforts are made to escape the problem, separations.

Stage 6 - families are reorganized without the husband.

Stage 7 - husbands recover and families once again reorganize.

Jackson found that wives and families, especially wives, behave in a manner which they hope will meet the crisis and permit a return to stability. Wives, Jackson stated, are at all times affected by their own personalities, their previous role and status in the family, the previous history of the present crisis and the past effectiveness of their own actions, and also by cultural definitions of alcoholism. Thus, behaviors of wives of alcohol abusers are described in large part as a function of changing patterns of interaction and not solely as a consequence of personality disturbance, or personality type. Jackson pointed out a limitation of the study being concerned with only those families seeking help. But Jackson succeeded in presenting the wive of alcoholics in different light. The concepts of stress, crisis, and roles could be used in explaining the wives behaviors instead of neurotic and decompensating behaviors. Jackson pointed out in her 1962 article the similarities between alcoholism and the achievement of sobriety, and other situations such as the husband's mental illness and recovery, and war duty and return of the veteran husband in their effects on the wife.

Alcohol abuse was seen as a family crisis like other family crises.

Lemert (1960) attempted to replicate Jackson's (1954) study on a wider cross-section of the population. A 49 item scale was used without reference to reliability and validity information of the scale. Lemert was unsuccessful in verifying Jackson's sequence of events in wives' adjustments to the crisis of alcoholism.

In a different approach, Orford and Guthrie (1968) asked 80 alcoholics' wives about their methods of coping with their husbands' alcoholism. By factor analysis they identified five coping styles: 1) safeguarding family interest, 2) withdrawal within the marriage, 3) attacking, 4) acting out, and 5) protecting their alcoholic husbands.

James and Goldman (1971) tried to integrate these findings with Jackson's (1954) concepts of stages. No coping style of the wife was found to be unique to any one stage. In support of Jackson, James and Goldman found that 78 percent of wives in their sample had married before their husbands became excessive drinkers and that the wives' threats to leave were the most effective means of inducing abstinence in their husbands. The frequency with which any coping style was used was highly correlated to the stage of alcoholism in the husbands. The wives' reactions seemed to correspond to the changes in their husbands' conditions.

Studies by Orford and Guthrie (1968) and James and Goldman (1971) represented a new approach to looking at wives of alcoholics. They considered coping styles in identifying and measuring the wife of an alcoholic.

The Stress Theory made two major contributions to the understanding of alcoholism and marriage. First, the model clearly suggests that wives engage in a range of behaviors in response to drinking. Second, these behaviors were seen as coping behaviors, rather than psychopathology. Jackson (1954, 1955, 1959, 1962) clearly introduced the field to a more humane view of the difficulties of living with an alcoholic. The next section is a discussion of the literature that represents a fusion of the Disturbed Personality Theory, the Decompensation Theory, and the Stress Theory.

The Psycho-Social Theory

Beginning with Jackson in 1954, the trend in studies of the wives of alcoholics was to question and criticize much of the earlier impressionistic clinical literature and to suggest concrete and testable hypotheses concerning the functioning of wives in these marriages. These studies (Bailey, Haberman, & Alksne, 1962) set the stage for a fusion of ideas and the development of the psycho-social perspective.

The fusion of the three theories began to appear with studies by Bailey, Haberman and Alksne (1962). Their studies, like those of Clifford (1960), sought to determine the differences between wives of alcoholic husbands who are abstinent and those whose husbands are still drinking. However, Bailey, Haberman, and Alksne added a third group of wives who had terminated their marriages. The three groups were matched on education and length of marriage. The 69 wives were given interviews based on their perceptions which included psychophysiological symptoms and neurotic symptoms. The scores of these three groups were compared with a representative community sample from another study.

All 69 wives experienced considerable economic, social, or psychological deviance in their marriages. However, the degree of deviance appeared to be significantly related to marital outcome, the separated family revealing the greatest disturbance. The families which remained together with the husband achieving abstinence tended to be upwardly mobile and highest in occupational status. Of the 23 abstinent husbands, 17 wives had been helped by Alcoholics Anonymous and 14 wives had been helped by Al-Anon. This suggested that alcoholic families who recover do not appear in the caseload of social workers and psychiatrists, as they may have turned to self-help groups instead. Therefore, studies based on such caseloads may not be representative of the population, such as those studies supporting the Disturbed

Personality Theory (Lewis, 1937; Price, 1945; Whalen, 1959). Wives of still-drinking husbands reported relatively little stress beyond the drinking itself and showed little anxiety about socio-economic matters. The authors suggested perhaps circumstances had not motivated these wives to take action about their alcoholic husbands.

Almost two-thirds of the wives of alcoholics reported a high level of psychophysiological symptoms at the time of the interview compared to 35 percent in the representative community sample. However, only 55 percent of this two-thirds were the separated wives, and 43 percent were those wives with sober husbands. Therefore, the data lend support to the Stress Theory.

Kogan, Fordyce and Jackson (1963) conducted a study questioning whether the wife of the alcoholic necessarily displays personality disturbances and investigated the rate of occurrence and uniqueness of personality disturbance in a selected group of wives of alcoholics compared to a group of wives of non-alcoholics. Measures from the MMPI indicated that although significantly more wives of alcoholics exhibited personality dysfunction than did wives of non-alcoholics, the total number of disturbed subjects was less than half on any measure. Personality patterns thought to belong to wives of alcoholics were not demonstrated. The authors implied that the personality of the wife of the alcoholic should be treated as a variable for future

research. Also, the authors questioned whether there should be a unique concept describing the "wife of an alcoholic".

Kogan and Jackson (1963) tested the assumption that wives of alcoholics have unique personality types. They found no differences between the perceived roles of the ideal wife and the ideal husband, when compared to wives of alcoholics and wives of non-alcoholics. In 1964, Kogan and Jackson further examined the alcoholic wives responses with an additional group of alcoholic wives. The authors found that 80 percent of the wives perceived their own personalities as being much the same whether their husbands were drinking or not.

Bailey (1965) carried out an extensive study with 262 wives of alcoholics. Her chief findings were that Al-Anon members knew more than did other wives in the sample about alcoholism and had gained more self-understanding in relation to their husbands' drinking.

Using the same 262 wives, Bailey (1967) elicited histories of their marriages by means of a structured interview. The resulting data revealed a continuum; the longer the time since the wife had been exposed to her husband's drinking, the less likely she was to report symptoms of her own psychophysiological impairment. Also, women who had not been divorced or separated were less likely to be disturbed. Therefore, the least impairment was reported by currently married women whose husbands were not

abstinent. The conclusion was that there was a wide range of psychophysiological disturbances in these wives, but that data did not support the hypothesis that most would decompensate emotionally if their husbands stopped drinking.

In examining two social variables, Al-Anon membership and educational level, Bailey found that wives who belong to Al-Anon suffered psychophysiological symptoms to a lesser degree than those who did not belong to Al-Anon and had at least a high school education. Thus again, data support the inclusion of a stress component in a psycho-social theory.

Kogan and Jackson (1965a) further attempted to examine the psycho-social hypothesis. They attempted to estimate the relative effects of assumed pre-existing personality traits and of ongoing stress on personality function in wives of alcoholics. Selected measures derived from the MMPI responses of 26 wives of inactive alcoholics, 50 wives of active alcoholics, and 50 wives of non-alcoholics were compared. The results indicated that the wives of non-alcoholics had the lowest rate of personality disturbance, and wives of actively drinking alcoholics had the highest. Wives of recovered alcoholics were in the mid-range position. However, the authors also found that women married to non-alcoholics and those married to alcoholics did not differ significantly in their MMPI scores, thus supporting the Stress Theory.

In an attempt to define some societal variables which tend to contribute to personality dysfunction, Kogan and Jackson (1965b) compared the life history reports of 45 alcoholics' wives to a matched group of non-alcoholic wives. Those who reported an undisturbed childhood seemed more able to deal with marriage, even to an alcoholic, without personality disfunction. The authors suggest that both early experiences and current relationships were involved in the interaction between life experience and personality function.

Moos, Finney, and Gamble (1982) designed a study to achieve a broader understanding of spouse functioning by examining the impact of the alcoholic partner's characteristics and other factors such as life change events, social support, and coping responses. The study sample was divided into three groups: spouses of recovered, and relapsed alcoholics compared to spouses of community members. The spouses of recovered and relapsed alcoholics were drawn from alcoholics treated at one out of five different residential facilities. The community group was selected from the same census tract as the treated families and were matched by several significant variables.

The authors mailed self-administered questionnaires, examining behavioral and functional characteristics using the Health and Daily Living Form, Family Environmental

Scale, and the Work Environmental Scale. After the original questionnaires were sent out, there were follow-up questionnaires sent six to eight months later. At the end of two years, there were 105 participants. The test, one way ANOVA and ANCOVA found no differences between the three groups. The Student-Newman Keuls Multiple Range Test was done to find significant differences between socio-demographic characteristics. The only significant finding was that spouses of recovered alcoholics were less depressed than the other two groups. The researchers concluded that spouses of alcoholics are basically normal people who are trying to cope with disturbed marriages and behaviorally dysfunctional partners. Findings are consistent with crises, especially when the partner is drinking heavily. The recommendation was to train the spouses in coping skills and family cohesion. Again, this supports the psycho-social approach for wives of alcoholics.

Finney, Moos, Cronkite, and Gamble (1983) designed a study of spouses of alcoholics and those married to spouses with a variety of other functional impairments (heart attack, renal disease, unemployment, depression). The researchers followed 105 spouses over an 18 month period following residential treatment of their partners for alcohol abuse. The model was tested using path analysis to determine the effects of seven predictor variables (spouse ethnic status, education, initial spouse functioning,

partner impairment, environmental stressors, spouse coping responses, and family social environments) on the functions of 105 spouses over an 18 month study period following residential treatment for alcohol abuse. The researchers indicated that partner impairment was usually the strongest determinant but that almost all other predictors had a significant impact on one or more dimensions of spouse functioning. The authors felt that the results supported both the stress hypothesis and coping perspectives on spouse functioning.

The psycho-social research on wives of alcohol abusers seems to indicate that these women have basically normal personalities and are not a unique group. Personality fluctuations may occur if the husband is actively drinking. The wives of alcohol abusers may actually suffer personality dysfunction while their husbands are actively drinking, but if their husbands have been abstinent for a period of time the wives experience a much lower rate of dysfunction. Additionally, wives of alcohol abusers who ar abstinent experience less depression. The next section is a discussion of the literature reviewed on the interactional approaches to alcohol abuse.

The Interactional Approaches: Systems Theory and Social Learning Theory

In the 1970's the trend at looking at spouses of alcoholics as individuals began to shift toward considering the marital and family system as a unit. General systems theory-based models and social learning theory-based models have taken a more interactional approach to conceptualizing alcoholic marriages.

The main premise of the general systems theorists (Steinglass, 1981) is that alcoholism is an integral component of the family's functioning. Thus, while an individual may have developed alcohol problems prior to his or her marriage, once the alcoholic enters a marriage, a new system develops. Each person in the family system has certain roles that he or she fulfills. The possible roles in a family are limitless, but an alcoholic family member may occupy the sick role in the family. The homeostatic balance in the family is believed to depend upon this role. Therefore, if the alcoholic member stops drinking, the homeostasis of the family is threatened.

Systems theorists (Steinglass, 1981) would predict then that the actions of the family would be directed toward reachieving homeostasis, which could result in family efforts to help the person return to drinking, or could

result in the development of sick behaviors in another family member. It is interesting to note that this model and the decompensation hypothesis both predict that the spouse of an alcoholic could exhibit problem behaviors after the alcoholic stops drinking.

Social learning theory approaches also consider the positive role of alcohol in the marriage, by examining reinforcing consequences of drinking that maintain the drinking behavior. In general, social learning theorists (Sobell, Sobell & Sheahan, 1976) view problem drinking as a learned behavior, which occurs in response to certain discriminable cues, and which is maintained both by positive reinforcement and avoidance of aversive consequences.

Alcoholic couples are postulated to have poor communication and problem-solving skills (Sobell, Sobell & Sheahan, 1976). They engage in positive exchanges at a low rate, and evolve, over the years, a mode of interacting that involves attempts to control each other coercively, such as through threats or nagging. As the aversive situation escalates over the years, communication becomes more ambiguous, vague, and inconsistent. As a result of these poor communication skills and ineffective methods of control, a large backlog of problems accumulates.

On these dimensions, communication and problem-solving skills alcoholic couples resemble other couples experiencing marital distress. The differences between alcoholic and

other distressed couples is that drinking is a high-probability response to these marital antecedents, and may result in marital consequences that serve to maintain the drinking behavior (Sobell, Sobell & Sheahan, 1976). Thus, while antecedent variables and communication patterns may be similar across many types of distressed marriages, the responses and consequences are quite different in alcoholic couples.

Systems models are difficult to test. Most traditional research methods utilize linear, deductive hypothesis testing. Systems models involve complex patterns of interactions, rather than cause-effect relationships. The two main types of studies used to study general systems theory models of alcoholic marriages were pioneered by Steinglass and his colleagues at George Washington University (1978). The first methodology involved complex observations of alcoholic families' interactions, using various methods of coding these interactions. The second approach has been to study communication patterns, by either using simulated interactional games or by coding samples of conversations.

Steinglass (1981) observed couples in both intoxicated and sober states. Observations of couples revealed that alcoholic couples tend to have distinct and different styles of interaction that characterize their drinking and nondrinking interactions Steinglass has suggested that

alcohol intoxication can facilitate the expression of certain family interactions while inhibiting others. These changes in relationships may serve as temporary solutions to chronic family problems and thus may act to stabilize an unstable family system. It is in this sense that Steinglass has described the "adaptive consequences" of drinking, which reinforce drinking and establish a stable cyclical system centered on the differential interactions of the family as a function of sobriety and intoxication. Therefore, Steinglass (1981) advocates the importance of family-oriented treatment and prevention plans.

Some researchers (Dunn, Jacob, Humman & Seilhamer, 1987; Jacob & Leonard, 1988) feel that the major limitation of Steinglass's work however, is that this systems model was developed from small numbers of clinical observations, and descriptions. Convincing empirical data were needed to provide stronger evidence for the validity of this model.

Jacob, Dunn, and Leonard (1983) compiled empirical support to validate the Steinglass model. They studied alcoholic husbands who consumed large amounts of alcohol in the past month. These husbands tended to obtain low scores on the Minnesota Multiphasic Personality Inventory (MMPI), and reported high marital satisfaction. Their wives obtained relatively low scores on various MMPI scales, relatively low scores on the Beck Depression Inventory, and

reported greater marital satisfaction on the Locke-Wallace Marital Adjustment Test and Dyadic Adjustment Scale.

The most striking outcome of the study was that when the subjects were categorized into steady versus binge drinkers, the correlations between alcohol consumption scores and marital satisfaction measure were nonsignificant for the binge drinkers but were highly significant, satisfactory and consistent for the steady drinkers. These findings may indicate that those married to steady drinkers may still experience marital satisfaction. Wives married to binge drinkers may not experience marital satisfaction.

It was also noted that the binge drinkers tended to do their drinking outside of the home. The steady drinkers were divided between in-home drinkers and out-of-home drinkers. The authors concluded that more research, especially of a longitudinal nature needed to be done concentrating on drinking patterns (steady versus binge) and on drinking location relative to marital satisfaction.

Zweben (1986) placed emphasis on investigating the interdependency between alcohol misuse and marital adjustment and how different patterns of alcohol use vary with different levels of marital satisfaction. Additionally Zweben was interested in how the marriage relationship might be mediated by the sociobehavioral consequences of problem drinking. From data on 87 couples it was found that the likelihood of marital disruption was greater in heavy

drinking households than in nonheavy drinking households. However, differences between heavy drinking and nonheavy drinking settings with respect to the marital relationship became largely nonsignificant when the number of sociobehavioral consequences of alcohol use for the marriage was controlled. Zweben concluded that the patterns of alcohol misuse and marital adjustment seem to be complex and variable and are in need of further study. He also recommended treatment for wives and family members not only for the alcohol abuse but for any underlying marital issues.

O'Farrell and Birchler (1987) compared 26 couples with alcoholic husbands, and 26 maritally conflicted and 26 nonconflicted couples without alcohol problems. As predicted, the alcoholic and maritally conflicted couples did not differ, and both groups of problem couples showed greater relationship distress than nonconflicted couples on measures of marital stability, change desired, and positive communication behaviors. Contrary to predictions, alcoholic couples were not unique with respect to struggles for control, a pattern of wife dominance, a responsibility-avoidance style of communication by the alcoholic husband, or impaired perceptual accuracy. Unexpectedly, alcoholic husbands reported less marital unhappiness than both their wives and maritally conflicted husbands on most of the self-report marital satisfaction measures.

The authors explain the positive bias of the alcoholic husband about his marriage in a number of ways. Perhaps the alcoholic's denial and his being at least partially anesthetized by the alcohol to the complaints and dissatisfactions of his wife contribute to his being less aware of his marital problems. Or, perhaps the continued drinking serves to prevent the alcoholic from recognizing the problems in his marriage. Another possible reason is that the wife of an alcoholic may stop talking to her husband because sharing her thoughts with him when he is drinking is fruitless. Therefore, he may be unaware of his wife's dissatisfaction.

The relation between alcohol consumption and marital stability was assessed longitudinally by Dunn, Jacob, Humman, and Seilhamer (1987). Through the use of univariate and bivariate time-series analyses, the study identified a causal relation between alcohol consumption and marital stability and a significant impact of drinking location on obtained relations. The steady drinking in-home group exhibited the strongest positive association between husbands' drinking and wives' marital satisfaction. the steady drinking out-of-home group as well as the binge in-home group and the binge out-of-home groups, revealed very weak associations between the two variables. The authors felt that the findings would suggest that the steady drinking in-home group might occupy a unique position among

the various subgroups. It was also noted that the binge drinkers were involved in more sociopathic behavior and showed more disturbed relationships inside and outside of the marriage than did the steady drinkers.

Drawing from the findings the authors concluded that the high-rate drinking among in-home drinkers is likely to be reinforced and associated with positive consequences. This outcome is even more likely when 1) the alcoholic's behavior is more predictable during periods of steady drinking, 2) the experience of stress in family life is minimized during these times, and 3) the family has adapted to and incorporated high-rate, steady drinking into family life. For both binge drinkers and steady out-of-home drinkers, there appears to be greater individual pathology than steady in-home drinkers, and the drinking pattern is extremely variable, at times chaotic and is not incorporated into the family life. Although some of these individuals exhibit a predictable drinking pattern (that is, heavy weekend drinking superimposed on a background of variable consumption levels throughout the week) the significant disruption associated with these cycles continues to have a destabilizing influence on a relationship already undergoing significant distress. This study would support the Steinglass model.

