A STUDY OF THE INFLUENCES ON THE DEVELOPMENT OF ALCOHOLISM AND PROBLEM DRINKING

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CONTENTS

ABSTRACT

A Study of the Influences on the Development of Alcoholism and Problem Drinking.

Alcoholism is a world-wide problem which effects a large section of the Irish population. It is estimated that as much six per cent of all drinkers in Ireland drink more than the safe limits.

This study provides a review of the literature dealing with the influences on the development of alcoholism to date and it reports on the results of an empirical study carried out on the causes of alcoholism in an Irish sample. An alcoholic group and a control group, each consisting of twenty eight people, was interviewed using a standardized questionnaire. A qualitative approach was adopted which best suited the exploratory nature of the study. Data rich in detail on personality, family background, and social environment was gathered. Responses were categorized and tabulated for each question, and the differences between the two groups were tested for significance.

The results of the study indicate that the four models of alcoholism tested, (medical, psychoanalytic, behavioural, sociological), achieved support. The strongest correlation was seen between psychological influences and alcoholism followed by sociological and medical factors. This suggests that people who develop alcohol problems are disadvantaged psychologically and socially. Added to this there is the implication of genetic factors in the development of the problem.

It is concluded that there is a need to disentangle the various models and to define each one clearly. Also it is recommended that their respective influence on the development of alcoholism should be tested in a larger study.

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DEDICATED TO

MY FAMILY

INTRODUCTION

Alcoholism has been viewed at different times as a form of moral weakness, as a medical problem, as a social problem, and as a symptom of an underlying personality disorder. Increasingly it is seen as a combination of all of these, and the term 'multifactorial' is often used to indicate the complex nature of the origins of alcoholism. The confusion which surrounds the definition of alcoholism/problem drinking adds to the difficulty in arriving at a clear understanding of the condition. It was decided at the outset of this study to address this problem of definition.

Definitional Issues

Definition of terms: In this study the term "alcoholic" applies to those people whose drinking causes a continuing or periodic problem in any department of their lives. The term is chosen because of its common usage and is not intended to imply that there is an established disease entity called alcoholism. Rather, it refers to alcohol-related problems and problem drinking.

The term "aetiology" when used in this study is intended in a general sense to refer to the development of the condition of alcoholism / problem drinking in the individual. It is not used in a strict medical sense to imply there is a precise and identifiable disease entity at work.

The diagnoses of alcoholism remains problematic simply because there are many different conditions that can be diagnosed as alcoholism. Consequently there is extreme difficulty arriving at a core definition of alcoholism. A Royal College of Psychiatrists'(1979) special committee reports - "The word "alcoholism" is in common use but at the same time there is general uncertainty about its meaning."1 E.M. Jellinek in his important book "The Disease Concept of Alcoholism"(1960), attempted a descriptive approach to diagnosis when he labelled different drinking patterns as alpha, beta, gamma, delta, epsilon. He was well aware of the limitations of his typologies when he wrote - "The lay public uses the term "alcoholism" as designation for any form of excessive drinking, instead of as a label for a limited and well defined area of excessive drinking behaviour. Automatically, the disease conception of alcoholism becomes extended to all excessive drinking, irrespective of whether or not there is any physical or psychological pathology involved in the drinking behaviour. Such an unwarranted extension of the disease conception can only be harmful because, sooner or later, the misapplication will reflect on the legitimate use too and, more importantly, will tend to weaken the ethical basis of social sanctions against drunkenness."2 These cautious words of Jellinek's anticipated the definitional confusion which has existed for the past twenty years.

The definitions of alcoholism proposed by the World Health Organization (WHO) are built upon aetiologic assumptions. The WHO report of 1952 stressed the notion of dependence, which was claimed to be primarily psychic with secondary physical dependence as a crucial element in alcoholism. In another WHO report in 1964 the term dependence was defined as - "A state,

psychic, and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes avoid the discomfort of its absence. Tolerance may or may not be present."3 These reports led to a second milestone in the debate about the meaning of alcoholism which was the formulation of the "alcohol-dependence syndrome" by Edwards and Gross in 1977. This new definition of alcoholism was incorporated into the International Classification of Diseases as a new medical diagnosis in January of 1979. Edwards and his colleagues described the following seven elements of the alcohol-dependence syndrome - (1) narrowing of the drinking repertoire; (2) salience of drink-seeking behaviour; (3) increased tolerance to alcohol; (4) repeated withdrawal symptoms; (5) subjective awareness of a compulsion to drink; (6) relief of avoidance of withdrawal symptoms by further drinking; and (7) reinstatement of dependence after abstinence.4

The term syndrome as used by Edwards and Gross means "an observable coincidence of phenomena."5 They assert that not all of the elements of the alcohol-dependence syndrome need always be present, nor present to the same degree for the coincidence to qualify as a syndrome. It appears that Edwards has acknowledged the continuity between the syndrome and earlier disease concepts when he wrote - "it is an idea roughly coterminous with what many people would call the disease of alcoholism, or with the Alcoholics Anonymous notion of what counts as alcoholism."6

In 1972 the Criteria Committee of the National Council on Alcoholism in America (NCA) published a diagnostic criteria instrument consisting of 86 items of importance that are considered to be commonly associated with alcoholism, ranging from autopsy findings, to laboratory tests, to drinking behaviours, to information from family or friends. The main criticism of this instrument is its undue dependence on physical items. For example, Breitenbucher(1976) examined 70 identified alcoholics, 27 of whom were identified by clinical medical examination and 43 were identified by the MAST self-report. Only 5 of the 70 had physical criteria matching the NCA diagnostic criteria.7