Jacob and Leonard (1988) assessed the impact of alcoholism subtype on marital interaction, a research focus

stimulated by the previously described study (Dunn, Jacob, Humman & Seilhamer, 1987) linking drinking style with differential levels of marital satisfaction and stability. In this effort, the observations of 49 alcoholics and their wives were conducted during sessions when alcohol was consumed and during nondrinking sessions. Different patterns of interactions emerged for episodic and steady alcoholics. On the drink nights, episodic alcoholic couples evidenced less problem-solving than did the steady alcoholic couples. Additionally, among episodic couples, the husbands were more negative on the drink nights than were the wives, whereas among steady couples, wives were more negative than were the alcoholic husbands. The interaction displayed by the episodic alcoholics and their spouses was suggestive of a coercive control pattern. In contrast, the steady alcoholic and his spouse displayed a pattern suggestive of high levels of problem-solving. The authors feel that further research is necessary to determine whether these two different interaction patterns are predictive of continued alcohol abuse or the exacerbation of marital problems.

To review, those who support the systems model (Steinglass, 1978, 1981) hypothesize that the alcoholism is an integral component of the family's functioning. Each person in the family plays a certain role, including the alcoholic. If the defined roles are not fulfilled then the family's homeostasis is threatened. Drinking can sometimes

facilitate expressions and interactions within the family unit. However these interactions usually only provide temporary solutions to chronic family problems.

The social learning theory supporters (Jacob, Leonard, 1988; Zweben, 1986) believe that abusive drinking is a learned behavior which occurs in response to learned cues. Poor communication and problem-solving can result, especially if the alcoholic's pattern of drinking is unpredictable.

Researchers (Jacob, Dunn & Leonard, 1983; Dunn, Jacob, Hummon & Seilhamer, 1987) are finding that certain subgroups of alcoholics are in unique positions. Those alcoholics whose pattern of drinking is steady and predictable, and who drink at home tend to have marital satisfaction. Those alcoholics who binge drink or who have unpredictable drinking patterns tend to have low marital satisfaction. The next section is a review of articles on the topic of co-dependency.

Co-Dependency

The term co-dependency describes a person who is emotionally involved with and who becomes obsessed with another person's misuses or abuse of a substance or process (Zerwekh & Michaels, 1989). The ideas surrounding the term co-dependency seem to come from several different

theoretical frameworks, including family systems approaches, psychology, and behavioral and interpersonal models (Zerwekh & Michaels, 1989).

In reviewing the literature on co-dependency, there did not appear to be any specific studies defining or explaining the concept. Rather the literature reflected definitions and suggestions for treatment based on previously done research, such as work by Jackson 91968) and Steinglass (1981). This literature also reflected personal opinion based on private practice and experience.

Burnett (1984) described the wife of an alcohol abuser as one who denies the existence of the alcohol abuse. Often the wife seeks professional help for marital problems and comes to discover that the real problem is that of the husband's drinking.

Burnett described the wife of an alcohol abuser as attempting to control, cure, hide, cover-up and make excuses for her husband. This is especially true if the wife feels emotionally and economically dependent on him, or if she feels trapped in the marriage.

As a practicing psychologist, Burnett treated women in divorce therapy. She believed that she has a feministic approach to wives of alcohol abusers. Burnett suggested that wives of alcohol abusers need to first understand the illness of alcoholism. Second, they need to stop trying to control their husbands' drinking. Third, these women need

to start paying attention to their own feelings. Fourth, the wives need to become economically independent and learn to accept support from others. Often Burnett's recommendation is for divorce if the husband is not willing to go for treatment.

Sapp (1985) compared co-dependency with Kubler-Ross's Five Stages of Grieving. These five stages include denial, anger, bargaining, depression and acceptance. Sapp proposed that this application provided a framework within which family members of an alcoholic could begin to understand their own responses and needs.

Sapp described the family of an alcoholic as quite adept at denying the existence of this serious problem. Often the family members will shield the alcoholic, make excuses for his/her behavior, cover up for him/her, withdraw from social interaction and other such "protection". Sapp states that the only other person who denies the alcohol abuse more than the family members is the alcoholic.

Even though the family's denial may be well maintained, there is usually an increasing hostility and anger toward the alcoholic. This anger can lead toward poor interpersonal dynamics. Additionally, it is easy for the anger to become displaced and directed toward oneself. Often, Sapp states, this type of anger can take the form of guilt.

Bargaining comes into play as the family members seek to cope with the alcohol abuse. The spouse is usually the front-line bargainer. Statements such as "If you don't drink this weekend I'll...," or "If you don't stop drinking I'll leave you," can be heard. Bargaining also can occur with God.

Sapp explained that after so many promises, bargains and even sober periods with raised hopes and expectations, those close to the alcoholic can plunge into a depression. This depression can be a complete feeling of hopelessness. This feeling of hopelessness is not all bad, according to Sapp, as this can lead to the final stage.

The final stage is that of acceptance. The acceptance which Sapp describes is that of "loving detachment." In otherwords, the family must realize that they cannot live another's life for him or her. They must step back and let the alcoholic make his/her own choices and suffer his/her own consequences.

Rothberg (1986) described the dynamics of co-dependency from a family systems perspective. Both spouses were viewed as contributors to the alcoholic problem, as well as both being affected by it. Rothberg utilized three models in this article to explain the various dynamics between couples, which included work by Maslow (1954) on the hierarchy of basic human needs, Jackson (1968) and Steinglass (1981).

In applying Steinglass's work, Rothberg described a decline in the communication within the family unit. Spouses frequently blame each other for their marital problems. Dysfunctional relationships can be maintained for long periods of time by mechanisms of silence and diminished sharing and feelings.

A loss of equilibrium may be reached within the family unit as the alcoholic's drinking increases. A commonly used method to restore the equilibrium is scapegoating or blaming. In turn the blamed alcoholic member feels burdened, which increases their drinking behaviors.

Rothberg examined Jackson's work in light of changes in the roles and expectations in the family as they reach a crisis from the alcohol abuse. There is usually a major role shift as the wife increasingly has to take on more of the husband's responsibilities, such as becoming the family breadwinner.

Rothberg used Maslow's hierarchy of basic needs to suggest a mode of treatment. The family's basic needs must be met before they can effectively deal with the alcohol abuser. These basic needs include physical safety, food and shelter, socioeconomic environment, social interaction and self-actualization. Rothberg concludes that while there are not firm methods to treatment which contribute to improved family systems, there is a positive relationship between a stable marriage and success in family treatment.

Zelvin (1988) described dependence and denial in co-dependent women. These two characteristics were considered key in the understanding of these women.

Co-dependence was defined by Zelvin as an exaggerated dependence upon a significant other, in which the self is neglected, identity lost and self esteem at a minimum. Implicit in this term is that the beloved other is emotionally unavailable due to his addiction. Coalcoholics manifest their dependence in an exaggerated need for approval; acute fear of abandonment; fear or risk-taking; denial of feelings, especially anger; a need to nurture and rescue others at the expense of their own needs; a concomitant need to control; and above all, an obsessive focus on the beloved object, from whom they attempt to derive their identity and self-esteem.

Zelvin also described denial in wives of alcohol abusers. Denial is the inability to perceive the connection between alcohol and the problems it creates. The ways in which coalcoholic women deny the relationship between their problems and their partner's drinking range from denial in the psychoanalytical sense to denial of the label "alcoholic" to refusal to acknowledge the situation to outside world or to take steps to change their relationship in the situation. At another level of awareness, a second key feature of the coalcoholic's denial is her inability to perceive how her behavior may be contributing to the

dysfunctional situation. Coalcoholic denial generates feelings of confusion, guilt, anxiety and rage.

Zerwekh and Michaels (1989), two nurses, looked at co-dependency in terms of assessment and recovery. They reviewed several definitions of the term from different theoretical frameworks. A co-dependent is someone who develops an unhealthy pattern of coping as a reaction to another's alcohol, drug pattern or other addictive process. The word co-dependent legitimizes the feelings of the family members and gives them permission to begin to focus on their own personal behaviors. Of the definitions reviewed, Zerwekh and Michaels found that most experts described co-dependency as a disease entity with a definable onset, a set of physical and psychological symptoms, and a predictable course.

The core of the etiology of co-dependency is related to a low self-esteem. Co-dependents have difficulty relating to others because they associate low self-esteem with a person who has little ego strength. Co-dependents get their feelings of self worth from other people. Frequently, co-dependents appear normal, yet they describe themselves as "dying on the inside."

Co-dependents have a difficult time recognizing and setting boundaries. They do not know where they end and other people begin. They are constantly invading others' boundaries or allowing significant others to invade theirs.

Learning to set boundaries and not put up walls as defenses is difficult for co-dependents.

Zerwekh and Michaels also describe shame and guilt as the core of the co-dependent pathology. Most co-dependents take on more shame and guilt than is necessary. Confronting shame and guilt begins with awareness. Learning to give oneself positive daily affirmations and getting in touch with the "inner child" are two suggested treatment methods.

In summary, the term co-dependency is used to define any person who becomes obsessed with another who is involved with an addictive process an develops an unhealthy pattern of coping as a response. The concept of co-dependency has been developed from several theoretical frameworks, including psychoanalytical and systems perspectives. Co-dependency as a concept is currently based on previously done research, such as work by Steinglass (1981), and by personal opinion and clinical practice.

Commonly identified characteristics of co-dependency include denial, dependency, shame and guilt, low self-esteem, a need to control the addict's behavior and poor family interactions. Recommended methods for treatment vary but are designed to increase the co-dependents awareness of the addiction; to promote increase self-esteem; and to promote self care on physical, psychological, social and economical levels.

Summary

In conclusion models of alcoholic marriages developed in the last 50 years have gradually shifted in emphasis from a focus on the individual alcoholic and the individual spouse, each with their own separate psychological problems, to a focus on the marriage as an interactional system in which alcohol is a problem. The description of wives of alcoholics as aggressive, domineering women who marry to mother or control a man, has been demonstrated to be inaccurate (Jackson, 1962; Lemert, 1962; Corder, Hendricks, & Corder, 1964; Kogan & Jackson, 1965b). Further, none of the researchers were able to establish a personality type unique to alcoholics' wives (Kogan & Jackson, 1963; Kogan, Fordyce, & Jackson, 1963). The idea that wives would decompensate, if their husbands became abstinent, was also not validated. In fact, researchers found with their husbands' abstinence wives tended to improve (Jackson, 1962; Bailey, Haberman & Alksne, 1962; Haberman, 1964; Bailey, 1963, 1965, 1967).

In opposition to the Disturbed Personality Theory was the Stress Theory originally hypothesized by Jackson (1954, 1956, 1959, 1962). Jackson first outlined seven stages which were features of marriages in which the husband was an alcoholic. Second, she felt that personalities of the wives would fluctuate relative to their husbands involvement with alcohol. The latter part of Jackson's hypothesis has

received support (Bailey, Haberman & Alksne, 1962; Bailey, 1963, 1965, 1967; Kogan & Jackson, 1965a; Moos, Finney & Gamble, 1982; Finney, Moos, Cronkite & Gamble, 1983). Research has shown that wives whose husbands have been abstinent display fewer symptoms than those whose husbands were active alcoholics (Bailey, Haberman & Alksne, 1962; Bailey, 1963, 1965, 1967; Haberman, 1964). The level of disturbance in the wives of alcoholics with that of wives of problem marriages was not found to be different (Deniker, deSaugy & Ropert, 1964; Bailey, 1965). The concept of wives changing their duties and responsibilities as their husbands' degree of involvement with alcohol changed has been supported (Clifford, 1960; Lemert, 1962). Research on coping styles found support for Jackson's theory that wives' manner of coping with their husbands alcoholism changed when the husbands' alcoholism changed (Orford & Guthrie, 1968; James & Goldman, 1972; Moos, Finney & Gamble, 1982).

Wives of alcoholics are now considered to have basically normal personalities of different types rather than one particular type. They may suffer personality dysfunction when their husbands are actively drinking. However, these personality disturbances lessen when the alcohol abuse of their husbands decreases of becomes abstinent. Along with the personality fluctuations are changes in the wives' methods of coping with their husbands' drinking and with their roles in the family.

With the shift in emphasis of models from an individual focus, to a focus on the alcoholic marriage as a unit, a more interactional approach has evolved. More emphasis is now placed on patterns of interactions in the marriage than on a cause-effect type relationship.

Steinglass (1978, 1981) pioneered the development of the systems approach toward alcoholic marriages and families. The alcoholic, the wife and each family member plays a role in the alcohol abused family. If the alcoholics' drinking stops or changes patterns the homeostasis of the family unit is threatened. Evidence suggests that those alcoholic husbands who drink steadily and in the home usually experience marital satisfaction, along with their wives (Jacob, Dunn & Leonard, 1983; Dunn, Jacob, Hummon & Seilhamer, 1987). Those alcoholic husbands who drink steadily out-of-home, and those who binge drink showed involvement in more sociopathic behavior and showed more disturbed relationships both inside and outside of the marriage (Jacob, Dunn & Leonard, 1983; Dunn, Jacob, Hummon & Seilhamer, 1987). There is a decreased marital satisfaction for the wife in this group because the variable drinking patterns are unpredictable and chaotic and are not incorporated into the family life (Dunn, Jacob, Hummon & Seilhamer, 1987). Looking at the alcoholic marriage as a unit has allowed the importance of the variables of drinking patterns and drinking place to be identified.

Different interactional patterns have been identified for the episodic and steady alcoholics (Jacob & Leonard, 1988). Episodic alcoholic couples evidenced less problem-solving and had more negative levels of problem-solving. In contrast the steady alcoholic couples showed high levels of problem-solving.

The term co-dependency describes a person who has let someone else's behavior affect him or her and is obsessed with controlling another person's behavior. The concept of co-dependency has evolved from several different theoretical frameworks, including psychoanalytical and systems approaches. Co-dependency is considered to be a disease entity with a definite onset, characteristic symptoms, and a predictable course (Zerwekh & Michaels, 1989). The word co-dependency offers validation for family members' feelings and gives permission for them to seek treatment (Zerwekh & Michaels, 1989). Commonly occurring characteristics include denial, dependence, guilt, shame, a need to control the addict, and poor family interactions.

Implications from Recent Literature

The previously reviewed literature on wives of alcohol abusers relates to this present study in several ways. First the wives of alcohol abusers can be considered to be basically normal people with varied personalities. Their roles and functioning in the marriage and family unit change

as the patterns of alcohol abuse change or when abstinence occurs.

Second, the concept of co-dependency appears to be based on previously done research and suggested opinions from clinical practice. Since co-dependency offers validations to the experience of the wife of an alcohol abuser, research needs to be done to clearly define the concept and to strengthen treatment modalities. Therefore the experiences of the wives in this study can be compared to the literature on co-dependency to observe for similarities.

Third, there has not been any studies identified in particular that relate to age as a variable, or which look specifically at help-seeking behaviors of the wife of an alcohol abuser. There have not been any studies identified by nurses in relationship to wives of alcohol abuser. Therefore, the exploratory nature of this study is appropriate. There is a need for a generation of testable hypothesis which will include age as a variable, as well as identifying help-seeking. Additionally exploring an individual wife's experience in an alcohol abused marriage will lend toward the development of nursing, as patterns of human/environmental interaction are described. As well as fitting with Rogers' (1970) theory of nursing, the American Nursing Association (1980) in their social Policy Statement

specifies that the phenomena of concern to nurses are those human responses actual or potential.

In the next chapter the specific methodology of this study will be described. This chapter will include the study design, data collection procedures, and the reliability and validity of the study.

CHAPTER IV

METHODOLOGY

Introduction

The purpose of this chapter is to review the methodology utilized in this study. The areas described include the study design, the study questions, the objectives of the study based on the conceptual framework, the sample, the protection of human rights, the operational definitions of the main concepts, the instrumentation, data collection methods, reliability and validity of the data, and the data analysis.

The Study Overview

This study was designed with the following purposes in mind:

1). To describe and compare the life experience of three women who are married to elderly alcohol abusers which led up to the first attempt at professional help-seeking.

2). To describe and compare any changes in the life experience of the three women since the first attempt at help-seeking.

3). To suggest a pattern of response that best describes the phenomenon experienced prior to and after help-seeking of these three women.

4). To contribute to nursing by studying the lived human experience based on Martha Rogers' theory for nurses.

5). To serve as a pilot study for future research by describing the meaning of the experience and by promoting hypothesis generation.

The Study Design

The design of this study is based on qualitative research using grounded theory as described by Chenitz and Swanson (1986). Grounded theory is a highly systematic research approach for the collection and analysis of qualitative data for the purposes of exploring social and psychological phenomena (Chenitz & Swanson, 1986). It provides a method to study fundamental patterns known as processes which account for variation in interaction around a phenomenon or problem (Chenitz & Swanson, 1986).

According to Chenitz and Swanson (1986) grounded theory is applied to produce abstract concepts and propositions about relationships. Grounded theory studies have been reported at both the descriptive and theoretical or process level. Researchers may stop at any level and report

findings. For the purposes of this study, finding will be reported on the descriptive level.

Grounded theory uses the constant comparative method of analysis throughout (Chenitz & Swanson, 1986). Data are initially coded which reflects what the subjects said in an interview, or what was observed by the researcher. The data in this study will be coded based on using main concepts of objectives which relate to Martha Rogers' Theory of Unitary Man (1970). The data are compared and clustered. The clustered codes are given a label to form a theme. Themes can be observed for relationships until a pattern is conceptualized.

Data are usually collected until the themes are saturated and the data is not adding any new information. This is called theoretical sampling (Chenitz & Swanson, 1986). From the themes labeled, described, and saturated a core pattern emerges as best explaining the problem or phenomena being processed. Since this study was at a descriptive level with a small sample, theme saturation was not possible.

By isolating and comparing the data this researcher hoped to understand the meaning and similarities in the life experience of three wives of elderly alcohol abusing husbands who sought help for the first time. The major pattern that emerged to describe this phenomenon can only be generalized to these three wives. However describing this

experience by transforming it into a hypothetical statement regarding the evolution and impact of help-seeking moved the description to a higher level of discourse.

Study Questions

1). What past life experiences were perceived to lead to the evolution of the first professional help-seeking attempt on the part of the wife who believes her elderly husband to be an alcohol abuser?
2). According to the wife, how did that first attempt at professional help-seeking change the life experience?

Conceptual Framework

The conceptual framework, as discussed in Chapter Two of this thesis, which served as the rationale for the basis of this study, was the Theory of Unitary Man conceived by Martha Rogers (1970). Unitary Man or human beings are wholistic, are identified by pattern and organization, and manifest characteristics that are more and different from the sum of the parts. Humans are constantly exchanging energy with the environment which includes other humans. The interactions between other human energy fields and the environment is such that both are repatterned mutually, continuously, simultaneously and with increasing complexity

in a four dimensional time matrix along a space-time continuum.

Human beings are sentient and seek to organize the world of their experience and to make sense of their lives. In patterning and repatterning the life experience, human beings make choices. These choices are based on past life experiences which are made up of interactions. These interactions contain responses, thoughts and emotions.

Human beings seek to direct their life experience toward health and general well-being. A sense of overall well-being with a future view is seen as health (Rogers, 1983).

Objectives of the Study

From this conceptual base, the objectives for this study were developed. These objectives contain the main concepts to be described. They are as follows:

1). To describe the interactions between the wife and the elderly alcohol abusing husband that gave rise to seeking professional help for the first time.

This objective was developed from the concept that man and his environment are inseparable and have continuous mutual interactions. These mutual interactions give rise to mutual change.

2). To describe the thoughts and emotions that surrounded the choice to seek professional help for the first time.

This objectives was developed from the concept that man has the ability to think and feel which allows him to make choices. These choices can effect change.

3). To describe the repatterning of the life experience of the wife after the first professional help-seeking attempt.

This objective was developed from the concept that change precedes repatterning. Pattern and organization of the life experience is a constant process of evolution.

Sample

The sample studied consisted of three wives of elderly alcohol abusing husbands from long term marriages. These wives were a convenience sample of volunteers. These volunteers came from one of several local senior citizens apartment complexes. Those interested in volunteering were

asked in the announcement to contact the researcher by phone. Those who volunteered were screened by the researcher on the phone according to the sampling criteria. The criteria for being a part of this study included the following:

1) the perception of the wife that her husband is an alcohol abuser.
2) the ability of the wife to express herself, to relive the past and present and the ability to reflect and conceptualize.
3) the couple has been married for at least five years to establish patterning and repatterning of marital interactions. The couple may be presently separated, but not divorced.
4) the alcohol abusing husband must be at lest 55 years of age in order to reflect the older population of alcohol abusers. The wife has no age requirement.
5) the wife will have attempted to seek professional help for the alcohol abuse of her husband at least once in the past. This professional help can come from a physician, a nurse, a psychiatrist, psychologist, social worker, marriage counselor, or family therapist, going to Al-Anon, or going to a geriatric assessment center.

6) the opportunity to meet privately once for a two hour period of time. This interview would have to be conducted without the presence of the husband. The husband could be aware of the meeting however.

Protection of Human Subjects

The main goal of this study was to explore the phenomena of the life experience of three wives of elderly alcohol abusers who sought help for the first time. An additional goal was to protect the privacy of those who agreed to participate. The University Committee on Research involving Human Subjects reviewed and approved an abstract and proposal on this study pertaining to the protection of the human subjects. The committee required: 1) a statement to the subjects prior to the interview containing an explanation of the study including any risks, 2) the subjects be freely allowed to participate in the study, 3) the subjects could discontinue the interview at any time, and without ramifications, and 4) the results would be treated with strictest confidentiality.

These criteria were met in the following way:

1). Written announcements describing this study were distributed in several senior citizen apartment complexes (see Appendix B). Those interested in volunteering were asked in the announcement to contact the researcher by phone. Those who

volunteered were screened on the phone according to the sampling criteria.

2). The phone contact was also used to allow the volunteer to ask questions. The inherent risk of possibly becoming more aware of and disturbed by any new or old issues raised by this interview was discussed. The volunteer was urged to discuss her concerns and feelings, if engendered, with supportive persons, professionals, or if desired the researcher.

3). A time for a private interview was set. The interviews were held at the homes of the respondents to offer privacy and comfort. The interview was set for a time when the husband would not be present.

4). A consent form was presented at the beginning of the interview promising confidentiality, asking permission for audiotaping and offering the respondent the option of withdrawing from the interview at any time (see Appendix C).

5). The transcriptions of the audiotaped interviews and their memos were placed in the researcher's private files. Fictitious names were used in reporting the data.

6). The audiotapes were erased after the data analysis took place.

Operational Definitions

Mutual Interaction - is a dynamic inseparable, exchange process in which both the husband and the wife are interdependent. They will act and react upon one another. Mutual interaction consists of actions and responses to one another.

Thoughts and Emotions Surrounding Choice - are understandings, perceptions and strong feelings which effect the ability to see fit, or to select from two or more options.

Repatterning After Help-Seeking - a change in the overall pattern of interaction which is preceded by choice based on a sense of options.

Instrumentation

The instrumentation of this study has been designed to explore and describe the life experience of three wives of elderly alcohol abusers before and after the first attempt at professional help-seeking. The method for obtaining the data is based on the grounded theory qualitative method of research (Chenitz & Swanson, 1986). The data collection

method used in this study was the face to face unstructured interview which is the formal qualitative interview technique for grounded theory (Swanson, 1986).

The funnel approach was used in the interview (Swanson, 1986). The funnel approach begins with general questions to allow for description, and then moves into closed questions for more specific details. Swanson (1986) suggests the use of the funnel approach when: 1) the interviewer wants to discover unanticipated responses, 2) the respondent is motivated to give a detailed description of an event of situation, 3) the interviewer wants to avoid imposing his or her frame of reference on the respondent.

The researcher conducted all of the interviews. An interview guide (Appendix D) was used. The interview guide contained an outline of the general areas to be covered developed from the research questions and objectives. Unlike a structured interview, the unstructured formal interview does not rigidly have to adhere to specific questions (Swanson, 1986). The interviewer in the unstructured formal interview introduces a pertinent category and the questions are framed to pursue the development of that category as the interview progresses (Swanson, 1986).

The interviews were audiotaped. The taping was done to help reduce interviewer bias and to increase the accuracy of the written analysis. Additionally, the audiotaping allowed

the interviewer to observe nonverbal behaviors that added to the data collected. Occasional notes describing nonverbal behaviors observed by the researcher were written on the interview guide for each subject. Taping the interview gave the respondent the appearance of listening rather than constant notetaking.

If the respondent had had more than one professional help-seeking experience then they were asked to fill out a questionnaire briefly describing the other occasions. The purpose of this questionnaire was to provide description on any other help-seeking experiences and how they may have affected the present life experience, in addition to the first experience.

Data Collection Method

Potential participants were garnered from volunteers from several local senior citizen apartment complexes. The potential participants had volunteered after receiving a written announcement. Three women were chosen after being screened on the phone based on the criteria for the study and their willingness to participate. Private meetings were then set in the participants' homes. The husbands were not present.

At the beginning of the interview session, the researcher offered the respondent a letter with a promise of

confidentiality. Permission was obtained for audiotaping, with the promise that the tape would be destroyed after the private use of the researcher for data analysis.

Approximately 15 minutes were used at the beginning of the interview to establish rapport and to collect basic demographic data. The formal qualitative interview followed. The researcher conducted the interview from the interview guide, asking specific questions in order to pursue the categories being explored as needed.

If the respondents had had more than one professional help-seeking experience then they were asked to fill out a brief questionnaire describing each of those other experiences. There is a place on the interview guide that indicates when to collect this additional information (see Appendix D). This information was collected when exploring the third objective, the repatterning of the life experience of the wife after the first professional help-seeking attempt.

The researcher also noted non-verbal behaviors during the interview and documented them (APPENDIX E). Non-verbal cues included facial expressions, gestures, body positions, movement of hands, feet, and head, pace of speech, pitch, intensity, and volume of voice. Inconsistencies were noted in relationship to the content and situational context of the interview. If inconsistencies were noted, the

researcher probed until they were clarified, for the objectives of the interview.

The role of the researcher was strictly to collect data. A therapeutic effect may have occurred due to the listening approach of the researcher. However, this subject matter was of a sensitive nature, and could touch on difficult areas of a person's life experience. Therefore, if the respondent was in need of assistance or counseling, referrals to local agencies were made to fit the need.

Validity and Reliability

Validity and reliability are critical issues in evaluating research findings. In most forms of research, validity and reliability are established through the use of certain procedures for data collection and analysis. In qualitative research these issues are not addressed in the same way as in quantitative forms of research since the nature of the research process is different.

There are two major forms of validity that encompass many factors. These two forms are "internal" and "external" validity.

In qualitative research internal validity is concerned with the truth of the evidence in the data and of the analysis (Chenitz & Swanson, 1986). The internal validity

of this study was threatened by several factors. These factors include the following:

1). Subject bias - subject bias refers to the difference between the kinds of people studied and those not studied (Chenitz & Swanson, 1986). Subject bias must be acknowledged in this study as those interviewed were volunteers. The possibility exists that volunteers may be different from the rest of the population of wives of elderly alcohol abusing husbands. In order to minimize this threat open-ended questions were used in the interview guide so that there were not wrong or right answers. Demographic information was taken to account for possible differences such as social, financial, or educational factors.

Subject bias can also mean that the respondents will answer in ways that they perceive the researcher is looking for or expecting rather than what is true. To minimize this threat the researcher observed the body language and facial expressions during the interview for congruence with what was being said. These observations were documented in field notes (APPENDIX E). If there seemed to be an incongruence in what was being said and what was being observed then the researcher probed for clarification.

2). Subject maturation - since this study involves the one time interview contact, subject maturation was defined as the tiring or withdrawing effect that the interviewing process had on the respondent. This is due to the sensitive nature of the subject matter and to the length of the interview. This threat to validity was addressed by allowing rest periods if the respondent needed them and by limiting the interview to a maximum of two hours. Two hours was determined to be a reasonable time limit after the interviewing process had been role played.

3). Reactive effects - reactive effects of the respondent to the researchers presence and involvement in the interviewing process is the factor with which qualitative researchers are most concerned (Chenitz & Swanson, 1986). Attempting to control these effects is one way to minimize this bias. This was done by the researcher by strictly adhering to the data collection procedures and interview guide. Emerson (1983) suggests that researchers are actually a part of the reality of the interviewing process and it is taken for granted that they alter what is observed. The reactivity observed such as

tearfulnes, anger and other responses were carefully documented in the field notes.

4). Consistency - consistency of the data is defined as the degree to which the evolving story of the respondent is in harmony with itself and has no self contradictions. The threat to validity with this factor occurs when the respondents begin to tell their story in a guarded fashion. As the interview progresses and the respondents relax and get into telling the story a truer picture of the situation can be described. To control for consistency in this study the researcher would rephrase and reask some of the questions. This was done by the researcher saying several questions late "I want to be sure I have this right. Did you say...?" This allowed for the respondent to validate the information and to clear up any inconsistencies. This was done at least once for each of the three objectives and any time that there was a noticeable inconsistency.

5). Observer change - changes in the observer or researcher as affected by the respondents can be a threat to validity if the researcher takes on the behaviors and attitudes of the respondents. It is expected that the observer will change as a result of the study and of the interactions with the

respondents (Chenitz & Swanson, 1986). The researcher controlled for the change in her feelings and attitudes by writing memos after each interview. The writing of these subjective memos was used as a tool to increase the awareness and sensitivity of the researcher to the data analysis.

External validity rests on the generalizability of the observations (Chenitz & Swanson, 1986). It must be remembered that unlike quantitative research which relies on statistical generalization, survey research relies on analytical generalization. This means that the aim of the researcher is to generalize a particular set of results to some broader theory. In this study, the results are generalizable to the Theory of Unitary Man (1970) from which the study objectives were derived and upon which the interview questions were based.

Reliability is the degree of consistency with which an instrument is measuring the attribute it is supposed to be measuring (Polit & Hungler, 1983). Qualitative researchers look at reliability in terms of accuracy and credibility (Chenitz & Swanson, 1986). The overall reliability was established from a panel of experts who reviewed the interview guide. The following are reliability factors which were possible threats to this study:

1). Environment - the environment was defined as the surroundings or circumstances that were present during the interview. An uncomfortable chair as an example, might affect the accuracy of the data being given. The environment was acknowledged through the field notes of the researcher. The field notes included such things as the appearance of the room and the respondent's clothing.

2). Personal Character of the Respondent - In order for the data to be credible and accurate the respondent had to be able to express herself, to relive the past and present, and had to be able to reflect and conceptualize. The control for this was included in the sampling criteria. When any interested possible respondent contacted the researcher, these criteria were evaluated.

3). Mechanical defects - mechanical defects refers to anything external that might go wrong with the interviewing process. The controls for this included taking extra batteries for the tape recorder, extra pens and interview guides. During the pre-interview an appointment was set with the qualifications that the interview take place at a quiet place in the home and at a time when the husband was not available. The interview process was role played prior to the first interview to

give the researcher practice and to observe for any unanticipated complications.

4). Coding - the issue of credible and accurate coding of data in the analysis was handled in several ways. First, the specific steps in the data collection and analysis were adhered to in a strict fashion. Second, the transcripts typed by a transcriber for the audiorecordings were reviewed by the researcher with the recordings for accuracy. Third, another clinical nurse specialist familiar with qualitative research, reviewed the transcripts, field notes and other help-seeking experience questionnaires for emerging themes based on her own perception. The themes were from each of the three objectives. The researcher's themes and those of the clinical nurse specialist were compared and discussed. If the themes for each objective matched with at least 75% accuracy then the emerging pattern for that objective was considered reliable.

Data Analysis

The analysis of the data collected for this study was based on grounded theory. This is a very complicated method that is broken down into steps, each step building upon the

other (Corbin, 1986). Each individual interview is analyzed separately and then compared with each of the others. The data analysis steps used for this study are described below.

The individual interview was transcribed and then reviewed in depth by the researcher using the audiotape to validate the data collected. Memos were written by the researcher describing her own subjective feelings toward the respondent's experience. This was done to heighten the sensitivity of the researcher to any personal changes in feelings or attitudes that might have occurred based on being an interactive part of this study.

Analysis is the separation of the whole into constituent parts for the purpose of the study. The researcher reviewed the transcripts for critical elements or statements articulated by each subject. In this case, the critical elements were defined according to the major concepts in the objectives. These major concepts are: 1) mutual interactions, 2) thoughts, emotions, and choices, and 3) change and repatterning.

The researcher then used constant comparison between the critical elements identified in the three women's stories. When similar critical elements were observed to be existing for all three women, then the researcher placed these elements into a category. The categories in the respondents' language, were examined in light of the major concepts and formed the basis for constructing major themes

which represented the phenomenon as lived by these three women. The identified major themes represented a move away from the respondents' language to a higher level of discourse. Finally the themes were interrelated to form a coherent, integrated statement regarding the pattern of experience of seeking professional help for the first time by the wives of elderly alcohol abusers.

Field notes were written and reviewed to control for validity. Included in the field notes were facial expressions, gestures, body position, movement of hands, feet, and head, pace of speech, pitch, intensity, and volume of voice. Descriptions of the interview environment, the respondent's appearance, and any interruptions were included. The questionnaires regarding other help-seeking attempts were analyzed based on the concepts for the third objective - change and repatterning of responses.

To ensure reliability of the analysis the raw data were examined by a clinical nurse specialist familiar with qualitative research. The themes from the analysis of the researcher and of the clinical nurse specialist must have matched to have been considered reliable.

Summary

The purpose of this chapter has been to describe the methodology and procedures utilized by the researcher in this qualitative study on the life experience of three wives

of elderly alcohol abusers who sought help for the first time. This study was based on the grounded theory method of qualitative research (Chenitz & Swanson, 1986). The formal qualitative interview approach was used. This approach was a face to face unstructured interview.

The data analysis consisted of documenting and examining the interviews, observations, and questionnaires. Critical elements were identified for each of the three main objectives for each respondent. The three main study objectives were derived from the conceptual framework presented. Comparisons were made looking for the similarities between the three life experiences. Categories were formed representing similar critical elements for all three women for each objective. These categories formed the basis for major themes representing the meaning of the first help-seeking experience for these three women.

The protection of human rights for subjects was reviewed. Comments which addressed reliability an validity were included. In the next chapter the analysis of the data will be presented.

CHAPTER V

DATA ANALYSIS

Introduction

This study was undertaken to explore the life experience of three wives of elderly alcohol abusers who sought professional help for the first time. The aim of this study was to describe the mutual interactions, thoughts and feelings that led up to the choice to seek help. Additionally, the repatterning of the life experience after the first help-seeking attempt was described. From the words of the three women common themes were isolated which represented the meaning of this experience to them.

The data will now be presented. Included in this presentation will be a brief description of the sample and of the methods of analysis. The results of the analysis will follow. The results of the analysis include common themes identified from across each of the three women's interviews. These themes will be supported by statements in the words of the three women. Finally, reliability and validity issues with respect to the data analysis will be discussed.

The Sample Description

The three women in the sample all met the criteria for being included in this study. All three were able to verbally express themselves and to reflect and recall past and present life experiences. The three women will be known as Mary, Jane and Sally. These are fictitious names used to protect their real identity.

Mary and Jane's marriages ranged in length from 43 to 47 years. Sally's marriage has lasted 36 years in comparison. They all perceived that their husbands abused alcohol from 20 to 25 years. The present age of the husbands ranges from 63 to 76 years old which met the criteria of the husband being at least 55 years old (See Table 2).

Presently all the women are living with their spouses. Sally, however, was separated at one time from her husband for several years. Each couple have children. Sally and her husband have three. The other two couples have two children. All three women perceive their own health to be good. Jane perceives her husband's present health to be fair as he now has Parkinson's and heart disease. The other two wives believe that their husbands' health is good at this time.

Table 2: Socio-Demographic Information About The Three Husbands and Wives

	Mary-A	Jane-B	Sally-C
Age of Wife	68	71	Not Recorded
Age of Husband	73	76	63
Years Married	47	45	36
Years of Alcohol Abuse	20	25	20
Together or Separated	Together	Together	Together
Number of Children	2	2	3
Health-Husband	Good	Fair	Good
Health-Wife	Good	Good	Good
Educ.-Husband	12th Grade	12th Grade	7th Grade
Educ.-Wife	12th Grade	12th Grade	Bus. Coll.
Profession-Husband	Ret. Banker Present Bkpr.	Ret. Grain Inspector	Sales
Profession-Wife	Activities Director	Former Store Clk.	Sales/Off.
Income Range	Under $10,000	$10,000 - 19,999	$10,000 - 19,999

Two of the wives and their husbands had completed high school. Sally attended business college and her husband only completed the seventh grade. The occupations of the husbands had varied from banking, to grain inspector, to sales. Mary and Jane's husbands maintained their jobs over the years. Sally's husband moved from sales position to position, often being asked to resign. Sally's husband is presently unemployed. Mary and Jane's husbands have retired, but Mary's husband works as a bookkeeper for the local school district part-time.

All three of the women have been employed outside of the home at various times. Mary is presently employed as an activities director in a nursing home. Sally has worked in sales and office work and is also presently employed. Jane was employed as a store clerk when her children were in high school, but does not presently work. Jane and Sally's income level ranged from $10,000 to $19,999, and Mary's income is under $10,000 a year.

The following section includes brief case studies for each of the three women describing their experiences as wives of elderly alcohol abusers. This will be followed by a description of the methods and the data analysis.

Mary - CASE A

It was Mary's belief that the beginnings of her husband's alcohol abuse began back when they were dating. Mary and her husband John would go out drinking and dancing with friends every weekend. The drinking was not problematic then, but Mary believed that this is when John's tolerance to alcohol started to change. John's drinking pattern continued to develop after they were married.

Mary began to perceive the drinking as problematic after the children were grown. John was then about 58 years old. Mary became aware of the alcohol abuse in her husband after reading articles and listening to a speaker on the subject of alcoholism.

Mary perceived John's drinking to be problematic over a six year period of time. He routinely drank every day, once in the morning, several times at lunch, and then again every evening. He began to periodically get up during the night for a drink. On the weekends he drank more consistently than during the week. John did most of his drinking at home. Mary believed that John was very careful with his drinking in order to maintain his banker image in their small community.

As the abuse progressed John would hide the alcohol and sneak drinks. He began to experience black outs. There were times when he forgot where he was or he forgot to pick Mary up from work.

Mary described herself as being frightened and on "a merry-go-round" during this time. She would monitor John's drinking and confront him periodically with her concerns. She marked the bottles and filled them with water. Mary sometimes fixed John drinks at home to prevent him from going out to the bars.