In 1980 the American Psychiatric Association published the new diagnostic criteria for alcoholism in the Diagnostic and Statistical Manual of Mental Disorders 3rd. edition (DSM-111). They approach the definition of alcoholism in descriptive terms much like Jellinek, but as with other definitions they are "too general and imprecise for the purposes of treatment prescription or prognosis."8

Mark Keller in his article entitled "The Disease Concept of Alcoholism Revisited"(1976), offers a definition of alcoholism which runs:- "Alcoholism is a dysbehaviourism, manifested as repeated ingestion of sufficiently large amounts of alcohol-containing beverage (a) to allow an inference (or to arouse a suspicion) that the behaviour is bizarre, abnormal or deviant, and (b) to cause harm to the ingester's health or social or economic functioning. It is the same as alcohol addiction and is classified as a chronic disease of uncertain etiology and undetermined site."9 Keller intends "disease" in this definition to mean "disablement":- "to be disabled

from consistently choosing whether to ingest alcohol, or, if one does drink some, to be then disabled from consistently choosing whether to stop or not, that is a disease."10

While it is clear there are many disease concepts of alcoholism there are a number of assumptions which seem to be common to them all and which make up what is sometimes called a "unitary model" of alcoholism. Pattison et al.(1977) present the following assumptions of this model-

1. There is a unitary phenomenon that can be identified as alcoholism. Despite variations, there is a distinct entity.
2. Alcoholics or prealcoholics are essentially different from nonalcoholics.
3. Alcoholics experience an irresistable physical craving for alcohol, or an overwhelming psychological compulsion to drink.
4. Alcoholics develop a process of loss of control over initiation of drinking and/or inability to stop drinking.
5. Alcoholism is a permanent or irreversible condition.
6. Alcoholism is a progressive disease that follows an inexorable development through a series of more or less distinctive phases.

Examining the empirical scientific research on each of these assumptions they report "substantial and serious contravening evidence against all six assumptions."11 The current state of flux as regards the meaning of "alcoholism" requires that an adequate working formulation of alcoholism, rather than a strict disease concept, informs attitudes to the development and treatment of the condition. Pattison et al.(1977) have presented such a formulation consisting of the following propositions -

1. Alcohol dependence subsumes a variety of syndromes defined by drinking patterns and the adverse consequences of such drinking.
2. An individuals use of alcohol can be considered as a point on a continuum from nonuse, to problem drinking, to various degrees of deleterious drinking.
3. The development of alcohol problems follows variable patterns over time.

4. Abstinence bears no necessary relation to rehabilitation.

5. Psychological dependence and physical dependence on alcohol are separate and not necessarily related phenomena.

6. Continued drinking of large doses of alcohol over an extended period of time is likely to initiate a process of physical dependence.

7. The population of individuals with alcohol problems is multivariate.

8. Alcohol problems are typically interrelated with other life problems, especially when alcohol dependence is long established.

9. Because of the documented strong relationship between drinking behaviour and environmental influences, emphasis should be placed on treatment procedures that relate to the drinking environment of the person.

10. Treatment and rehabilitation services should be designed to provide for continuity of care over an extended period of time. This continuum of services should begin with effective identification, triage, and referral mechanisms, extend through acute and chronic phases of treatment, and provide follow-up aftercare.

11. Evaluative studies of treatment of alcohol dependence must take into account the initial degree of disability, the potential for change, and an inventory of individual dysfunction in diverse life areas, in addition to drinking behaviour. Assessment of improvement should include both drinking behaviour and behaviour in other areas of life function, consistent with presenting problems. Degrees of improvement must also be recognized. Change in all areas of life function should be assessed on an individual basis. This necessitates using pretreatment and posttreatment comparison measures of treatment outcome.12

There appears to be many definitions of alcoholism, but as Pattison and Kaufman(1982) point out - "This is not necessarily undesirable, as long as one specifies the context, goals and purposes for which a specific definition of alcoholism is employed."13

THE IRISH SITUATION

Facts about alcohol and Ireland:

O Connor and Daly(1985), looking at smoking and drinking behaviour in Ireland report - "Of all those who drink, 40 per cent are moderate drinkers, 39 per cent are light drinkers and 15 per cent are virtual abstainers. Six per cent of all drinkers drink more than the safe limits.....Overall, Irish drinking patterns tend to be more extreme in that they are characterised by both heavier consumption and greater abstention than those in England and Wales."14

Hospital admissions for alcoholism: Admissions for alcoholism and alcoholic psychosis accounted for 25.9% of all admissions and 29.3% of first admissions in 1980. The number of people in their twenties and thirties presenting for treatment for alcoholism and alcohol related problems is increasing.15 It is obvious from these facts that alcoholism is a major problem in Ireland.

Theories about alcoholism in Ireland:

Blaney (1974), in an article on the medical and social aspects of alcoholism in Ireland, looks at some of the theories on the causes of Irish alcoholism.16 Environmental theories at one time often cited the inclement weather, poor food, and the lack of social alternatives to drinking as the origins of alcoholism. Excessive drinking in Ireland is still thought to be related to the lack of social alternatives for young people.