Mary made the decision to seek professional help when she found her husband passed out on the bed with a bloody gash on his head following an event where he forgot to pick her up from work. She sought help from their family physician when she took John to the hospital. Mary felt that the physician did not realize the severity of the problem. The physician sent them home after John agreed not to drink heavily anymore.

Mary described herself as feeling angry about the alcohol abuse and about the lack of resources. Mary decided she would not help her husband in any way with his drinking She ceased mixing him drinks and continued to be verbal with John about her concerns regarding his drinking.

Three months after this initial attempt to seek help, John experienced delirium tremens. Mary again sought professional help from her physician. This time the physician directed John and Mary into a treatment program. This treatment has been successful for them. John has been sober for nine years.

During treatment Mary was able to release many built up

feelings. She saw that she was not alone with the alcohol abuse problems. Mary believed that the treatment program was a very spiritual experience and one that gave her life and marriage greater meaning.

Jane - CASE B

Jane described her overall marriage as having been difficult. Her husband Bob had dated a friend of his family's prior to marrying Jane. Bob continued to see this woman after he married Jane. This continued relationship created marital problems for Jane. The more she confronted him about this lady friend, the more Bob would drink. Jane described Bob as being very obnoxious. He continued to keep in touch with this lady friend throughout their whole marriage.

Approximately 20 years ago, when Bob was 56, Jane noticed that he was gaining weight, and was smoking and drinking more than previously. It was at this time that Bob suffered his first heart attack. After Bob returned home from the hospital Jane observed that his drinking had increased more and more. When Bob returned to work, he joined his co-workers who drank. This group of men went for a beer at lunch and sometimes drank on the job.

Jane felt that their entire family was aware of Bob's alcohol problem. When the family was invited to a gathering and Bob became intoxicated, someone would have to give them a ride home as Jane did not drive. When someone at the

gathering did not offer Bob alcohol, he would blame Jane for this denial even if she had said nothing.

Jane felt that Bob was obnoxious and verbally mean to her when he drank. He behaved in many peculiar ways. One time he raced with a fire engine on the interstate when the family was in the car. Another time his boss called Jane to complain that Bob always smelled like liquor. Jane then decided to investigate the house. She found a collection of little pill bottles full of vodka hidden in the garage. Apparently Bob would take these vials to work with him every day.

Jane felt extremely ashamed of the situation. Even though Bob was drinking heavily and seeing another woman, Jane did not feel that she could leave him. Jane felt that her children needed a father and she felt too proud to let anyone know about her problems. She also had great concerns about getting along financially without him. Jane felt that she coped with these problems by getting a job and by being very involved with family and friends.

After Bob's first heart attack and a disastrous 25th wedding anniversary, Jane went to her family physician, who was a recovering alcoholic, to seek help. The physician was aware that Bob abused alcohol and suggested that Jane attend Al-Anon. However Jane did not feel that she could go to Al-anon because she did not want anyone to know about Bob's alcohol abuse and their marital problems.

Nine years later when Bob was 64, he had his second heart attack. He was severely ill. Jane again approached the family physician for help. The physician discharged Bob to the alcohol rehabilitation unit. Bob was very angry with Jane and the physician for placing him in this situation. He would not admit that he really had a drinking problem.

Jane went through the alcohol treatment program for spouses, and found this very beneficial. She felt that she was able to identify and express many suppressed feelings. She felt that she gained self esteem from the experiences of sharing her feelings with others who had similar problems. She gained much knowledge about alcoholism and how it affects the family. This knowledge was also helpful to her.

Bob still continued to see his lady friend and to sneak a few drinks after treatment. Four years after treatment Bob developed Parkinson's Disease. Bob has had a quadruple bypass surgery as a result of his heart disease. Jane currently feels that Bob does not drink much because of his health problems and numerous medications. Bob's lady friend committed suicide several months ago. It is Jane's opinion that Bob is grieving her loss.

In spite of everything Jane knows she still loves Bob. "When he isn't drinking he is a good man." Jane feels amazement for what she has endured over time. "There's a different kind of strength there I didn't know I had."

Sally - CASE C

When Sally met Tom she would "drink him under the table." They spent the early stages of their relationship going to parties and to the bars, socializing and drinking heavily. Sally and Tom got married one month after they met.

However when Sally had their first baby she felt life had changed. She wanted to stay home with her new son. She began to find that she was home alone often. Tom continued to go to the bars and parties without her. At first this did not bother her as she was so involved with her baby.

Three years after the birth of their son, they had their second child. Sally had to go back to work because Tom was drinking heavily and spending a lot of their money at the bars. She felt terrible about leaving her children while she worked.

She worked for three years before they had their third child. Tom was drinking heavier than earlier in their marriage and running around with other women. Sally blamed herself for their problems and felt she was too tolerant of the alcohol abuse. She described herself as being lonely as they could not afford baby sitters and she could never go out with Tom. In addition she felt ashamed to have any sitter come to their house because of her husband's drinking.

Sally described Tom's drinking as controlled. He never

appeared drunk. Tom most often drank at the bars or at parties. Tom's primary employment was various sales positions where he would drink with clients at lunch. He rarely drank at home, although he kept alcohol available.

Sally described Tom as a binge drinker because some months he drank less than others. When he drank heavily, he would meet women at the bars and not come home at night. He had trouble keeping jobs. He lost his real estate license and some of his jobs due to situations that occurred from his drinking.

Sally felt that living with Tom during those times was mental abuse. He would blame her for things that he himself did. Although Sally confronted Tom about his alcohol abuse she also covered up for him. When he would be gone for long periods of time Sally would take her children in the car and search all the neighborhood bars looking for him.

Sally once remembers finding Tom in the bar sitting with another woman. He had not been home for several nights. She was so angry with him that she slapped him across the face. Tom became angry at her for slapping him and followed her home. They became involved in a very bad fight and the neighbors called the police. It was following this event that Sally decided to get help. She felt out of control and decided to go to Al-Anon.

During her first Al-Anon meetings Sally felt very ashamed. She began to realize that other people shared

similar situations. She finally began to share her feelings and experiences with the other people in the group. Sally felt that her behavior changed because she no longer felt a need to make excuses for Tom. She now had a support system. She gained knowledge about herself and about alcoholism and felt that she gained more control and self respect.

Several years ago Tom's drinking worsened and their relationship really deteriorated. Sally separated from Tom. After a year Sally began to see Tom again as he had slowed his drinking down from the level prior to the separation. They are now living together and Sally is the sole financial support.

Several months ago Tom started to drink more heavily. Sally stated that as she is now in control of her life she would ask Tom to leave again if necessary. She allowed Tom to stay because she desired his companionship and hoped that his alcohol abuse had gotten better.

The three women in the case studies described above all experienced very unique marriages with their alcohol abusing husbands. In the next section the methods of the data analysis will be described. The presentation of the data analysis will follow.

Description of Methods

The analysis of the data in this study involved comparison and synthesis of the experiences of the three women. There were three main objectives which guided the analysis. These three objectives were derived from Rogers' (1970) framework for nursing and from the relevant literature surrounding alcohol abuse in the elderly and from wives of alcohol abusers. Main concepts from these three objectives were operationalized in order to identify the appropriate data in the language of the responding women. The pertinent data were identified and compared across all the respondents. Common themes were identified for each of the three objectives representing the meaning of the first professional help-seeking experience for these three women.

The common themes identified by the researcher were then compared with common themes identified by a clinical nurse specialist who followed the same analytical process. This comparison was done to ensure that the data analysis was reliable.

Threats toward the validity of this study were controlled for in a variety of ways. These included a personal journal kept by the researcher, a panel of nursing experts who reviewed the methodology and results, rephrasing of interview questions, keeping field notes for nonverbal

communication and environmental factors, collecting demographic information.

Results of the Data Analysis

The results of the data analysis will be presented as common themes for each of the study objectives. Each of the identified themes will be described and supported by data in the language of the subjects.

Study Question One

What past life experiences were perceived to lead to the evolution of the first professional help-seeking attempt on the part of the wife who believes her elderly husband to be an alcohol abuser?

OBJECTIVE ONE: To describe the mutual interactions between the wife and the elderly alcohol abusing husband that gave rise to seeking professional help for the first time.

> "This was all just a game. Game playing. Playing games. And there's a lot of that. This is why I reached a point where I knew that I needed help. (Mary)

The three women in this study described the interactions in their marriages as having occurred in a variety of ways. Although there seemed to be many different situations, there were three common themes identified. All

three of the women perceived that the interactions in their marriages were problematic because of the alcohol abuse of their husbands. Additionally a significant event occurred which seemed to lead the women to seek professional help. Finally, the interactions surrounding the alcohol abuse in the marriages did not appear to be mutual. While the wives used responses to stop their husbands drinking, the husbands continued with behaviors which supported their abusive habits.

THEME 1

Problematic Marital Interactions

> "There was one time that he even raced with a fire truck. We were going out the interstate going to our daughter's house after she was married and the fire truck was going ahead of us. They kept waving to him don't get on. He just kept on racing a path. He was so loaded that he didn't know what he was doing. So then I said stop right now I'm getting out of here, I'm not riding with you any further. So he stopped the car and we sat there probably two hours. He would not move that car again. He was just so upset with me. I think he realized that he had a little too much to drink. There were so many things that were very peculiar and I knew it was all from drinking." (Jane)

> "It was getting to the point where he was drinking so much. That brought my separation to a head. He got involved and had his girlfriend sign my name to several things. Things like that are really an eye opener. You realize how sick they are. I had to do something or I would have lost my property." (Sally)

> "He stopped going to church with me. He'd go to church late mass, I'd go to early mass. This is when I knew he was really progressing. Sometimes I even felt that he was drunk when he was going to church because it seemed he couldn't walk straight. He always said his feet hurt him. See there was always an excuse. That's when we were still going to church together. But then

he stayed at home while I went to early mass so he could have a drink or two. That's what was happening." (Mary)

The three wives perceived the interactions in their marriages to be problematic. Often situations which occurred reflected difficult behaviors on the part of the husbands which seemed to result from their drinking. Not only were there problems in the marital interactions because of the husbands' behaviors, but also there seemed to be problems with the husband and wife actually relating to each other.

"He's never been able to sit down and discuss things. Oh you know a lot of things just about general sorts of things. But for what you feel and what do you think, that's unknown to him. Most of the time I don't think he can." (Sally)

"We just had many problems that way back and forth. I knew he was in touch with this lady all the time. He had been warned not to see her because her husband worked nights. So, of course, it was so convenient. And the more I fussed about her then the more he drank and then he was just so obnoxious. He would come home and call me different names and swear at me. And I'd say I'm not going to take this. And he says this is the way I talk to the guys all the time. I don't know what difference it makes. I'd say I'm your wife, not the guys." (Jane)

"He was never abusive as far as violence or anything. But when he became such a heavy drinker he was very passionate. Oh sometimes I thought I could just scream because we'd be sitting at the table drinking and he'd grab me and kiss me. This is the type of thing he did. I sometimes think that he became so passionate and loving and all, not that he wasn't before, but it was unusually so that h was afraid that I was going to leave him. I couldn't live that way anymore. Like I said I felt that I was losing my mind." (Mary)

THEME II

Significant Event

The three women in this study all described a significant event which occurred that seemed to lead to professional help-seeking. For Mary and Jane this significant event involved the health status of their husbands. Sally described a significant event in her life, however it did not relate to her husband's health.

> "I was working in a dress shop then, three days a week. I couldn't wait until five o'clock came around...and that' another thing, blackouts, those blackouts. He says, well I'll come an get you because sometimes the weather was a little cold and that and he wasn't showing up and wasn't showing up. So I would practically run all the way home because I knew there was a problem. and one day I did come home and he was in bed blood on his head. I says what the hell are you doing there? He says why, what? I says look at yourself, you're all blood. Well he fell in the tub. As he walked by the tub he slipped and he fell and he hit his head...so I called the son. It kind of shocked him when I said you know your father has a drinking problem. And he was really quite surprised. So the son came down and we took him to the hospital. And that was the first time." (Mary)

> "It was around our 25th wedding anniversary. At that time he had been drinking and smoking heavily. He had just been letting himself get heavy and so forth. Then he had this heart attack. He was in the hospital for about three weeks. Then after he got home he just didn't want to do anything the doctor wanted him to do. I think he was feeling pretty down be cause he felt what good is he now that he's had a heart attack and so forth. So I went to see our family doctor, who was also an alcoholic." (Jane)

> "He would usually stay out over night. That was when you really got concerned about the partying. I did such stupid things. I can remember when the kids were little I went into a bar and there he was sitting at the bar. I was so angry at him I just hauled off and

slapped him and walked out of the door. And that was the night he struck me because I was so angry. All this anger came out and I just hit him. I practically hit him off the stool. But I left immediately and I went out to my car and he chased me. I'll never forget t his. And I got in my car and I drove home and he came after me. When I got home he came after me and he got a hold of me and that's when he grabbed me and he got real angry. The neighbors heard us scuffling and they called the cops. That was the only time that I can ever remember him touching me you know...But that was one of the turning points in my life because I had to get some help. I had to do something." (Sally)

THEME III

Lack of Mutuality

The marital interactions for these three women seemed to lack a sense of mutuality. Instead of each couple working together for the same goals in their marriage, the husbands and the wive seemed to be headed in different directions. The wives behaved in ways which served to eliminate the alcohol abuse of their spouses. The husbands however behaved in ways which promoted and maintained their drinking patterns. Not only were the marital interactions perceived to be problematic, they also lacked common goals, or mutuality regarding the drinking behaviors of the husbands.

"The whole family was over. We were playing badminton or croquet or whatever out in the yard. My husband went into the house. Well I knew why, so I'd run to the house to see if I could stop him. This is the merry-go-round you get on. Anyway he was downstairs and he walked across there just as I came in the house. I says what are you doing down there. He gave me some excuse and I said oh come on I know better than that. I says I don't think you need that." (Mary)

"Yes, yes there was always bottles around. Bottles of liquor and of course I used to do one of those stupid ones and pour some if out just like everybody else did. I used to get so angry. But as I said he did most of his drinking away from home." (Sally)

"He didn't want me to see any of the alcohol. You see be cause he knew that I was marking it. I'd mark it with a dot, but he knew it. And so he started hiding it. One time I found a bottle of alcohol in the car under the front seat. I confronted him with it and I says what is this doing out there. I says you need a drink even if we were out? You'd sneak to the car and have a drink? Of course that really shocked him because I found it. And then I found it hidden in the garage and in another couple places. I knew that it was reaching a point where it was really bad." (Mary)

"What he was doing, he had little bottles, they're like pill bottles. He'd fill these with vodka and he'd stick them in his pockets or have them in his lunch pail. I didn't know this until after his boss called and I thought I would investigate. Here in our cupboard in our garage were a whole bunch of these little bottles just full of liquor. Just little as can be but just enough to give him a shot once in a while. So then I got looking further and I could see where there would be parts of vodka bottles like this and maybe full ones all over the garage hidden in various places. I started to ask him why he was going to go down and wipe the window off in the garage so much or various things. He was going down and tipping." (Jane)

There were three common themes identified which described the interactions between the three couples that led to professional help-seeking on the part of the wives. The wives perceived that overall the interactions in their marriages were problematic over a period of time. Secondly, they experienced a significant event which led them to the decision to seek help. Finally all three wives described a lack of mutuality in the interactions with their husbands regarding the alcohol abuse. The husbands tried to maintain

their drinking patterns, while the wives responded with behaviors which sought to eliminate the abuse.

OBJECTIVE TWO: To describe the thoughts and emotions that surrounded the choice to get professional help for the first time.

There were two main themes identified which represented the common thoughts and emotions that surrounded the choice to get professional help for these three women. The feelings of shame and isolation flowed through each of the three women's stories. Additionally, each of the three women experienced a loss of control in their lives. This loss of control was powerful.

THEME IV

Shame and Isolation

> "I was ashamed. I felt that I was the only one. I think this is the worst thing about alcoholism because they put you in a predicament that you are so very ashamed of your situation. You blame yourself for a lot of things and you don't want anyone else to know cause you think you are the only one in the world that has problems, see." (Sally)

There were many thoughts and emotions which were identified throughout the stories of these three women. Feelings such as anger, guilt, embarrassment and fear were found at various times throughout their abused marital experiences. However the sense of shame and isolation seemed to flow consistently throughout their discussions.

"I guess I still just didn't want to admit that he really was an alcoholic. I didn't want people to think that he was this kind of person. I guess I was still thinking I was trying to hide this thing. I thought if people are going to hear that I'm going to Al-Anon, what are they going to think? What are our friends going to think? So I didn't do anything about it. Which was a mistake." (Jane)

"So it was to the point where he was having blackouts. And I mentioned, too, that I was on a merry-go-round. Well, when I finally realized that he was an alcoholic and the family would come over and they didn't know it, I didn't let on or anything. I was trying to hide it and so was he." (Mary)

"If he didn't want to go to family affairs, well, he isn't feeling good again today and so forth. If anybody asked about him it's he's doing fine, everything is fine. It was awfully hard to take. And it wasn't really true." (Jane)

"I was very lonesome and I had a lot of trouble you know as far as getting sitters for my children. I was ashamed of the fact what my situation was because it really makes you feel like you just haven't done your part. You blame yourself. You really do for a lot of your problems." (Sally)

THEME V

Loss of Control

The loss of control experienced by the three women was a powerful stimulus towards seeking professional help. This loss of control seemed to appear in conjunction with the significant event which occurred. Shortly after both the occurrence of the significant event and the loss of control, the three wives sought professional help.

"It reached a point where I told him that if he wouldn't go for help that I was going to find help somewhere. I couldn't live like this anymore, because I felt like I was losing my mind. Even though he

> wasn't abusive or anything, but it was abuse, mental abuse." (Mary)
>
> "I kept thinking why in the world don't I do something. That's the part that I thought I was crazy. Crazy to stick with him when all this other was going on." (Jane)
>
> "I had to get some help because I knew that I had to do something. You know because I was just losing control and it was stupid things that you knew you did. You would just get all wound up and as I say I could never talk to him. Just never. We could never discuss anything and it's an unbearable life." (Sally)

There were many thoughts and emotions identified by the three wives which surrounded their choice to seek professional help. However the sense of shame and isolation seemed to be constantly described throughout the marital experience prior to help-seeking. The wives were ashamed of the alcohol abuse in their marriages. This shame led to their feelings of isolation, as they could not share their problems with others.

The other identified feeling prior to professional help-seeking, which was described by the three wives was that of loss of control. This loss of control seemed to be associated with the significant event which occurred. The combination of the significant event and the loss of control seemed to be a powerful stimulus towards professional help-seeking.

Study Question Two

According to the wife, how did the first attempt at help-seeking change the life experience?

OBJECTIVE THREE: To describe the repatterning of the life experience of the wife after the first professional help-seeking.

The three wives sought professional help for the first time after a significant event and a loss of control took place in their lives. Mary and Jane looked to their family physicians for help. The significant event which occurred for these two ladies involved the health of their husbands. Sally, on the other hand, attended Al-Anon. The significant event in her life did not include the health of her husband.

There did not appear to be any major life changes after the first help-seeking experience for these three women. All three husbands denied their alcohol abuse problems and all three continued with their drinking patterns. The three wives were therefore still in the same marital circumstances.

Two common themes were identified for these three women which describe the changes in their life after the first help-seeking experience. These two themes included an increased awareness of the alcohol abuse, and that the wives would seek professional help again.

THEME VI

Increased Awareness

After the first help-seeking experience all three wives still perceived themselves to be in problematic marriages because of the alcohol abuse. Their husbands were unwilling or unable to change their drinking patterns. The three wives did however describe themselves as gaining an increased awareness to the alcohol abuse as the real problem in their marriages.

> "I even went so far as putting water into the bottles...to make it look like he had more there than he did before so that he wouldn't have to buy another bottle. You just try all kinds of tricks, you know. He started hiding it in different places. He did even hide it in our rented garage where we stored our boat. He'd leave in the morning and drive down there. I learned later why he had the alcohol down there. He didn't want to drink it in front of me because see I was so aware of it already." (Mary)

> "I didn't have any friends that had the trouble that I was having. At least that's the way I felt. You think you are so alone in the world. You know there's people I realized that have a worse situation than I have. I think that it's really a rude awakening." (Sally)

> "One day I brought up all the bottles from the garage and set them right up. I said what do you think you should do with those? I felt like I could have taken them all and poured them on top of his head. Then I think back of all the money that was wasted, too. We could have done more for the girls and so forth. So then he took his bottles and I said you do what you think you should do with those bottles. So then he poured them down the sink. After that I knew he still had some nip. That was 12 years ago after his first heart attack. Yes he'd say just one now and then isn't going to hurt me so I would just stand there an stare at him." (Jane)

There seemed to be times where because of the increased awareness of the problems from the alcohol abuse, the wives responded to their husbands differently than before help-seeking. They would be less likely to cover up, or to tolerate their husbands abusive behaviors. Although these changes in response occurred, they were not consistent. The old patterns of response were still present.

> "Well his boss called me one day and said something about what are you giving your husband for breakfast. I said I don't know. Why? He said well he comes to work smelling like liquor all the time. I said why don't you get rid of him. It would be the best thing." (Jane)

> "I said let's go home and I'll make some coffee. We went home and I made some coffee, and of course he began shaking. He says, boy, I feel sick. He went into the living room and sat down and I sat there on the hassock, right in front of him. He said get me a drink please dear. I said no, never, as long as I live will I pour you a drink again, never. I said if you want it you'll have to get it yourself." (Mary)

> "I think you get some respect for yourself again when you start going to Al-Anon. You realize that you don't have to do all this stuff and you start looking out for yourself a little bit more. You realize how stupid it is to chase him all around, that's not going to change things...You take a little bit different attitude towards yourself." (Sally)

THEME VII

Will Seek Professional Help Again

All three women in this study sought professional help again. Sally continued to go to Al-Anon for approximately seven years. Mary and Jane sought professional help again

from their family physicians. Another significant event occurred for them which involved the health of their husbands.

> "When I went to Al-Anon I just sat back and I was just too ashamed to say anything. Finally you open up and you just let it all out. It's wonderful! You can sit and cry and get rid of all this stuff inside you and people understand. I was going to two meetings a week at first. I needed it. My husband found out that I was going to the meetings and it was a terrible threat to him. He got very violent at first. Just what was I doing. How stupid I was, but I didn't care. I just kept on going." (Sally)

> "Well the doctor released him from the hospital the first time. I told the doctor I just don't think that is going to work. He says it isn't that bad. I says, you don't know. Then, when he finally ended up in the hospital the second time, the doctor says I'll find a good place for you to go. And I says you don't realize doctor, how much he drinks. He says it can't be that much. I says well it's too much for him. But see, the tolerance there is what makes the difference...So my husband left before I did. Then I went to the family group you know, for two weeks. He was in treatment for six weeks." (Mary)

> "Then he had a second heart attack. He was in the hospital then for a couple of weeks. So just when they were going to release him I said you know my husband has a drinking problem. Two of the doctors were there. My old family doctor had passed on. I said what ar we going to do about his drinking problem? Do you think we can get rid of that? The doctor said I'm glad you said that. We are going to send him right over to the alcohol center. He had no choice. He was so sick the doctors just moved him over there. He stayed nights there and I went home. I had to go through the program too." (Jane)

The treatment program was successful for Mary and her husband. He has not had a drink in nine years. Mary describes her marriage presently as the best it has ever been and she attributes this to her husband's sobriety.

Jane and her husband also went through a treatment program. However Jane's husband continued to sneak drinks for another four years until he developed Parkinson's Disease. Jane believed that her husband never considered himself an alcoholic.

Sally does not now attend Al-Anon. She did go for about seven years. Sally feels that she has many good friends which she met through Al-Anon who act as her support system. Sally's husband is presently drinking.

Two common themes were identified by the three wive which represented the change in the life experience after the first professional help-seeking attempt. The wives perceived that they had an increased awareness of the alcohol abuse of their husbands. Although this increased awareness was significant, behavior changes were not consistently described. The wives did react differently to the abuse occasionally, with increased confrontation, and less protective responses. All three wives sought professional help again.

In summary, there were seven common themes identified which represented the experience for these three wives of elderly alcohol abusers who sought professional help for the first time. (See Table 3). Five of the themes described surrounded the past life experience which led up to the first help-seeking attempt. The three wives perceived their marriages to be problematic and lacking mutuality regarding

Table 3

The Common Themes Which Described the First Professional Help-Seeking Experience for Three Wives of Alcohol Abusers

Study Question One

What past life experiences were perceived to lead to the evolution of the first professional help-seeking attempt on the part of the wife who believes her elderly husband to be an alcohol abuser?

- **Problematic Marital Interactions**
- **A Significant Event**
- **Lack of Mutuality**
- **Shame and Isolation**
- **Loss of Control**

Study Question Two

According to the wife, how did the first attempt at help-seeking change the life experience?

- **Increased Awareness**
- **Will Seek Professional Help Again**

the husbands' drinking behaviors. Feelings of shame were consistently described. This shame led to the feelings of isolation, as the wives did not share the alcohol abused marital experience with others. A significant event occurred for all three women, which led to a loss of control. the first professional help-seeking attempt then occurred.

The first professional help-seeking attempt did not lead to any major changes in the life experience for these three women. The alcohol abuse of their husbands continued along with the above described feelings and patterns of interaction. All three wives experienced an increased awareness of the problems from their husbands. This increased awareness seemed to affect how the wives responded to their husbands. They were less likely at times to cover up, or to tolerate their husbands' abusive behaviors. These changes in response, however were not described consistently.

All three wives did seek professional help again. After the second help-seeking attempt two of the husbands received treatment. One of the husbands who received treatment has been sober for the past nine years. His wife describes their present marriage as very good. The second husband continued to deny his alcohol abuse and still drank. His wife described their marriage as the same, except that she felt better about herself. The third husband never

received treatment. His wife described herself as having received social support and a sense of control from Al-Anon.

Methodology - Quality of Design

To ensure the quality of the design with regard to this study, the truth and accuracy of the data and of the analysis must be addressed. As described in Chapter IV there are three areas of concern. These areas include the internal validity, the external validity and the reliability of this study.

Internal Validity

Internal validity in qualitative research is concerned with the truth of the evidence in the data and of the analysis (Chenitz and Swanson, 1986). In this study several factors threatened the internal validity. These factors were handled as described below.

1). Subject bias - refers to the differences between the kinds of people studied and those not studied (Chenitz and Swanson, 1986). The possibility exists that these three respondents differ from the rest of the population of wives of elderly alcohol abusers. The researcher noted that these women were volunteers. Demographic information was gathered to indicate any differences in the

women and their spouses. (Please refer to the demographic comparison.) The only outstanding difference noted was that one husband had only a seventh grade education level. This husband also had difficulty maintaining a job for any length of time. Therefore his job problems could also be indicative of his lower level of education as well as his alcohol abuse. From the wife's perception however, the alcohol abuse seemed to have the most impact on his job performance.

Subject bias can also mean that the respondents will answer in ways that they perceive the researcher is anticipating. Observations were made and documented in the field notes for congruence with facial expressions and body language to what was being said. There did not seem to be any occasion of incongruence amongst any of the respondents.

2). Subject maturation - refers to the tiring or withdrawing effect that the interview process had on the respondents. All three interviews lasted approximately one and one half hours to two hours. None of the respondents appeared to tire or withdraw. All three spoke with the same intensity and interest throughout the interviews.

3). Reactive effects - refers to the reactive effects of the respondents to the researcher's presence and involvement in the interviewing process. Any tearfulness or other responses were noted in the field notes. The response of all the respondents to the initial questions was to begin to talk for lengthy periods of time. During their discussions many of the questions on the interview guide were answered without being asked. The researcher let the women talk without interruption. When the women would pause, the researcher would ask any questions that had been left unanswered from their discussions. All three women appeared to be comfortable with this interviewing approach and all data for each objective was collected.

4). Consistency - refers to the degree to which the evolving story of the respondent is in harmony with itself and has no self contradictions. In order to check for the consistency of the story the researcher would rephrase and reask some of the questions for each objective. Any time that something being said was not clear the researcher asked for clarification. Common phrases used by the researcher included: "Did I hear you say..." or "I want to be sure I have this right." all three stories appeared to be consistent.

5). Observer change - refers to the researcher actually taking on the behaviors and attitudes of the respondents. It is expected however that the researcher will change as a result of interactions with the respondents in the study (Chenitz and Swanson, 1986). This researcher controlled for the effects of change by writing personal memos recording feelings and attitudes after each interview. These memos were used as a tool to increase the researcher's awareness to the data analysis.

This researcher was surprised at the impact she actually had from the interviewing process. The intensity of the interviews led the researcher to an increased sensitivity to the life experiences of these three women. This increased sensitivity was beneficial to the researcher doing the data analysis as she was more in touch with the meaning of these life experiences and therefore better able to identify common themes.

Subject bias, subject maturation, reactive effects, consistency and observer change were identified as threats to the internal validity of this study. Measures such field notes, demographic information, rephrasing interview questions, keeping a personal journal, and watching for

facial expressions and body language were used as a means of control for these threats. The controlling measures used seemed to validate the truth of the information collected. Therefore this researcher feels that internal validity for this study was achieved.

External Validity

External validity in qualitative research relies on analytical generalization. This means that the researcher is able to generalize a particular set of results to some broader theory. In this study the results can be generalized to the Theory of Unitary Man (Rogers, 1970) from which the study objectives and interview guide were derived.

A committee of four advanced practicing nurses familiar with research methods reviewed the overall study and methodology. Their opinion was that the common themes identified were compatible with the Theory of Unitary Man. Therefore this researcher feels that external validity exists in this study.

Reliability

Qualitative researchers look at reliability in terms of accuracy and credibility in the data collection and in the analysis. One measure which this researcher took to ensure overall reliability was to have a panel of experts review the methodology of this study. The following descriptions

are of specific reliability factors which this researcher identified as posing a threat to this study.

1). Environment - refers to the surroundings or circumstances that were present during the interview. The environmental factors were acknowledged through the field notes. In all three cases the overall environments were comfortable and without major distractions. During one interview the telephone rang three different times. The respondent chose not to answer, and continued her discussion without any major effect. A second interview was interrupted by someone at the door. The subject responded to the situation. When she returned the researcher backtracked and summarized what had been discussed. The interview then proceeded without any major disturbance.

2). Personal character of the respondent - in order for the data to be credible and accurate the respondent had to meet the sampling criteria. The researcher judged prior t the interviews that these three respondents met that criteria.

3). Mechanical defects - refers to anything that might go wrong with the interviewing process. There were no identifiable mechanical problems during any of the interviews. Prior to one of the

interviews the respondent cancelled the appointment until a time her husband would not be present. The interview was to take place in privacy and the subject did not want her husband to know that she was partaking in this study. When she was finally available for the interview there were not any mechanical problems identified at that time.

4). Coding - the issue of credible and accurate coding of the data in the analysis was handled in several ways. First, the specific steps of the data collections were adhered to in a strict fashion. Second, the transcripts of the interview were reviewed for accuracy by the researcher. Minor changes and omissions were corrected. Third, another clinical nurse specialist reviewed the transcripts and field notes.

The clinical specialist reviewed the transcripts and field notes using the same analytical process as the researcher. She identified common themes for each of the three objectives based on her own analysis of the transcripts. The researcher and the clinical specialist then met and together discussed their findings.

For objective one the researcher and the clinical specialist agreed that there were identifiable common themes. They agreed that the wives perceived their marriages to be problematic and that there was a significant event which prompted help-seeking. The clinical specialist however had not originally identified that there was a lack of mutuality in the marital relationships. The clinical specialist felt that she had not originally thought of the relationships in that way. After discussion, she agreed that a lack of mutuality probably did exist.

For the second objective agreement was reached on both of the themes. Both the researcher and the clinical specialist identified a loss of control and shame and isolation as common themes. However the clinical specialist thought there might also be a suppression of feelings. But neither the researcher nor the clinical specialist could clearly document suppressed feelings from all three women when they went back and reviewed the transcripts.

> For the third objective, the researcher and the clinical specialist agreed on both of the identified themes. The themes of an increased awareness of the alcohol abuse and seeking professional help again existed for all three women.

The threats to the reliability of this study were identified as environmental factors, the personal character of the respondents, mechanical defects, and issues of coding the data. These threats were controlled for by adhering strongly to the planned methodology, acknowledging and working around any mechanical or environmental problems. Reliability was also ensured by having a clinical nurse specialist review the transcripts following the same analytical process as the researcher to provide accuracy of the data analysis. After discussion, the identified themes were agreed upon 100% by the researcher and the clinical nurse specialist. This researcher feels that reliability was achieved for this study.

Analysis of the data was undertaken by comparing the experiences of the three wives of elderly alcohol abusers who sought professional help for the first time. Common themes were identified for each of the three main study objectives. These common themes were supported by the words

of the three women. Finally, the quality of the data was discussed with regard to internal validity, external validity and reliability.

In Chapter VI, the final chapter, a synthesized statement will be presented using the identified common themes. This synthesized statement will represent the meaning of the first professional help-seeking experience for these three women. The identified themes will be discussed and related to the conceptual framework and to the relevant literature. Finally implications for research, education and practice will be discussed.

CHAPTER VI

Overview

A descriptive study was conducted to examine the experiences of three wives of elderly alcohol abusers who decided to seek professional help for the first time. The purpose of this research was to synthesize the essence of the qualitative reality of these three women who made the choice to seek professional help. The research questions formulated for this study include: 1) What past life experiences were perceived to lead to the evolution of the first professional help-seeking attempt on the part of the wife who believes her elderly husband to be an alcohol abuser? The second question was: 2) According to the wife, how did that first attempt at help-seeking change the life experience?

In accordance with the methodology the concepts underpinning the study were derived from a theoretical framework. That framework is Rogers' (1970) Theory of Unitary Man. These main concepts were developed into objectives and examined with reference to the interactions between the husband and wife, choice, thoughts and emotions, and patterning and repatterning of the life experience. These concepts surrounded the first professional help-seeking attempt by the wife of an elderly alcohol abuser.

In Chapter V, major common themes were identified which

represented the meaning of the first professional help-seeking experience for the three women. These themes were supported by data in their words. The common themes identified by the wives include: problematic marital interactions, a significant event, lack of mutuality, shame and isolation, loss of control, increased awareness, and seeking professional help again.

Using these themes as a base, the researcher interrelated them to form a hypothetical statement. This hypothetical statement represented for the three women, the meaning of the first professional help-seeking experience. The hypothetical statement synthesized from these common themes for the three women is:

Over time the wife of an elderly alcohol abuser developed a sense of shame and isolation within a problematic marriage, which lacked mutuality. When a significant event occurred which was related to the alcohol abuse, the wife experienced a loss of control which led her to seek professional help for the first time. The first professional help-seeking experience led to an increased awareness of the alcohol abuse in the marriage and then led the wife to seek professional help again.

Discussion

For these three women the choice to seek professional help for the first time is one which emerged from many

circumstances and feelings that occurred over time. As the interactions in the marriages developed between the wives of the alcohol abusing husbands, certain themes evolved. For these three wives, many of the interactions in their marriages were perceived by them to be problematic. As their husbands' alcohol abuse progressed, there were numerous descriptions of discussions, behaviors and circumstances which were viewed by the wives as being increasingly difficult. Many of the difficult times described related directly to their husbands' drinking.

As the difficult and problematic interactions continued throughout their marriages, the three wives began to feel isolated. They did not share these marital concerns with others. As commonly described by the wives, they believed that they were the only ones with marital problems which stemmed from their husbands' drinking behaviors. They all described themselves as too ashamed to talk to anyone about their problems. This shame seemed to grow from their own lack of self worth in that the wives felt that somehow their husbands' drinking problems were their fault. The wives also were ashamed of their husbands drunken behaviors. This experience of shame served as a barrier to seeking professional help.

Since these wives were married to elderly alcohol abusers, the variable of age must be considered. Some of the feelings of isolation could be related to age. Two of

the wives would have never considered sharing their problems or feelings with others because they were brought up to believe that one handles their own affairs. In addition these same two wives did not consider divorce because it was against their values and upbringing. Also these wives lacked skills and job security.

The three wives described many occasions where they had difficulty relating to their husbands. They were unable to discuss important family matters, or to share feelings because the husbands would be intoxicated. Because of the marital problems and the shame and isolation experienced by the wives, a lack of mutuality in their marriage existed. This lack of mutuality revolved around the alcohol abuse of the husbands. The wives described some of the behaviors which served as protective mechanisms for themselves, their husbands and their families. Often the wives covered up for their husbands' drinking and hang-overs by making excuses. In their stories the wives often feared that their husbands would have lost their jobs or that an embarrassing situation might have occurred. The wives described times when they monitored their husbands' alcohol intake, poured out the liquor, or tried to prevent them from drinking.

The behaviors of both the wife and husband which were described by the wives, demonstrated a lack of mutuality in their marriages. In response to the wives attempts to stop the alcohol abuse, the husbands simply continued to drink.

Two of the husbands hid their alcohol, and one of them drank away from home. The behaviors of the husbands continued to support their abusive habits and those of the wives focused on stopping the problems. Therefore many of the interactions in their marriages lacked common goals. It can be hypothesized that because the marriages lacked common goals, they were therefore perceived by the wives to be problematic.

As these three marriages continued over time the themes described evolved. After many years of problematic marital interactions, shame and isolation, and a marriage lacking in mutuality, events occurred which held great significance for the wives. For two of the wives this significant event had to do with their husbands' health status. For the third wife, the significant event seemed to be an end to an accumulation of many problematic circumstances.

The key ingredient to these significant events as described by the three wives was a loss of control. When they had lost control of the events of their lives, the three wives seemed to feel a sense of urgency for seeking help. They no longer were able to tolerate their lives and marriages in their present situations. All three wives sought professional help after the occurrence of the significant event. Two of the wives sought professional help from their family physicians. The third wife went to Al-Anon.

There were no major changes described by the three wives after their first help-seeking experience. The overall perception of their marriages and themselves did not change. Their husbands continued with their alcohol abuse. The only identified difference was an increased awareness by the wives of the alcohol abusive problems in their marriages.