Theories relating to the make-up of the Irish, constituting a racial predisposition, are also referred to by Blaney (1974) in his article.17 Wilson (1969) he says proposed that the taste of alcohol in the mouth is more attractive to the Irish than to others. Views advancing a psychological predisposition to alcoholism, in particular proneness to depression and feelings of inferiority also receive attention.18 These latter psychological factors will be examined in this present study as questions relating to personality. Blaney himself relates the prevalence of alcoholism to the overall level of alcohol use in a population. He points to epidemiological findings of an enormous decline in apparent alcohol abuse at the beginning of this century. From this he concludes that "deeply ingrained Irish racial or even cultural characteristics are unlikely to be a major 'cause' of alcoholism. Prevention of the problem would be more effectively exerted through licencing legislation and taxation policy".19 Issues of an epidemiological nature will not be dealt with in this study.

Cooney (1971) in an article entitled "Alcohol and the Irish" also stresses the relationship between mental illness, especially depression, and alcoholism.20 O'Connor (1978) in a study on drinking among young people in Ireland found that "Parental attitudes towards drinking, rather than parental drinking behaviour or general family relationships, are the most important influences on childrens' drinking behaviour."21 She also found that overall peer group support for drinking was important in shaping the drinking behaviour of young people. Both of these issues are examined in the present study in questions dealing with parents' attitudes to respondents drinking and peer group influence on drinking behaviour.

Purpose of the Study

This study compares two groups of people, an alcoholic group and a non-alcoholic or control group, on questionnaire items of a medical, psychological, and sociological nature. It is intended to investigate whether or not the two groups differ significantly on these items and ultimately to arrive at a conclusion as to the influence of these aspects on the development of alcoholism.

Need for the Study

While studies as to the causes of alcoholism abound there is as yet no definitive view of its aetiology. Up to recent years researchers in the study of alcoholism tended to view the problems from the perspective of their particular discipline only. What existed was a multi- rather than an inter-disciplinary approach to the aetiology issue.

The need for an interdisciplinary approach is increasingly being accepted, and this study hopes to contribute findings of an interdisciplinary nature. This will mean that the relative importance of each discipline, be it medical, social, or psychological in the development of alcoholism can be assessed.

As far as can be ascertained, this is the first study of its kind carried out in an Irish context. It will have the value of testing the various theories of aetiology on an Irish sample, and will lay the groundwork for larger scale research on the causes of alcoholism in Ireland. It could provide information to construct a predictive questionnaire. In addition the study hopes to

inform policy for those intending to take preventive measures in relation to alcoholism in Ireland.

Limitations of the Study

This study is limited to a sample number of fifty-eight which makes it difficult to generalise findings to the greater population of alcoholics and non-alcoholics. However, it is intended that the findings of the study will generate further research on a larger scale into the causes of alcoholism in Ireland. Also this is a retrospective study which requires the respondents to reflect on their past experiences. In the case of the alcoholics, who have undergone treatment for alcoholism, they may have accepted a particular treatment view of their past experiences and may respond according to that view. A related limitation is the unreliability of studies which use self-reporting techniques.

Organisation of the Study

Chapter 1. INTRODUCTION.

Chapter 2. REVIEW OF THE LITERATURE
This chapter is divided into four sections each of which offers a review of a major school of thought on the aetiology of alcoholism. These are (a) The Medical Model; (b) The Psychoanalytic View; (c) The Behavioural Approach; (d) The Sociological Perspective.

Chapter 3. PROCEDURE
This chapter will (a) describe the sample used in this study; (b) describe the methods used to test theories of aetiology; and (c) describe the data-analysis plan.

Chapter 4. PRESENTATION OF RESULTS
This chapter will consist of a presentation of results in the form of a contingency table for each question, statistical analysis, examples of typical responses, and a statement as to the utility of the item.

Chapter 5. DISCUSSION OF RESULTS
This chapter will consist of a discussion of results addressing what the author thinks the results mean with reference to the literature review.

Chapter 6. CONCLUSIONS AND IMPLICATIONS FOR FUTURE RESEARCH
This chapter will consist of the conclusions which can be drawn from the findings of the study and the implications for future research.

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REVIEW OF LITERATURE

THE MEDICAL MODEL OF ALCOHOLISM

A number of theories which come within the scope of the medical model of alcoholism are reviewed here. Genetic theories, with an emphasis on heredity, and offering the most promising results, take up the largest section of the review. Endocrinological, brain dysfunction, and biochemical theories are also considered.

There exists to date unequivocal evidence in support of alcoholism as a family condition. Reviewing studies conducted in the last forty years N. S. Cotton(1979) concludes that on the average almost one-third of any group of alcoholics will have at least one alcoholic parent.1 This admittedly, is a very general statement of aetiology which needs specification. The medical model narrows the field of enquiry since it "applies disease terminology, places responsibility for the care of alcoholics in the hands of physicians, and prods the research establishment to find a cure for the disease."2 Much of the medical research into alcoholism has focussed on heredity as a primary factor in aetiology. Consequently, genetic theories attempt to account for the development of alcoholism in certain individuals.

Genetic Theories

In order to separate the influences of "nature" (heredity) and "nurture" (environment) and so tease out the genetic contribution to alcoholism, two kinds of studies have been used - adoption studies and twin studies.

Adoption studies: Goodwin et al.(1973), in a Danish adoption study, report that male adoptees with an alcoholic biological parent "had nearly twice the number of alcohol problems and four times the rate of alcoholism" as male adoptees whose parents were never hospitalized for alcoholism.3 This study was restricted to male adoptees since it has been found that the transmission of "alcoholic genes" is strongest in men.4 Bohman (1978), in a large scale Swedish study found support for Goodwin's position. Two recent analyses of the Bohman data, Cloninger et al. (1981) and Bohman et al. (1981), "provide substantial evidence that alcoholism does, at least in part, have a genetic basis and that there are two distinct patterns of alcohol abuse with different modes of inheritance."5 The first, more common type is seen in both men and women, has a low degree of inheritance and is triggered by environmental influence. The pattern of abuse is relatively mild, and an alcoholic adoptive parent does mot increase the liklihood of alcoholism in the adoptee. The father seems to supply the "alcoholic genes" to the sons and the mother transmits the genetic influence to the daughters. There is a problem in establishing the mechanism of matrilineal transmission since "an alcoholic intrauterine environment may affect the developing brain of the fetus and influence sensitivity to alcohol in later life."6

The second type of alcohol abuse affects only men. It is a more severe form of abuse, is often associated with criminality, and displays a high degree of inheritance. Environment does not seem to play a significant role in this pattern of alcoholism, although, relying largely on official statistics, the investigators in these studies could not adequately take account of many

environmental stress factors. Cadoret et al. (1980), in an American study, have also remarked on the relative unimportance of environment in early life in the aetiology of alcoholism in men.

These notable studies by Goodwin et al(1973), Bohman(1978), and Cadoret et al(1980), all agree that heredity rather than environment, in the form of an alcoholic upbringing, plays a primary role in the development of alcoholism. Goodwin finds a recurring theme arising from his Danish study- "The possibility that severe forms of alcoholism are influenced by heredity, but less severe forms are not...."8 Concurring with this view, Christian Amark, a Danish psychiatrist found that the children of "periodic" and "compulsive" alcoholics more often became alcoholics than the children of less severe alcoholics.9 One important problem in adoptive studies has been mentioned by Goodwin. That is the fact that very many adoptees are illegitimate, thus making it difficult to establish the identity of the biological father, and so the source of the genetic contribution.10

Twin Studies: The use of twin studies is a second way of isolating the genetic factor in the aetiology of alcoholism. The findings in these studies have been inconsistent, however. In a Swedish study Kaij(1960) found a higher concordance rate for alcoholism among monozygotic(identical) twins than among dizygotic (fraternal) twins, thus indicating a genetic influence.11 Later studies produced more equivocal results. In a Finnish study Partenen et al (1966) found only a difference between monozygotic and dizygotic twins as

regards the amount of alcohol consumed and the frequency of drinking, but there seemed little genetic contribution to the development of addiction to alcohol or alcohol-related problems.12 Making the outcome of these studies even less conclusive, Jonsson and Nilsson(1968) found that "neither the frequency of drinking nor the occurence of intoxication was more concordant in monozygotic than dizygotic twins."13 More recently, two British studies by Clifford et al(1980) and Gurling and Murray(1980) had findings similar to those of the Finnish work "showing a strong genetic influence on the amount of alcohol consumed weekly but not on the occurence of dependence symptoms."14

These findings in the twin studies contrast sharply with the adoption work of Goodwin et al.(1973) where the most severe type of alcoholism showed the greatest genetic component. A reason for this contradiction may be found in the different ways countries classify alcohol-related problems. What might be considered as heavy drinking in one country may be labelled alcoholism in another. There is obviously a definitional problem to be overcome here.

It has been suggested that the most rigorous way to tease out the genetic influence in alcoholism would be to study monozygotic twins reared apart. Shields(1977), in fact, reported on five pairs of monozygotic twins reared apart and found similar drinking habits in four of them.15 However problems arise even here since "zygosity may influence environmental effects".16 Persons who look alike may be treated similarly in life, eg. attractive

female twins may invite similar responses from other people, even though reared apart.

Notwithstanding the difficulties inherent in twin studies, there exists impressive evidence in support of a genetic contribution to alcoholism. Clifford et al.(1981), using techniques of biometric genetics, which are sensitive to the environmental similarities of twins, have shown that "the level of alcohol intake is influenced by inherited factors in both sexes and that in men there is a genetic contribution to escape-drinking and some alcohol-related problems..."17

Mechanisms of Heredity: If one agrees, and the weight of evidence exists, that heredity plays an important role in the aetiology of alcoholism, how does the transmission take place from one generation to the next? A single dominant or recessive gene responsible for the inheritance of alcoholism does not seem likely since family studies by Amark(1951) and Winoker et al.(1971) report that "the alcoholism rates for first-degree and second-degree relatives of alcoholics are the same."18 Studies by Goodwin et al.(1973) and Partenen et al.(1966) suggest that the mode of inheritance "seems specific for drinking behaviour (at least in men) and is not just symptomatic of a more generalized personality disorder or psychiatric disturbance".19

Neither are the physiological mechanisms involved in the inheritance of drinking behaviour very clear. It is known that there are differences

between populations in the relative frequency of the genetic variant of the enzyme alcohol dehydrogenase(ADH). This enzyme oxidizes ethanol to acetaldehyde (an intoxicating substance). A form of the enzyme known as "atypical" ADM in the West is commonest in Japan. In fact Stamatoyannopoulus, Chen and Fukui(1975) reported the frequency of "atypical" ADH in the Japanese to be about 85% which related exactly to their frequency of alcohol sensitivity. These results hypothesized a causal link between the enzyme and alcoholism which has not been tested, however.