The increased awareness on the part of the wives affected their behavior at various times. The wives began to try other responses after the first professional help-seeking attempt. These new behaviors were not consistently described however. Some of these changed behaviors included not mixing drinks for their husbands, not going out looking for them, and not covering up for their drinking behaviors.

Even though the behavior changes were not consistent, the significance of this finding is that the wives were trying on new behaviors. The increased awareness that was developed from the first professional help-seeking experience prompted them to respond in different ways. Perhaps over time these new behaviors would become reinforced in a positive way, and become the more common pattern of response.

All three wives sought professional help a second time. All three wives were seeking change from the problems in their marriages. Two of the wives sought help due to the occurrence of another significant event. For these wives

the interactions in the marriage repeated themselves. There did not seem to be enough time or positive reinforcement of the new behaviors for them to make any difference with the alcohol abusive problems in their marriages.

The third wife went to Al-Anon for seven years. She separated from her husband for several years during this time and reunited with him after his drinking behaviors changed. At the time of the interview she described her husband's drinking as increasing again, but stated that she would leave him a second time if necessary. This wife was the only one who described the importance of social support. The social support seemed to reinforce her behavior changes.

The significant themes which led up to the first professional help-seeking experience for the three wives included a problematic marriage which lacked mutuality. This problematic marriage led to feelings of shame and isolation as the wives could not share their problems with others. The shame and isolation served as a barrier to seeking professional help.

As time progressed and the alcohol abusive problems continued, a significant event occurred which prompted a loss of control by the wives. This lost control led them to seek professional help for the first time.

Even though there was not any significant changes in the alcohol abusive problems of the marriages, an increased awareness on the part of the wives developed. This

increased awareness was important in leading the wives to try on some new responses to the alcohol abuse.

The three wives all sought professional help again. The significance of this finding was in the outcomes of the second or continued help-seeking experiences. The first wife and her husband received treatment which led to nine years of sobriety and a sense of life satisfaction. The second wife and her spouse received treatment. This did not lead to sobriety for the husband but the wife experienced an increase in her self esteem. The third wife went to Al-Anon and even though her husband continued to drink she experienced an increase in her self esteem and help from social support. Seeking professional help again can lead to positive changes.

THE DISCUSSION OF FINDINGS AS RELATED TO THE CONCEPTUAL FRAMEWORK

The findings of this study will now be examined in light of the conceptual framework on which it was based, Rogers' Theory of Unitary Man (1970). In Chapter II, Rogers' view of nursing was described and discussed. In this section, the study's findings will be examined and compared with the objectives derived from the theoretical concepts.

From Rogers' (1970) perspective, man is wholistic, manifesting characteristics that are more and different than the sum of their parts. Man is constantly changing energy with the environment in a unidirectional life process. Change in the life process of man is predicted to be inseparable from environmental changes. Man is sentient and seeks to organize the world of his experience and make sense of it. In patterning and repatterning the human field, man makes choices that are innovative and based on the "infinite now." Health is active interaction with the environment to pattern a reality that creates a sense of well-being with a future view.

OBJECTIVE ONE: To describe the mutual interactions of the wife and the elderly alcohol abusing husband that gave rise to seeking professional help for the first time. This objective was developed from the concept that man and his environment are inseparable and have continuous mutual interactions. These mutual interactions give rise to mutual change.

Rogers' Principle of Complimentarity refers to the inseparability to the human and environmental fields. The continual mutual process of the human and environmental fields changes together. The elderly alcohol abusing husband and his wife are considered to be a group field with each member, the husband and the wife, being an individual

field. Therefore, the wife can be thought of as part of the environment to the husband.

As the husband in his own field begins to become dependent on alcohol, he develops patterns of behavior which help him not only maintain his dependence, but to maintain his social or environmental functioning as well. These patterns of alcohol abuse can be described by Rogers as a unidirectional process which will progress through time and space patterning and repatterning as the husband experiences changes in tolerance and dependence. The wife responds to the alcohol abuse with behaviors that serve to protect the husband, herself and the family. These response are patterned and repatterned based on the husband's unidirectional pattern of alcohol abuse. Many behaviors of the wife are seen as responses to her environment which includes the alcohol abusing husband.

Clearly the marriage relationship between an elderly alcohol abusing husband and wife is an interactive process which makes up a group field. As the individual patterns of the husband and wife evolve over time, each in their own direction, the group field of the marriage becomes dysfunctional. The husband and wife are not headed toward change together.

According to Rogers, mutual interactions give rise to mutual change. However since the interactions in the marriage do not appear to be mutual, repatterning of the

group field will not happen. The same patterns which have evolved over time and space will continue. The husband and the wife must experience a sense of mutuality in their interactions before change in th eir marriage can occur.

Because there is a lack of mutuality in the group field the wife perceives her marriage to be problematic. Only when there is mutuality in the marriage can there be a sense of well-being and change for the future.

OBJECTIVE TWO: To describe the thoughts and feelings that surrounded the choice to seek professional help for the first time. This objective was developed from the concept that man has the ability to think and feel which allows him to make choices. These choices can affect change.

Rogers' basic nursing assumption of sentience and thought can be used to describe the thoughts and feelings which surrounded the choice of the wife to affect change in the marriage. Sentience and thought refer to the capacity of the wife to think, to understand, to experience and to perceive her husband and her environment. Because the wife has the ability to think and to perceive her own environment, she is able to make choices about the direction of her own life experience.

As the wife proceeds through time and space with her alcohol abusing husband, she experiences a multitude of dysfunctional marital interactions. The wife experiences an

overwhelming sense of shame. Shame is a complex feeling that consists of guilt and disgrace. Therefore the wife can not see that there might be choices available as she is so immersed in this constant pattern of interaction within the group field of her marriage. The feeling of shame serves as a barrier to choice. The wife does not think that she can seek professional help to affect change in her marriage because she does not want anyone to know about the alcohol abuse situation.

As the wife continues to keep silent about the alcohol problems in her marriage a sense of isolation develops. Since the wife is unable to share her concerns and emotions, she begins to feel all alone.

It will be very difficult for the wife to make the choice to repattern her life experience. As a part of a group field with her husband, she must continue to interact with his alcohol abusive patterns. In addition, the feelings of shame and isolation serve as very powerful barriers to choice. It is only with choice that she can effect change in her life experience.

As the alcohol abused marriage proceeds through time, the wife begins to experience a loss of control in her life. This loss of control can be explained by Rogers' Principle of Helicy. Change evolves in sequential stages and increases in diversity. The accumulation of mutual interactions which are perceived by the wife to be

dysfunctional, lead to a loss of control. This loss of control is a sequential stage based on multiple previous mutual interactions which were perceived to be dysfunctional by the wife. The loss of control is a diverse response to the accumulation of interactions within the alcohol abused marriage.

This loss of control was emphasized by a significant event. The overwhelming sense of lost control outweighed the feelings of shame. The wife was then able to make the choice to seek professional help for the first time. Seeking professional help is seen as an attempt by the wife to repattern her alcohol abused marriage field.

OBJECTIVE THREE: To describe the repatterning of the life experience of the wife after the first professional help-seeking attempt. This objective was developed form the concepts that change precedes repatterning. Pattern and organization of the life experience is a constant process of evolution.

The husband and wife who make up the group field of the marriage move through time and space. Even though the group field lacks mutuality, the power of the interactions are strong because they constitute one unique field of pattern and organization. Therefore each member of the group field interacting with the environment must change together as one for repatterning to occur.

There was no change for the husband after the first professional help-seeking experience. Because the marriage is seen as an interactive group field the wife could not change without the husband. Therefore the overall patterns of the life experience for the wife did not change.

An increased level of awareness of the alcohol abused problems in the marriage was identified by the wives. This is thought to be significant. According to Rogers, pattern and organization are in a constant process of evolution. Increased awareness of the problems can be seen as a part of that evolutionary process towards change and repatterning. As the wife became more aware of her problems, she was more likely to try some new responses within her marriage.

Just as the patterns of the husband affect those of the wife, the patterns of the wife can affect those of the husband. Even though the husband is not willing to change the alcohol abuse, if the wife changes her responses, she will affect change to some degree within that group field of her marriage.

The wife will also seek professional help again. This finding is important in several ways. First, is that it reinforces the belief that the wife still sees herself in a problematic situation. The overall patterns in the group field have continued to evolve without any change or repatterning. Second, it suggests that an evolutionary process might be occurring in that the wife is attempting to

cause change because she is willing to seek help again. This help-seeking behavior can be seen to be a change in the wife's overall pattern of response.

In summary, the themes identified in this study are consistent with Rogers' Theory of Unitary Man. It is the strength of the group field, and in the evolutionary process of change, that the wife of an elderly alcohol abuser can seek to repattern her problematic life experience.

Logical Mapping

The findings in this study were incorporated into Figure 3, which includes the constructs derived from Martha Rogers' Theory of Unitary Man. This diagram represents the overall pattern of professional help-seeking of the three wives of elderly alcohol abusers.

This pattern consists of interactions, sentience and thought. The interactions were perceived by the wife to be problematic and lacking in mutuality. The feelings of shame and isolation were common in this pattern. The interactions in the marriage and the thoughts and feelings of the wife were inseparable, and affected one another.

Over time the problematic, mutually lacking interactions evolved into a significant event. The meaning of this significant event was a loss of control. The significant event which meant loss of control prompted the wife to make the choice to seek professional help.

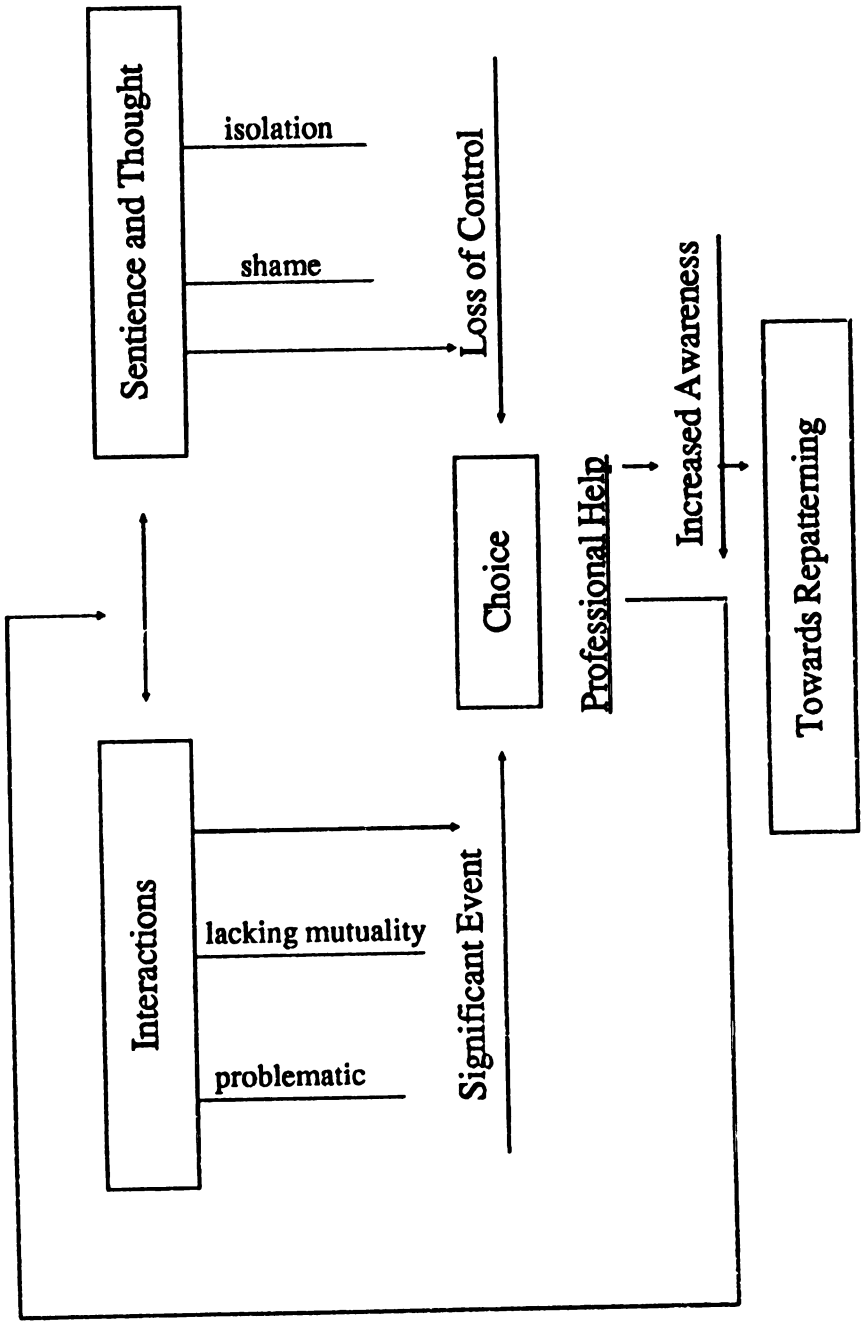


Figure 3: Logical Mapping of Common Themes

The professional help experience led to an increased awareness on the part of the wife. Even though the overall life pattern did not change, help-seeking occurred again. This increased awareness and continued help-seeking can lead to repatterning of the life experience.

DISCUSSION OF FINDINGS RELATED TO THE RELEVANT LITERATURE

Alcohol Abuse in the Elderly

There were two areas in the literature which were supported by this study concerning alcohol abuse in the elderly. The first area supported was concerned with alcohol abuse in the elderly as being a part of one's overall life pattern. The second area supported was that the health status of an elderly adult may be more indicative of alcohol abuse than other defining criteria.

Some researchers (Rosin and Glatt, 1974; Zimberg, 1974; and Glantz, 1980) have suggested that alcohol abuse in the elderly is often related to the stresses and changes of aging. Other researchers such as Christopherson, Escher and Baiton (1984) found evidence in their studies that drinking alcohol is a stable and largely predictable aspect of one's overall lifestyle rather than the notion that alcohol consumption increases with response to the frustrations of

old age. LaGreca, Akers and Dwyer (1988) also found no support towards the hypothesis that higher frequency or problem drinking occurring in the elderly as a response to significant life events.

The concept that drinking behaviors in the elderly may be a stable and largely predictable aspect of one's overall lifestyle appears to be true for all three of the husbands in this study. Drinking alcohol was a part of all three men's overall lifestyles since the beginning of their marriages. The wives described their husbands' drinking as problematic over the last 20-25 years of marriage. The identification of the drinking as problematic by the wive occurred before the husbands were considered elderly. The descriptions of the marital interactions reflected problems from the alcohol abuse more as an on-going and evolutionary process rather than in response to the stresses of aging.

The second area of literature supported was health problems as being more indicative than social criteria for identification of alcohol abuse in the older adult (Rosin and Glatt, 1971; Graham, 1986). In this study, two of the three husbands had significant health problems which caused a loss of control for the wives and prompted them to seek professional help. These two wives sought professional help a second time also based on the health status of their husbands.

Health problems were not identified as a common theme. However, the significant event which prompted professional help-seeking was described by the wives most frequently as a health related event. If the number in the sample studied had been larger it is suggested that there would have been more professional help-seeking attempts prompted by health related events.

In summary, the researcher's findings in this study regarding the elderly alcohol abusing husband supported two areas of literature. The first area supported was that drinking behaviors in the elderly are based on a life long pattern. Secondly, health related problems should be important criteria for the identification of alcohol abuse in the elderly.

Wives of Alcohol Abusers

In the literature regarding wives of alcohol abusers, there were several perspectives from which this phenomenon could be viewed. These perspectives included the Disturbed Personality Theory (Lewis, 1937; Price, 1945; and Whalen, 1959), the Decompensation Theory (Futterman, 1953; and Macdonald, 1956), the Stress Theory (Jackson, 1954, 1956, 1959, and 1962), the Psycho-social Theory (Bailey, Haberman & Alksne, 1962), Systems Theory (Steinglass, 1981), and the concept of co-dependency (Zelvin, 1988; Zerwekh & Michaels, 1989). The findings in this study support areas in the

literature regarding the Stress Theory, the Psycho-social Theory, Systems Theory and the concept of co-dependency.

The Stress Theory was first advocated by Jackson 91954, 1956, 1959, 1962). She theorized that in their efforts to handle problems associated with alcohol abuse, family members came to feel guilty, shame, inadequate and isolated from social support. A major theme that emerged from the findings of these three women is that of shame and isolation. Jackson would have described the themes of shame and isolation as feelings which resulted from the wives' efforts to handle the alcohol abuse in their marriages.

Jackson (1954) studied wives of alcoholics who belonged to Al-Anon and indicated that they passed through stages in reacting to alcoholism. Although the themes of this study do not match Jackson's exact stages, it is suggested that there is a patterned response that occurs and evolves over time. Therefore both studies suggest that there is a response to the alcohol abuse and that this response can be described.

Jackson theorized that the behaviors of the wives were described in a large part as a function of the changing interactions and not from personality disturbance or type. The results from this study strongly suggest that the interactions between the husbands and wives affected the responses of the wives. The wives described many interactions, which they perceived as problematic and

lacking in mutuality. Many stories were told which reflected their responses to these alcohol related situations. Often their responses reflected protective or coping mechanisms in order to maintain marital and family security.

Supporters (Orford and Guthrie, 1968) of Jackson's Stress Theory identified several coping styles from factor analysis. They were: 1) safeguarding family interests, 2) withdrawal within the marriage, 3) attacking, 4) acting out, and 5) protecting their alcoholic husbands. Even though these coping styles were not common themes for these three women, these behaviors were described at various times throughout their stories. Within the described themes of problematic marital interactions and interactions lacking in mutuality, the wives used these coping styles at various times throughout their marriages.

The Psycho-Social Theory appeared with studies by Bailey, Haberman and Alksne (1962). The Psycho-Social Theory indicated that wives of alcohol abusers have basically normal personalities and are not a unique group. These wives developed personality fluctuations if the husbands are actively drinking.

Kogan and Jackson (1963) found that 80 percent of the wives they studied perceived that they had the same personalities whether or not their husbands were actively drinking. Moos, Finney and Gamble (1982) found that spouses

of alcoholics are basically normal people trying to cope with a disturbed marriage and dysfunctional partners. Their findings were consistent with crises. The three women in this study perceived themselves to be dealing with problematic marriages. All three women also experienced a significant event in their marriages which led to a loss of control in their lives. This significant event could be viewed as a crisis. Therefore the concept of these wives dealing with a crisis in their marriage would be appropriate.

In the 1970's systems theories and social learning based models appeared. Steinglass (1981) introduced the Systems Theory for families of alcoholics. The main premise is that the alcohol abuse is an integral component of the family's functioning. Thus, while an individual may have developed a way of functioning prior to her marriage, once the alcoholic enters in marriage, a new system develops. Systems theorists (Steinglass, 1981) believed that the actions of the family members are toward achieving homeostasis. Systems models involve complex patterns of interactions. Steinglass (1981) has described the "adaptive consequences" of drinking, which reinforce drinking and establish a cyclic system centered on the differential interactions of the family as a function of sobriety and intoxication. Steinglass advocates family-oriented treatment and prevention plans.