Some studies have found the rates of ethanol elimination to be under genetic control(Vessel1972; Forsander and Eriksson 1974). They reported heritability to be as high as 80 to 90 per cent.21 Following on these findings Schuckit and Rayses(1979) studied two different groups of young men who had been given alcohol. One group had an alcoholic parent and the control group had not. They found that the first group had "higher concentrations of acetaldehyde in the blood than did the controls - an important finding, since acetaldehyde has been postulated as a substrate in the formation of potentially addictive tetrahydroisoquinolines(THQS).

Marker Genes: The findings of a genetic contribution to alcoholism have led to a search for marker genes (genes which specifically contribute to a predisposition to alcoholism) which would make possible easy identification of the potential alcoholic. The most promising lead has been the association between alcoholism and the non-secretion of the ABH blood group substances in the saliva. This association has been noted by Camps, Dodd and

Lincoln(1969); Swinson and Madden(1973); and Race and Sanger(1975).23 Another lead is in the link between alcoholism, among other psychiatric conditions, and low platelat monoamine-oxidase(M.A.O.). Major and Murphy(1978) have shown that "the first-degree relatives of low-M.A.O. alcoholics have a higher incidence of alcoholism than the relatives of alcoholics with higher M.A.O."24 In spite of a great deal of research studies undertaken, a conclusive link between marker genes and alcoholism has not yet emerged.

Endocrinological Theories

Tintera and Lovell(1949) suggest that alcoholism is a self-perpetuating glandular disorder. The ingestion of alcohol by potential alcoholics, they argue, results in a disturbance to the endocrine system. Continued drinking leads to a deficiency in adrenocortical hormones which causes stress. The suffering individual drinks to alleviate the stress and exacerbates the condition resulting in adrenal insufficiency. A chronic imbalance results causing repeated alcohol consumption which in itself is thought to be the disease.25

Brain Dysfunction Theory

This theory suggests that minimal brain damage, genetically inherited, may account for the development of alcoholism. Tarter, Mc Bride, Buopane, and Schneider(1976) found that "severe drinkers reported more symtoms of childhood hyperactivity and other indices of minimal brain dysfunction than less severe drinkers." Also a parent or close relative of the severe drinkers was alcoholic.26 Goodwin et al.(1975) and Morrison and Steward(1973a;

1973b),in adoption studies, found alcoholism to be genetically inherited.27 Cantwell(1972) found that the children of alcoholics suffered from minimal brain dysfunction.28 Concluding from the above studies, Tarter and Schneider(1976) comment, "the mode of inheritance in alcoholism may be a neurochemical deficiency which in childhood is manifested as minimal brain damage."

Biochemical Theories

In this approach alcoholism is thought to be a food addiction(Randolph 1956).28 It is claimed that the potential alcoholic is sensitive to certain foods which afford a "pick-up" feeling. Alcohol also contains these stimulants and has the added advantage of quick absorption into the body. However, after the "pick-up" comes the let down with excretion and consequently the need for more alcohol to relieve this stressful state.

CONCLUSION

Of all the approaches within the medical model the genetic theory of alcoholism, emphasizing heredity, has shown the most promising results. Impressive evidence has been gathered from twin and adoption studies, which attempt to separate the influence of inheritance from the environment. The precise mechanisms of inheritance are not very clear. The enzyme, alcohol dehydrogenase, and the rates of ethanol elimination have been implicated in the inheritance process. The search for marker genes had led researchers to examine the association between the ABH blood group substances in the saliva and alcoholism; and also the link between alcohol addiction and low platelet monoamine-oxidase(M.A.O.). Endocrinological, brain dysfunction and biochemical theories have received some notice, but have not proved as promising as the genetic theory.

It appears there is a case for alcoholism as an inherited disease. It is doubtful, however, that genetic inheritance is the only factor in the aetiology of alcoholism. It seems likely that there are also many psychological, social and physiological factors impinging on any individual, and combining in certain predisposed individuals to result in the condition we know as alcoholism.

Factors relevant to the medical model which will be dealt with in this study are, alcoholism as a family condition, and the relation of hyperactivity and physical illness to alcoholism.

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PSYCHOANALYTIC VIEWS ON THE AETIOLOGY OF ALCOHOLISM

This section consists of (a) a brief introduction to psychoanalytic theory and therapy; (b) the psychoanalytic position on the aetiology of alcoholism, both traditional and recent; (c) the relationship between homosexuality and alcoholism; and (d) empirical evidence of the psychoanalytic views of alcoholism.

Psychoanalytic Theory and Therapy

Psychoanalytic theory is primarily concerned with intrapsychic events, that is, with events which take place within the mind. The focus of psychoanalytic enquiry is not on human behaviour but rather on the intentions behind behaviour and so deals mainly with personality. Psychoanalytic theory is based on a specific understanding of personality development involving the interaction of three major systems of personality, the Id, Ego and Superego. It proposes that the well adjusted individual has achieved a proper balance between the role of the Id (instinctual energy), the Ego (the rational self), and the Superego (the conscience), with the Ego in a dominant position. The crucial role of the Ego can be understood as follows- "the ego serves as a mediator among the three basic forces acting upon an individual - the demands of the id, the requirements of reality (of the external environment), and the limitations imposed by the superego. It is therefore the task of ego to see that instinctual needs are met in a realistic and at the same time, socially approved manner."1

Psychoanalytic therapy is employed to bring about the essential ego strength in the disturbed individual. This personality change is wrought by making conscious what is unconscious. Up to now the weak ego had failed to develop because too much psychic energy has been used up in ego defences(1) like repression(2) which blocks out of consciousness unpleasant memories and thoughts. It should be said that in Freudian psychology the individual has a limited amount of psychic energy at his disposal, so any accumulation of this energy in one system of personality will leave the other systems depleted. In the supportive analytic situation defences are gradually removed, allowing more of reality into consciousness and thus promoting the growth of the ego. The individual should emerge from an analysis with more ego strength at his disposal and consequently better able to deal in a realistic way with his life. As Freud saw it the ultimate goal of analysis "was to secure the best possible psychological equilibrium for the functioning of the ego, threatened and challenged on three sides as we have seen it to be: by the external environment, by the super-ego, and by the remorseless instinctual drives of the id."2

Although all contemporary psychoanalytic approaches to personality originate with Freud, they do not end with Freud. Neo-Freudian psychoanalysts, while retaining the concepts of biological endowment and early childhood development, have placed an emphasis on social-interpersonal factors which form personality. It can be said that neo-Freudian psychoanalysis utilizes two dominant personality themes: (a) the social interpersonal influence on personality and (b) the reality oriented ego psychology concerned with higher

mental processes such as thinking and problem solving. However most analysts would incorporate both themes in their approach to personality development.3

The interaction between psychoanalytic theory and therapy is quite vigorous; the advances in theory suggesting what therapeutic procedures will be adopted and findings in psychotherapy reflecting back on the theoretical assumptions. Before going on to review the psychoanalytic literature on alcoholism it would be useful to offer a definition of addiction generally accepted by psychoanalysts, which runs; "....in speaking of addiction, psychoanalysts refer to dependence on a substance, an activity or a person, believed to provide pleasure on the one hand and relief from psychic pain (anxiety, etc.) on the other hand. Such dependence is conceived of as resulting from development failure. Addiction protects the individual from the graver consequences of this failure, suicide, psychosis, asocial or criminal behaviour. It represents a compromise solution."4 This definition holds true when one considers that many alcoholics have secondary addiction problems with other mood altering chemicals, with gambling, and with over-eating.

Psychoanalysis and Alcoholism

Alcoholism is understood from the psychoanalytic viewpoint as a symptom of an underlying disorder in the individual which is in short, a failure to grow. E.M. Blum(1964) in her article entitled Psychoanalytic Views of Alcoholism regards the illness "as a substitute for emotionally mature adaptation, as a means of dealing with conflicts and attendant psychic pain..." She stresses

that addiction to alcohol "should be attributable to a multitude of specific failures in emotional growth and constellations of family circumstances."5 She also outlines some of the circumstances and consequences attendant upon the alcoholic's failure to grow as, undue dependency, unhealthy relations with inadequate parents, and fixation(3) at developmental stages. These factors among others receive close attention in the literature review that follows, which can be divided into (a) traditional and (b) recent psychoanalytic views on the aetiology of alcoholism.

Traditional Views

Traditionally psychoanalysts identified the defence mechanism of fixation, primarily at the oral stage of development, as a typical personality disorder in the alcoholic. Rado(1933), for example, understands alcoholism to be a narcissistic disorder comparing it to the narcissism of the infant. The alcoholic, he claims, is orally fixated and so has diminished ego strength resulting in a dependency on alcohol in the face of life. He says: " the ego (of the alcoholic) compares its current helplessness with its original narcissistic stature which persists as an ideal for the ego..."(p.68); suggesting again an orally fixated status in the alcoholic.6

Glover(1928, 1932) finds oral fixation and early aggression and destruction as highly significant in the aetiology of addiction to alcohol. He also makes the important point, often overlooked by investigators in the field of alcoholism, that the alcoholic syndrome is a defensive and restitutive symptom. In other words the alcoholic is (a) attempting to restore a

connection with reality, and (b) is protecting himself against a more serious pathological situation. He proposes a psychic condition in the alcoholic which is dangerous and which manifests in the individual's self-hate and ambivalent identification with objects. Alcohol is used in an attempt to cure the underlying disorder but results only in self-destruction.7

Fenichel(1945) is in agreement with Rado and Glover when he describes the addiction to alcohol as an attempt "to satisfy the archaic oral longing which is sexual longing, a need for security and a need for the maintenance of self-esteem simultaneously"(p.24). Fenichel emphasizes the psychological make-up of the individual as most significant in the aetiology of alcoholism.8

For Chodorkoff(1963) the defense mechanism of regression(4) plays a primary role in the onset of alcoholism. He talks of the alcoholic as a person with ego deficiency manifesting in disturbances in object relationships. "This may result," says Chodorkoff, "either from a loss of object (probably early in life, to which the ego reacts by a withdrawal from personal objects, i.e. regression), or from an absence, in early development, of an impetus to seek object relationships."

As a consequence, the prealcoholic (the personality of the individual prior to his addiction to alcohol), develops a relatively safe relationship with his own body as an object. In order to reassure himself of the continued existence of this relationship the person who becomes an alcoholic resorts to

alcohol, thus registering the fact of the ego-body relationship in experienced physiological changes. Constantly seeking to re-experience the physiological change the individual develops alcoholism. Given the precarious state of the ego in a person predisposed to alcoholism, the process of intoxication wards off the threat of dissolution of the ego.