The descriptions of the three women's lives were filled with complex marital interactions. Many of their responses in their marital interactions surrounded dealing with the alcohol abuse. All three women in this study appeared to be involved in a cyclic system of differing interactions. As a loss of control occurred they would choose to seek professional help to regain homeostasis in their lives. Since the husbands did not become sober after the first professional help-seeking attempt, then the patterns of interactions established from the alcohol abuse continued.

By using the Systems Theory, the loss of control experienced by the three wives can be thought of as a loss of homeostasis within the alcohol abused marriage. Seeking professional help is seen as the attempt by the wives to regain that homeostasis in their marriages. Steinglass would predict that there would be no major change in the alcohol abused marriage system if homeostasis is achieved. That is why there were no major changes after the first professional help-seeking attempts. In order for change to have occurred there must be change within the system, which would reflect a change in the husbands' drinking.

The last section of literature reviewed was on co-dependency. At this time the subject of co-dependency appears to be in an exploratory stage. Although there are some suggested models there is no real substantial research to validate any of them.

Authors (Burnett, 1984; Sapp, 1985; and Zelvin, 1988) described the co-dependent wife of an alcohol abuser as one who denies the existence of alcohol abuse. This was not true for the women in this study as problematic marriages were a common theme. The three wives were all aware of the alcohol abuse. The awareness of the alcohol abuse could be explained by the fact that these women were older and had lived for many years with this problem. When these authors were describing denial, perhaps they were thinking about the typical middle aged woman who has been married to an alcohol abuser for a much shorter period of time. After years of alcohol abusive patterns in the marriage, older women may have become more aware of the problem.

The lack of denial could also reflect the sample. In order to have sought professional help the wives had to be aware of the problems. Even though the wives descriptions in this study did not support the existence of denial, denial could certainly exist for those who have never reached out for help.

Zelvin (1988) described denial in wives of alcohol abusers as the inability to perceive the connection between the alcohol and the problems it creates. The ways in which coalcoholic women deny the relationships between their problems and their partners drinking range from denial in the psychoanalytical sense to denial of the label "alcoholic", to the refusal to acknowledge to the outside

world about their situation. At another level of awareness, a second key feature of the coalcoholic's denial is her inability to perceive how her behavior may be contributing to the dysfunctional marriage. Coalcoholic denial generates feelings of confusion, guilt, anxiety and rage.

In this study denial about seeking professional help was described by the wives. These women all had to experience a loss of control in their lives to feel that they could choose to seek help. The feelings of shame and isolation seemed to be barriers to that choice. These three women were so ashamed of the alcohol abuse problems in their marriages that they did not want anyone to know. They often described themselves as feeling like they were the only ones who had a spouse with an alcohol abuse problem.

After the first professional help-seeking experience these three women all used less protective behaviors towards their husbands on an inconsistent basis. It was clear from their descriptions that they did gain some awareness of the contribution that their responses made toward the alcohol abuse. At this time they began to try other responses towards their husbands. Although these changed responses were not consistent enough to support a common theme, they were significant in that the trial of new behaviors will precede any changes.

Zerwekh and Michaels (1989), two nurses, looked at co-dependency in terms of assessment and recovery. They

described shame and guilt as the core of the co-dependent pathology. Shame was identified as a common experience for the three wives in this study.

Zerwekh and Michaels suggested that confronting shame begins with awareness. An increased awareness of the problems in their marriages was a commonly occurring theme after the first professional help-seeking attempt. For one of the wives this increased awareness combined with a second help-seeking attempt led to treatment and her husband's sobriety. For the other two wives, seeking professional help again also occurred with an increased feeling of self worth, even though their husbands did not become sober. Therefore an increased awareness can indeed be the precursor to change.

In summary, this researcher's findings support the Stress Theory. The wives in this study can be seen as normal women who responded to the interactions of a problematic alcohol abused marriage with a variety of behaviors. The Psycho-Social Theory is supported because the loss of control of the wives to the alcohol abuse can be seen as a crisis. The Systems Theory seemed to be generally supported. The idea that the interactions between the husbands and the wives are complex and affect the family functioning appear to be supported by these findings. Lastly, the literature on co-dependency seems to be supported in part. Although the wives in this study did not

totally deny the existence of the alcohol abuse of their husbands, they did experience denial through not feeling that they could change the situation. The researcher's findings in this study did agree with the definitions and descriptions of the literature which included shame and isolation. However many of the definitions included more characteristics than those identified in this study.

NURSING IMPLICATIONS

In this last section of Chapter VI, the nursing implications and recommendations for research, practice and education will be discussed as they relate to this study, advanced practice and primary care.

Research

This study was conducted using a descriptive methodology. Three individual cases were analyzed and compared to elicit a common pattern of response. This pattern of response represents the three women in this study who were married to elderly alcohol abusing husbands and who sought professional help for the first time. The results are generalizable only to these three women. It is recommended that more women be included in this study in order to obtain saturation of the concepts. Additionally

the themes identified by the researcher can be brought back to the women for validation. Qualitative data can also be collected from those people who would be considered the immediate environment to these women. This would provide a broader data base. Longitudinal studies could also be carried out to watch the process of help-seeking over time.

One of the desired outcomes of qualitative research includes further enhancement of underlying theory. The findings of this examination were used to enhance and support the Theory of Unitary Man (Rogers, 1970) that formed the conceptual framework for this study. The results were consistent with that framework and help-seeking was better understood from the principles of mutual interaction and patterning. Additional research should be undertaken utilizing other principles from Rogers' theory to further illuminate the experience of wives of elderly alcohol abusing husbands as well as to enhance theory.

Another desire outcome of qualitative research is the generation of hypotheses. There are a number of recommendations that this researcher would like to suggest for future study based on the identified common themes.

In regard to the themes of problematic interactions, lack of mutuality, and a significant event the following studies are suggested:

1) A comparison of the first professional help-seeking attempt between younger and older wives.

2) A correlation between mutuality in the marital interactions and the success of the treatment of alcohol abused spouses.

3) The incidence of health problems as the significant event for alcohol abusers and their wives which led toward professional help-seeking.

4) The presence of a relationship between the perception of problematic interactions and mutuality in an alcohol abused marriage.

Correlation between the identified themes needs to be done to look for relationships Additionally since part of the importance of this descriptive study was to look at the uniqueness of the elderly alcohol abused marriage, then the variable of age must be measured for differences and for significance.

For the common identified themes of shame and isolation, and loss of control the following studies are suggested:

1) The relationship between shame, isolation and seeking professional help.

2) The relationship between loss of control and seeking professional help.

3) A comparison of younger and older wives of alcohol abusers regarding the choice of professional help-seeking.

4) To suggest and to test a model on the concept of co-dependency.

The concept of co-dependency is described by authors as having the characteristics of shame and isolation (Zerwekh & Michaels, 1989). Therefore it is necessary to test for the presence and relationships of these characteristics if we are to devise treatment modalities around them. Additionally it is important to know the impact of these characteristics on the choice to seek professional help. Again the importance of analyzing these characteristics with age as a variable is important for the identification and treatment of spouses of elderly alcohol abusers.

Finally, the following studies are suggested for the common themes of increased awareness and seeking professional help again:

1) A longitudinal study following alcohol abused couples starting at age 40-45 in order to describe changes over time.
2) A longitudinal study following the life experience of those wives who seek professional help for the first time.
3) The relationship between social support and success in treatment.
4) The relationship between increased awareness and future successful treatment.

In summary, future research needs to look at relationships between the identified common themes. Additionally, the variable of age must be considered to look for uniqueness and for specific treatment considerations for the elderly. The concept of co-dependence seems to be in the descriptive stage of research and needs to be validated with tested models. Longitudinal studies can provide information on the life experience of the wife of an alcohol abuser over time.

Practice

The findings in this study support the fact that the first professional help-seeking attempt for the wife of an elderly alcohol abuser is a problem-solving approach to a problematic marriage. For the three wives in this study professional help-seeking was characterized by a loss of control in the life experience. This loss of control evolved over time from problematic marital interactions which lacked mutuality, feelings of shame and isolation, and the occurrence of a significant event. Therefore, implications for the Clinical Nurse Specialist (CNS) in Primary Care indicate that intervention should be process oriented.

The CNS should recognize that by the time the wife seeks professional help she has experienced many dysfunctional interactions in her marriage and has feelings

of shame and isolation. To seek help from a professional mean that the situation has worsened to the point where the shame and isolation the wife usually experiences is outweighed by a loss of control. The CNS should help the wife identify and label the problems. Interventions based on crisis approaches may be useful at this time. This loss of control could indicate a crisis situation for the wife and family.Helping the wife access health care, shelter, finances and other basic needs may be necessary. Emotional support and guidance with decision making are also important.

The CNS must assess whether or not the alcohol abusing husband would be willing to get treatment. If the husband and his wife are willing, then the CNS should be able to make a referral to a quality treatment center. The ideal situation would be of course if both the husband and wife would consent to treatment. Encouraging both spouses into treatment would promote mutuality in the marriage and the probability of recovery for both would be greater.

Even if the husband is not willing to receive treatment there are approaches that could facilitate change for the wife. Providing information and education on alcohol abuse and co-dependency is needed. Helping the woman learn to set boundaries for herself in her interactions with her husband is necessary. Boundaries in the relationship will help the wife identify whose problem the alcohol abuse really is and

who should receive its consequences. Boundaries will help the wife see which of her responses actually enable the alcohol abuse to continue.

Helping the wife recognize shame and isolation is important since these characteristics are identified as the core of co-dependency. The CNS can help these wives label and become aware of their feelings. The wives need to know that an increased awareness of their self and of their husbands alcohol abuse is the first step toward change. Counseling these women to use powerful positive statements on a daily basis can help them increase their self esteem, and help them to try on new responses to their husbands alcohol abuse.

Coordinating services is another important area which can help facilitate these women. Encouraging them to join self help groups such as Al-Anon is significant. These groups help women to see that they are not alone in this experience. They can share with others and feel a sense of social support from understanding peers.

Other services such as job training or placement, financial assistance and others may be helpful on a more long term basis. Women in older age groups may not feel able to be financially independent as they have been homemakers for years. These women may feel that they do not have any valuable job skills. Job and financial security

could be a barrier to independence and change within a problematic marriage.

The CNS in primary care needs to give attention to assessing alcohol abuse as a health concern in all elderly clients. A change in health status may indicate an alcohol abuse problem. Interacting with both the husband and the wife can be important in order to assess the truthfulness of the situation in terms of the alcohol abuse. Additionally in doing a complete assessment of the alcohol abused situation, a home visit is warranted to get a first hand look at the immediate environment in which they interact.

Finally since alcohol abuse is a disease that affects the whole family, the CNS must use a family centered approach in planning care. Children, even adult children, must also be considered and treated. The wife of an elderly alcohol abuser needs to open up communication to her children so that they can seek the help that they may need.

The CNS must facilitate the responses of the wife of an elderly alcohol abuser as she attempts to repattern her life. Breaking the cycle of co-dependency is not an easy task. Repatterning her responses to the alcohol abuse is the best way in which the wife can help her husband reach sobriety, and/or by which she can improve her own life experience.

Education

Nursing implications for education can be derived from this study for nurses in both learning and teaching roles. The practice of nursing on all levels can be taught based on research. Research based interventions once learned, can in turn, be taught and modeled to others.

In this study the results are only generalizable to the three women. The results are reflected back to the theory underpinning the concepts that guided the study. In this study the theory used is that of Rogers' Theory of Unitary Man (1970). This theory speaks well to the process of the life experience being full of interactions and patterns of responses. In order to encourage nurses to value process as well as outcomes, processed based frameworks such as the one utilized in this study should be included in nursing curricula, especially that of advanced practice.

This researcher suggests that nursing education at all levels be theoretically based. Theory based education is necessary to maintain a universal frame of reference for all nurses. Theory can also guide nursing practice. Nursing educators at all levels should be well grounded in theory and its relationship to practice.

Nurses at the associate degree level should be introduced to nursing theory and to the idea that it guides practice. Those in baccalaureate programs should have

nursing theories included in their programs. They need to understand that theory guides their practice. Advance practicing nurses should have theory as a basic underlying component of their education. Nurses in advanced practice should be able to add to and improve nursing theory as well as to use it to guide their practice.

Advanced practice nurses should use the role of educator as extending not only to their clients but also to the general public. The need to educate the public on alcohol abuse in the elderly is timely since the elderly population is on the increase. Describing to the public ways to identify alcohol abuse in the elderly is important. The usual criteria for identifying alcohol abuse in this age group may not be as useful. In addition reinforcing the importance of treatment in this age group can be meaningful. Many people may have the opinion that if a person is older, then treatment is a waste. Nurses need to support and promote treatment for all alcoholics and their families to promote positive well-being and health for all.

Reaching out to the community on the issue of co-dependency is important. The characteristics of shame and isolation need to be described to the public. This will encourage those women who are experiencing these feelings to seek help. Additionally information may provide an understanding of the complexities of alcohol abuse and of the interactions in the family.

Physicians in collaborative practice with a CNS should be made aware of the possibility that wives of elderly alcohol abusers may seek them out for professional help. Those seeking help may also have husbands experiencing health problems at the same time.

Finally the goal of nursing is to facilitate the response of an individual. Nursing's mission must be that of research, education and practice which will promote that facilitation. Patterning and repatterning toward well-being and life satisfaction is a mutual interactive process. Nursing can and should be an interactive part of that process to facilitate the life experience.

SUMMARY

In summary, Chapter VI included an overview of this study. Findings were discussed and analyzed with regard to the subjects, Rogers' Theory of Unitary Man (1970) and to the relevant literature. Finally, the significance of this study with regard to nursing research, practice and education were discussed.

APPENDIX

APPENDIX A

CHARACTERISTICS OF ALCOHOL ABUSE

Based on Milam and Ketcham's (1981) framework on stages of alcohol abuse.

I. Predisposing Factors to Alcohol Abuse

Abnormal metabolism - diabetes, hypoglycemia, malnourishment.

Ethnic susceptibilities - Native American, Eskimo, Scandinavian, Irish, French.

Prenatal influence - mother was an active alcoholic during pregnancy.

Hereditary - history of alcoholism in the family.

Preference for alcohol - likes the taste and effect.

The aging process - less lean body mass, lower body water content, and a decreased ability for the liver to metabolize alcohol.

Prescriptions and over the counter drugs - cause interactions with alcohol to produce negative effects.

II. Early Adaptive Stage to Alcohol Abuse

A. BEHAVIORAL

Increased alcohol intake with the appearance of normal functioning.

Increased alcohol intake with drinking patterns persisting.

More likely to consume alcohol every day.

B. PHYSICAL

No impairment with walking or talking.
Occasional hangover, but not passing out or nausea.

C. PSYCHOLOGICAL

No impairment with thinking or reacting.

D. SOCIAL INTERACTIONS

Usually does not appear to affect or cause changes.

III. Middle Stage of Alcohol Abuse

A. BEHAVIORAL

Spending more time alone.

Changing drinking patterns.

Switching types of alcohol

Sneaking drinks.

Predrinking before social affairs.

Hides alcohol in the house.

Gulping first drinks.

Loss of control over drinking.

Inability to stop drinking.

Relocating to new places.

Changing jobs.

Drinking to alleviate tremors.

Poor nutritional habits.

B. PHYSICAL

Hangovers - (headaches, thirst that lingers "cotton mouth", light blinds eyes, noise hurts head, dizziness, nausea, and vomiting).

Tremors

Weakness

Nervousness

Insomnia

Excessive perspiration

Loss of appetite

Malnutrition

Gastritis

Ulcers

Convulsions

Loss of consciousness

Delirium tremens - however the elderly are less like to experience.

Falls

Accidents

Excessive incontinence

Lack of exercise

Poor housing

C. PSYCHOLOGICAL

Tense

Anxious

Nervous

Depressed

Agitated

Moody

Overwhelming desire for alcohol.

Guilt

Shame

Mood swings

Emotional outbursts

Self pity

Remorse

Self loathing

Black outs, unable to remember what happened when drinking when sober again.

Personality change

Confusion in the elderly.

D. SOCIAL INTERACTIONS

Blames others

Rationalizes to others

Defensive

Questions or discussions about alcohol causes distress.

Manipulative

Violent

Social Isolation

IV. Late Deteriorative Stage of Alcohol Abuse

A. BEHAVIORAL

Appears drunk

Morning drinking

Prolonged binges

Drinks alone

Changing drinking patterns.

Unable to do basic self care.

Drinks rubbing alcohol, cough syrup, shaving lotion.

B. PHYSICAL

Heart failure

Hepatitis

Cirrhosis

Ascites

Bruises and bleeds easily.

Broken blood vessels on face, head and chest.

Pneumonia

TB

Bronchitis

Emphysema

Lung Abscesses

Cancer - head, neck, esophageal, lung, and liver.

Pancreatitis

Polyneuropathy - tingling, "pins and needles" of toes, fingers, feet and legs, and loss of muscle tone.

Malnutrition

Gastritis

Ulcers

Hospitalizations

C. PSYCHOLOGICAL

Vague fears.

Paranoia

Hallucinations

Short term memory loss.

Blackouts

Suicide attempts

Psychosis

Confusion

D. SOCIAL INTERACTIONS

Disintegrated social contacts, isolation

Marital difficulties

Hysterical family battles.

Financial dependence

Poor work performance

Arrests

Drinking with the down and out in seedy taverns in order not to be recognized.

APPENDIX B

Dear Potential Volunteer:

My name is Sheila Livingston and I am a student at Michigan State University. I am conducting a study on the experience of the wife of an alcohol abuser. I am interested in exploring how, when, and why wive seek professional help. Hopefully this information will help future researchers and professionals know better how to help wives and their husbands especially in the older population who have experienced alcohol abuse in their marriages.

I am looking for wives who believe that their husbands have had an alcohol abuse problem. The husband must be at least 55 years old. You must have been married for at least five years. Additionally, you must have attempted to seek professional help for the alcohol abuse at least once.

There will be no immediate personal benefits from participating in this study. If you find that the interviewing process brings out some difficult areas in your life, referrals for assistance can be made. Your participation may add to an increased understanding for health care professionals of the experience of seeking help for the alcohol abuse in your marriage.

If you would be interested in participating in this study it will require about two hours of your time for a

private interview. The interview will be audiotaped for purposes of analysis by the researcher. The audiotape will be destroyed when the study is completed. All information will be held in the strictest confidence, and your anonymity will be protected. The information obtained from you will be used for research purposes only.

Please contact me if you are interested in volunteering, and if you have any questions. Participation in this project would be appreciated.

Sheila Livingston, RN, MSN (Candidate)
Nursing Researcher
15656 Jackson drive
Omaha, NE 68118
402-330-8699

APPENDIX C

Consent Form

Dear Volunteer:

The study in which you are about to participate is designed to explore the first professional help-seeking attempt of wives of elderly alcohol abusing husbands. Participation in the study will take approximately two hours of your time. You will be required to respond to the interview questions as honestly and accurately as possible.

The interview will be audiotaped to assure accuracy in analyzing the information. The audiotape will be destroyed after the study is completed. Your answers will be protected and no attempt will be made to identify you in any manner.

Your participation in this study is voluntary and you can withdraw at any time. You are also free not to answer any particular questions without recrimination.

No immediate personal benefits will result from partaking in this study. The interviewing process might touch on some sensitive personal issues. Therefore if you would like some assistance after the interview, referrals will be made. Your participation may add to an increased understanding for health care professionals of the experience of seeking professional help for the alcohol

abuse in your marriage.