Progression in the drinking behaviour results in increased physiological tolerance to alcohol. Thus the alcoholic becomes more threatened with ego extinction. Rather than feel the pain of original object loss the alcoholic allies himself, as it were, with the destructive drinking behaviour in an attempt to destroy the body. He drinks now in a suicidal manner, exhibiting a love/hate relationship with the substance that no longer supplies the desired bodily sensations or ego-body relationship. In an attempt to avoid the severe depression attendant on the loss of object early in life the alcoholic often destroys himself.

Finally, Chodorkoff(1963) focuses on the often neglected issue of the result of the drinking process itself. He believes "it serves to remove the alcoholic from external objects. It is as though after experiencing early object loss, or never possessing objects, he does not venture forth to reestablish old or establish new ones." The withdrawal from the external world magnifies the importance of the ego-body relationship. This view of Chodorkoff's, clinically verified in his paper(1963), gives weight to the description of alcoholism as, in popular parlance, "the lonely disease".9

Recent Formulations

Building on the traditional analytic view of alcoholism, with its emphasis on instinctual drives and fixations, "more recent formulations have attempted to account for the dynamics of alcoholism by considering the nature of the vulnerabilities and disturbances in psychic structure" of alcoholics.10 In particular the focus is on "ego structures responsible for regulating behaviour and feelings, and self-structures that are important in maintaining self-esteem and inner states of comfort and well-being."11 The ego and self structures develop in the child through internalizing(5) qualities of the parents such as caring, admiring and protecting. An absence of these qualities in inadequate parents results in underdeveloped ego and self structures in the child who will be more susceptible to alcohol addiction.

Ego Structures: Disturbances in ego structures would be evident by the absence of the capacity for self-care, a function which manages external dangers and consequences of careless behaviour. According to Khantzian(1982) alcoholics show a deficiency or absence of self-care, which accounts for much of their disastrous and destructive behaviour. This deficiency is reflected in the prealcoholic characteristics of impulsiveness, restlessness and delinquent, aggressive or violent behaviour which is commonly featured in the prealcoholic makeup. The capacity for affect regulation is diminished by the utilization of regression which undermines an important stimulus barrier resulting in an influx of unbearable feelings. To divert extreme affective discomfort denial and/or alcohol is used. Both Kernberg(1975), and Klein(1975) found

difficulties in affect regulation to have a significant relationship to alcoholism.12

Self-structures: Khantzian(1982) goes on to suggest a relationship between impairment in self-structures and alcoholism. The development of "a sense of self" involves internalizing qualities and attitudes from parents who are seen to care for the child. Unhealthy dependency arises from problems in the self-structure according to Khantzian. Again, detaching from Freudian interpretations of dependency in alcoholics, which stress oral cravings and infantile attachments, he attributes more to "the result of defects and vulnerabilities in ego and self-structures" in the aetiology of alcoholism. He further argues that faulty ego-ideal formation, (the self's conception of how he wishes to be), results in a low self-esteem where a particularly harsh superego(6) prevails. It is interesting to note here that the superego has been described as "the part of the mind that is soluble in alcohol".13 In that case the imbibing of alcohol would provide a temporary reprieve from self-condemnation, since it would work as an ally against an overly critical superego.

The reasons alcoholics become dependent on alcohol, people or activities is, in Khantzian's view, "not so much for gratification of oral, infantile drives and wishes, but more as attempts to feel better or good about themselves, as they are almost totally unable to achieve this for themselves from within."14

A serious result of disturbances in ego and self structures is the development of pathological self formations, such as compensatory defences. Kernberg(1978) underlines the rigid and primitive defences of splitting(7), denial(8), and projection(9), which cause repression(2) and dissociation(10) of parts of the self. The ingestion of alcohol serves to bring about a false sense of integration.15 Krystal and Raskin(1970) and Krystal(1977) argue that alcohol allows a return of blocked-off feelings of aggression and love affording temporary honest communication to exist.16 Kohut(1971,1977) emphasizes how alcohol "acts to release individuals from compensatory and/or defensive reactions such as massive repression, self-sufficiency, and disavowal, and allow self-soothing and resurgence of self-esteem."17 Siber(1970,1974) has remarked on how alcoholics have identified with and internalized (a process by which objects in the external world acquire permanent mental representation) pathological and destructive aspects of parents and how the damaging effects of alcoholism reflect this identification.

Homosexuality and Alcoholism: The often proposed positive relationship between alcoholism and homosexuality is most credible when viewed as a consequence of a narcissistic disturbance. Calvin Hall(1954) suggest that a person under a strong influence of narcissism may derive satisfaction only from choosing a love object who resembles himself and may choose homosexuality in preference to heterosexuality.18 Operating within the parameters of the narcissistic, pre-genital stage a number of views are put forward linking alcoholism and homosexuality.