If you agree to participate please sign the following statement. Thank you.

Sheila Livingston, RN, MSN (Candidate)
Nursing Researcher
15656 Jackson Dr.
Omaha, NE 68118
(402) 330-8699

I , state that I understand what is required of me as a participant in the above-described study and agree to take part in this investigation.

Signature

Date

APPENDIX D

INTERVIEW GUIDE

The reason for this interview is to get a detailed picture of your experience as the wife of an alcohol abusing husband who decided to seek professional help for the first time. There are three sections of questions. First I would like to know as much as possible about the interactions between you and your husband prior to your decision to seek professional help for the first time. Secondly, please describe the thoughts and feelings you had during the time you sought help. Finally I would like you to describe any changes that occurred as a result of that first help-seeking experience.

A). Objective 1 - To describe the mutual interactions between the wife and the elderly alcohol abusing husband that gave rise to seeking professional help for the first time.

This section of questions is directed at exploring the experience you had with your husband prior to seeking professional help for the first time.

1). Describe yourself, your husband and your relationship before you were aware that he had an alcohol abuse problem.

2). Describe the situation with your husband when you began to realize that he had an alcohol abuse problem.

a). How and when did you first suspect that your husband had an alcohol abuse problem?

b). Describe your husband's drinking behaviors at that time.

c). Describe your husband's physical health at that time.

d). Describe your husband's emotional and mental state at that time.

f). Describe any factors that might have contributed to your husband's alcohol abuse (family history, physical health, ethnic background, mother's use of alcohol when pregnant with your husband, preference for alcohol, age, use of medications).

3). Describe your response to your husband's alcohol abuse.

a). How did you feel when you began to realize that your husband abused alcohol?

b). How did you typically behave when your husband was drinking?

c). Did you try to cover up your husband's alcohol abuse problem, and if so, how?

d). What did you do to try and protect yourself and your family from this problem of alcohol abuse?

e). What did you do to try to get your husband to stop abusing alcohol?

f). What behaviors if any did you use that may have in fact promoted your husband's abuse of alcohol?

B). Objective 2 - To describe the thoughts and feelings that surrounded the choice to seek professional help for the first time.

The next section of questions will direct you to look at what happened when you decided to seek professional help for the first time.

1). What were you thinking and feeling when you decided to seek professional help for the first time?

2). Who did you decide to see for help, and how did you select that person? (You do not need to mention any individual person's name.)

3). Describe the experience of seeking professional help for the first time for either yourself, your husband, or both, because of the alcohol abuse.

a). What was occurring in your relationship with regards to the alcohol abuse at the time you decided to seek professional help for the first time?

b). Describe the actual professional help-seeking experience.

c). How did your husband respond to the professional help-seeking?

4). What were you thinking and feeling during this help-seeking experience?

5). What were you thinking and feeling after this help-seeking experience?

6). How was this help-seeking experience helpful to you?

7). How was this help-seeking experience helpful to your husband?

C). Objective 3 - To describe the repatterning of the life experience of the wife after the first professional help-seeking attempt.

This last section of questions deals with what has occurred in your life since that first professional help-seeking experience.

1). How has your husband changed, if any, since that first professional help-seeking experience?

a). How has your husband's drinking behavior changed?

b). How has your husband's physical health changed?

c). How has your husband's mental and emotional state changed?

d). How has your husband's interactions with you and others changed?

2). How many more times, if any, have you sought professional help since that first time? *(If there were more times then see below.)

*Since there has been more than one professional help-seeking attempt for the alcohol abuse of your husband, would you take a moment and fill out this brief survey? The survey is in regards to those other help-seeking experiences.

3). How, if any, has your responses toward your husband changed since that first professional help-seeking attempt?

a). How has your behavior changed toward your husband?

b). What has changed in your situation in terms of covering up for your husband's alcohol abuse?

c). What changes, if any, are there in how you try to protect yourself and your family from the alcohol abuse?

d). Are you doing anything now to either stop your husband from abusing alcohol or to prevent him from starting again?

e). How have your behaviors changed that may have in fact promoted the alcohol abuse of your husband?

4). How do you feel about your husband and your marriage today?

Is there anything else that you think I should be aware of in order to understand what life has been like for you either before or after the first professional help-seeking attempt?

Then I would like to thank you for your participating in this study. I hope that this interview has been beneficial to you, as it certainly has been to me.

Demographic Information

Age of Wife

Age of Husband

Years of Marriage

Perceived Years of Alcohol Abuse

Presently Living Together or Separated

Number od Children

Health Status of Husband

Health Status of Wife

Husband's Eduction

Wife's Eduction

Husband's Profession

Wife's Profession

Income Range per Year

Under $10,000

$10,000 - 19,999

$20,000 - 34,999

$35,000 - 49,999

$50,000 - 74,999

$75,000 - above

HELP-SEEKING SURVEY

1). This survey is describing the ____ time that I sought professional help for my husband's alcohol abuse.

2). Briefly describe what was occurring in your relationship with regards to the alcohol abuse when you decided to seek professional help this time?

3). Who did you decide to see and how did you select that person or group? (You do not need mention the person's name.)

4). How did your husband change, if any, after this professional help-seeking experience?

5). How did your response toward your husband change after this professional help-seeking experience?

6). How would you rate this professional help-seeking experience? Was the experience more or less helpful than the first time?

APPENDIX E

Field Notes

CASE A

Mary is a petite, meticulously-groomed woman. She was stylishly dressed. During the interview she was appropriate with facial expressions for her conversation. Mary was tearful at times and laughing at others.

We sat in the dining room on comfortable chairs at the table. We were alone. The phone rang three times during the course of the interview but was left unanswered. This did not seem to affect the flow of the conversation. Overall the environment was quiet and comfortable.

CASE B

Jane is a petite, well-groomed woman. During the interview she would laugh when appropriate. When discussing anything of an emotional nature she would become more stiff in her posture, pull at the hem of her skirt and generally have a blank look on her face. At the end of the interview she did become slightly tearful when talking about how she is presently feeling about her past.

The environment was quiet and there were no

interruptions. Jane sat on a hard chair with no sides next to a desk. We were alone.

CASE C

Sally is a tall, redheaded women who wore colorful clothes and large jewelry. She appeared comfortable during the course of the interview. Her facial expressions were consistent with the conversation. She used humor appropriately. She appeared to be in control of her emotions even during the discussion of painful events.

Sally cancelled two times prior to the actual interview. She wanted to be sure that her husband did not know that she was involved in this study. We met at her home and held our discussion in the living room. The room was comfortable. We had only one interruption which was when someone came to the front door. This broke the atmosphere of the conversation for a few moments. We backtracked our discussion briefly and then proceeded.

REFERENCES

American Nurses' Association. (1980) Nursing A Social Policy Statement. Kansas City, MO; American Nurses' Association.

Bailey, M.B. (1963). Research on alcoholism and marriage. Social Work Practice. New York, NY; Columbia University Press, 19-30.

Bailey, M.B. (1965). Al-Anon family groups as an aid to wives of alcoholics. Social Work, 10, 67-74.

Bailey, M.B. (1967). Psychophysiology impairment in wives of alcoholics as related to their husbands drinking and sobriety. In R. Fox (ed), Alcoholism: Behavioral Research, Therapeutic Approaches. New York; Springer Pub., Inc., 134-144.

Bailey, M.B., Haberman, P.W., Alksne, H. (1965). The epidemiology of alcoholism in an urban residential area. Quarterly Journal of Studies on Alcohol, 26, 19-40.

Bailey, M.B., Haberman, P., Alksne, H. (1962). Outcomes of alcoholic marriages; endurance, termination, or recovery. Quarterly Journal of Studies on Alcohol, 23, 610-623.

Barnes, G.M. (1982). Patterns of alcohol use and abuse among older persons in a household population. In W.G. Wood, M.F. Elias, R.C. Aldeman, and G.S. Roth (eds),

Alcoholism and Aging: Advances in Research Boca Raton, Fla.; CRC Press, 3-15.

Black, C. (1981). It Will Never Happen to Me! Denver; M.A.C. Printing and Publications Division.

Burnett, M.D., (1984). Toward a model for counseling the wives of alcoholics: A feminist approach. Alcoholism Treatment Quarterly. 1 (2) 51-60.

Chenitz, W.C., Swanson, J.M. (1986). From Practice to Grounded Theory. Qualitative Research in Nursing. Menlo Park: Addison-Wesley Publishing Co.

Christopherson, V.A., Escher, M.D., Bainton, B.R. (1983). Reasons for drinking among the elderly in rural Arizona. Journal of Studies on Alcohol. 45(15), 417-423.

Clark, W.B., Midanik, L. (1980). Alcohol use and alcohol problems among U.S. adults: Results of the 1979 national survey. Berkeley: Alcohol Research Group.

Clifford, B.J. (1960). A study of the wives of rehabilitated and unrehabilitated alcoholics. Social Casework, 42, 457-460.

Corbin, J. (1986). The formal qualitative interview for grounded theory. In W.C. Chenitz, and J.M. Swanson (eds), From Practice to Grounded Theory. Qualitative Research in Nursing. Menlo Park: Addison-Wesley Publishing Co., 66-78.

Corder, B.F., Hendricks, A., and Corder, R.F. (1964). An MMPI study of a group of wives of alcoholics. Quarterly Journal of Studies on Alcohol. 25, 551-554.

Deneker, P., deSaugy, D., and Ropert, M. (1964). The alcoholic and his wife. Comprehensive Psychiatry. 5, 374-383.

Dunham, R.G. (April-June, 1981). Aging and changing patterns of alcohol use. Journal of Psychoactive Drugs. 13(2) 143-151.

Dunn, N.J., Jacob, T., Hummon, N., Seilhamer, R.A. (1987). Marital stability in alcoholic-spouse relationships as a function of drinking pattern and location. Journal of Abnormal Psychology. 96(2), 99-107.

Edwards, P., Harvey, C., and Whitehead, P.C. (1973). Wives of alcoholics. A critical review and analysis. Quarterly Journal of Studies on Alcohol. 34, 112-132.

Finney, J.W., Moos, R.H., Cronkite, R.C., Gamble, W. (1983). A conceptual model of the functioning of married persons with imparied partners: spouses of alcoholic patients. Journal of Marriage and the Family. 45(1), 23-34.

Futterman, S. (1953). Personality trends in wives of alcoholics. Journal of Psychiatric Social Work 23,37-41.

Glantz, M. (April-June, 1981). Predictions of elderly drug abuse. Journal of Psychoactive Drugs. 13 (2) 117-126.

Graham, K. (1986). Identifying and measuring alcohol abuse among the elderly: serious problems with existing instrumentation. Journal of Studies on Alcohol, 47(4), 322-326.

Haberman, P.W. (1964). Psychological test score changes for wives of alcoholics during periods of drinking and sobriety. Journal of Clinical Psychology, 20, 230-232.

Jackson, J.K. (1954). Adjustment of the family to the crisis of alcohol. Quarterly Journal of Studies on Alcohol, 15, 562-586.

Jackson, J.K. (1956). The adjustment of the family to alcoholism. Marriage and Family, 18, 361-369.

Jackson, J.K. (1959). Family structure and alcoholism. Mental Hygeine, 43, 401-406.

Jackson, J.K. (1962). Alcoholism and the family. In D.J. Pittman and D.R. Snyder (eds). Society, Culture, and Drinking Patterns. New York, Wiley Press. 472-492.

Jacob, T., Dunn, N., Leonard, K. (1983). Patterns of alcohol abuse and family stability. Alcoholism: Clinical and Experiemental Research, 7, 382-385.

Jacob, T., Leonard, K.E. (1988). Alcoholic-spouse interaction as a function of alcoholism subtype and alcohol consumption interactions. Journal of Abnormal Psychology, 97(2), 231-237.

James, J.A., Goldman, M. (1971). Behavior trends of wives of alcoholics. Quarterly Journal of Studies on Alcohol. 32, 373-381.

Hochhauser, M. (April-June, 1981). Learned helplessness and substance abuse in the elderly. Journal of Psychoactive Drugs. 13(2), 127-133.

Kalashian, M.M. (1959). Working with the wives of alcoholics in an outpatient clinic setting. Marriage and Family 21, 130-133.

Kogan, K.L., Fordyce, W.E., and Jackson, J.K. (1963). Personality disturbances in wives of alcoholics. Quarterly Journal of Studies on Alcohol. 24, 227-238.

Kogan, K.L., and Jackson, J.K. (1963). Role perceptions in wives of alcoholics and non-alcoholics. Quarterly Journal of Studies in Alcohol. 24, 627-639.

Kogan, K.L., and Jackson, J.K. (1964). Patterns of atypical perceptions of self and spouse in wives of alcoholics. Quarterly Journal of Studies on Alcohol. 25, 555-557.

Kogan, K.L., and Jackson, J.K. (1965a). Stress, personality, and emotional disturbance in wives of alcoholics. Quarterly Journal of Studies on Alcohol. 26, 486-495.

Kogan, K.L., and Jackson, J.K. (1965b). Some concomitants of personal difficulties in wives of alcoholics and non-alcoholics. Quarterly Journal of Studies on Alcohol. 26, 595-604.

LaGreca, A.J., Akers, R.A., Dwyer, J.W. (1988). Life events and alcohol behavior among older adults. The Gerontologist. 28(4), 552-558.

Lazarus, R.S., Folkman, S. (1984). Stress, Appraisal, and Coping. New York: Springer Publishing Co., Inc.

Lemert, E.M. (1960). The occurrence and sequence of events in the adjustment of families to alcoholism. Quarterly Journal of Studies on Alcohol. 21, 679-697.

Lemert, E.M. (1962). Dependency in married alcoholics. Quarterly Journal of Studies on Alcohol. 23, 590-609.

Lewis, M.F. (1937). Alcoholism and family casework. Family. 18, 39-44.

Macdonald, D.E. (1956). Mental disorders in wives of alcoholics. Quarterly Journal of Studies on Alcohol. 17, 282-287.

Mandolini, A. (April-June 1981). The social contexts of aging and drug use: Theoretical and methodological insights. Journal of Psychoactive Drugs. 135-142.

Milam, J.R., Ketcham, K. (1981). Under the Influence: A Guide to the Myths and Realities of Alcoholism. New York: Bantam Books, Inc. by arrangements with Madrona Publishers, Inc.

Miller, P.M., and Mastria, M.A. (1977). Alternatives to Alcohol Abuse/A Social Learning Mode. Champaign, IL: Research Press Company, 1-16.

Miller, P.M. (1976). Behavioral Treatment of Alcoholism. Elmsford, NY: Pergamon Press, Inc., 116-134.

Moos, R.M., Finney, I.W., Gamble, W. (1982). The process of recovery from alcoholism II. Comparing spouses of alcoholic patients and matched community controls. Journal of Studies on Alcohol. 43, 889-911.

New York State Division of Alcoholism and Alcohol Abuse (Max, 1979). Elderly drinking patterns are studied. Alcoholism Newsletter. 1, 3.

O'Farrell, T.J., Birchler, G.R. (1987). Marital relationships of alcoholic, conflicted and nonconflicted couples. Journal of Marital and Family Therapy. 13(3), 259-274.

Orford, J., Gurthrie, S. (1968). Coping behavior used by wives of alcoholics: A preliminary investigation. International Congress on Alcohol and Alcoholism. 1, 97.

Petersen, D.M., Whittington, F.J. (April-June, 1981). Editors' introduction. Journal of Psychoactive Drugs. 13(2), 111-116.

Polit, D., Hungler, B. (1983). Nursing Reserach Principles and Methods (2nd Ed). Philadelphia: J.B. Lippincott Co.

Price, G.M. (1945). A study of the wives of twenty alcoholics. Quarterly Journal of Studies on Alcohol. 5, 620-627.

Rogers, M., E. (1970). An Introduction to the Theoretical Basis of Nursing. U.S.A.; F.A. David Company.

Rogers, M., E. (1980). Nursing: A science of unitary man. In J. Riehl and S. Roy (eds) Conceptual Models for Nursing Practice. NY: Appleton-Century-Crofts.

Rogers, M., E. (1982, May). Tapes of Lecture at Michigan State University, College of Nursing, East Lansing, MI.

Rosin, A.J., Glatt, M.M. (1971). Alcohol excess in the elderly. Quarterly Journal of Studies on Alcohol. 32, 53-59.

Rothberg, N.M. (1986). The alcoholic spouse and the dynamics of co-dependency. Alcoholism Treatment Quarterly 3(1) 73-86.

Sackin, C. (1981). Youthful and aged alcohol abusers: Some policy implication. Journal of Alcohol and Drug Education. 26(1), 69-75.

Sapp, J.S. (1985). The family's reaction to an alcoholic: An application of Kubler-Ross's five stages. Alcoholisim Treatment Quarterly 2(2), 49-60.

Smart, R.G., and Liban, C.G. (1981). Predictors of problem drinking among elderly middle-aged and youthful drinkers. Journal of Psychoactive Drugs. 13(2), 153-163.

Sobel, M.B., Sobel, L.C., Sheaham, D.B. (1976). Functional analysis of drinking problems as an aid in developing

individual treatment strategies. Addictive Behavior 1, 127-132.

Steinglass, P. (1978). The conceptualization of marriage from a systems theory perspective. In T.J. Paulino, Jr. and B.S. McCrady (eds) Marriage and Marital Therapy. NY: Brunner, Mazel.

Steinglass, P. (1981). The impact of alcoholism on the family: Relationship between degree of alcoholism and psychiatric symptomology. Journal of Studies on Alcohol. 42, 288-303.

Swanson, J.M. (1986). The formal qualitative interview for grounded theory. In W.C. Chenitz, and J.M. Swanson (eds) From Practice to Grounded Theory. Qualitative Research in Nursing. 66-78.

Warheit, G.J., Auth, J.B. (183). The mental health and social correlates of alcohol use among differing life cycle groups. In G. Maddox, L.N. Robins, N. Rosenberg (eds). Nature and Extent of Alcohol Problems Among the Elderly. Washington: NIAAA Research Monograph No. 14 Government Printing Office.

Wegscheider, S. (1983). The Family Trap...No One Escapes From A Chemically Dependent Family. St. Paul: Nurturing Networks, Inc.

Whalen, T. (1953). Wives of alcoholics; four types observed family service agency. Quarterly Journal of Studies in Alcohol 14, 632-642.

Whelton, B. (1979). An operationalization of Martha Rogers' theory and throughout the nursing process. International Journal of Nursing Studies. 16, 7-20.

Zelvin, E. (1988). Dependence and denial in coalcoholic women. Alcoholism Treatment Quarterly. 5(3/4). 97-115.

Zerwekh, J., Michaels, B. (1989). Co-dependency assessment and recovery. Nursing Clinics of North America. 24(1) 109-120.

Zimberg, S. (June 1974). The elderly alcoholc. The Gerontologist. 14(3), 221-224.

Zimmering, S., Domeischel, J.R. (1982). Is alcoholism a problem of the elderly? Journal of Drug Education. 12(2), 103-111.

Zweben, A. (1986). Problem drinking and marital adjustment. Journal of Studies on Alcohol. 47(4), 167-172.