Rado(1933) attributes the alcoholic's homosexual preference to masochistic and sadistic trends of personality resulting in an eventual lack of genital interest and where oral feelings predominate.19 Blum(1966) explains that alcoholics can be fixated or regress to three different stages of development, the oral, anal, and phallic-oedipal stages. Alcoholics fixated at the anal stage are considered to be homosexual- Knight(1937); Riggal(1923); Weisl(1944). Unwarranted hatred of members of the same sex and persecution complexes in alcoholics have been attributed to a cover-up for an unacceptable homosexual attraction- Abraham(1926); Ferenczi(1912); Kienholz(1924); Lewis (1941); Wholey(1918).20

Against the positive relationship between homosexuality and alcoholism Glover(1932) does not see an aetiological significance in homosexual fantasy systems. He says- "the element of unconscious homosexuality had never accounted satisfactorily for variations in the structure of different addictions and it was generally found to be non-specific."21

The point should be made that there is a danger in misinterpreting the relationship between homosexuality and alcoholism by confusing effect with cause. Hartman(1925) in his study of cocaine discovered that homosexuality was often acquired as an effect of taking the drug which caused regression to occur.22 "A similar situation", says Blum(1966) "obtains in alcoholism where the physiological effects also impair higher level functioning and initiate regressions."(p.269). In that case abstention from alcohol plus recovery

treatment would result in de-regression and a return to the heterosexual state for the individual.

So far it has been shown that psychoanalytic theory views alcoholism as symptomatic of a personality disturbance manifesting in a failure of the individual to grow. This disturbance was traditionally thought to be of an oral or narcissistic nature. However, while these traditional views are far from being obsolete recent attention has focused more on ego impairment as a predisposing factor in alcoholism. Disturbances in ego and self-structures have been found to underly much of the destructive and maladaptive behaviour of alcoholics.

Empirical Evidence

Findings relating to a personality predisposed to alcoholism present an uneven picture. While there is evidence to support the concept of a prealcoholic personality it is not definitive. Longtitudinal studies using M.M.P.I.,(Minnesota Multiphasic Personality Inventory), alcoholism scales, carried out by Hoffman, Loper and Kammeier (1974, 1978) have produced evidence to support the claim for a prealcoholic personality. They found that prior to the addictive stage alcoholics scored higher on the Pd (psychopathic deviate), Ma (hypomania) and MacAndrew Scales (a scale used to separate alcoholics from psychiatric patients), than did their college freshman classmates, thus proposing a personality type predisposed to alcoholism. Their findings also point to the fact that depression may be caused by alcoholism rather than being a prealcoholic personality trait. They conclude that while the

"personality component is only one factor in the development of the eventual condition of alcoholism.....the role of personality factors is no longer speculative."23

Jones(1968) reported similar results.24 McCord and McCord(1962), not using objective personality batteries and follow-up testing, found prealcoholics surprisingly more independent and self-confident than were controls of the same age level.25 Robins et al.(1962) found a higher incidence of antisocial behaviour among prealcoholics who had been in a children's mental health clinic than among a control group from the same clinic.26 These studies seem to show up a lack of control as a possible characteristic of prealcoholics which could serve as an umbrella term for disturbances in self and ego structures proposed by Khantzian(1982) above.

Loper et al.(1973) hypothesize that a prealcoholic may be lacking in ego-strength but this has not been directly tested using the ego-strength scale.27 McCord(1972), researching aetiological factors in alcoholism, found conditions predisposing to poor self-esteem to be significant in the onset of alcoholism.28 Williams(1965) showed that "problem drinking among college students was positively correlated with self-criticism and negatively correlated with self-acceptance and with real-self-ideal-self correspondence.29 Continuing the quest for a prealcoholic personality Kammeier et al.(1973) observed that neurotic traits in alcoholism seem to be more a result of the disorder than a reason for it. Neurotic characteristics tended to increase significantly during the drinking stage and tended to

decrease during treatment.30 However this finding does not discount the claim for a personality predisposed to alcoholism since drinking would exacerbate neurosis already present in an individual and treatment would go some way towards ameliorating the neurotic state.

Research into the relationship between field dependence, (the tendency to perceive the external world as being less well-articulated, accompanied by a similar tendency to perceive the internal functioning of one's body in a less defined way), and alcoholism has yielded significant results. A number of studies- Karp et al.(1965); Karp and Konstadt(1965); Karp et al.(1965); Jacobson et al.(1970)- concluded that alcoholism does not lead to field dependence.31 Because field dependence does not fluctuate during the drinking history or in treatment Witkin et al.(1962) regard it as a pre-disposing factor in alcoholism.32 Support for this argument is found in evidence that field dependence may predispose to other forms of addiction, like heroin addiction Arnon et al.(1974), and overeating Karp et Pardes(1965).33 Other studies - Goldstein and Chotlos(1966), Chess et al.(1971), Jacobson(1968), and Kristofferson(1968), - contest the stability of field dependence in the alcoholic personality. Their findings showed that field dependence was reduced after a period of abstinence.34 While debate continues over the association between field dependence and alcoholism there is strong evidence in favour of the possibility that field dependence precedes alcoholism.

Reviewing the phenomenon of field dependence in alcoholism Kalliopuska(1982) suggests that a study of the "separation-individuation process of the oral

stage and field dependence might provide a basis for approaching the development of the prealcoholic personality." Referring to Kohut(1971), who emphasized narcissistic problems of development in the aetiology of alcoholism, she further suggests that narcissistic disturbances "may later result in field dependence, external locus of control and low self-esteem."35

Vaillant(1983), in a large prospective study came to the conclusion that genetics play an important aetiological role in alcoholism. He goes further to suggest that people working in the field should "stop trying to treat alcoholism as if it were merely a symtom of underlying distress."36 Dismissing claims for underlying psychopathology in alcoholism he explains the condition by refering to an old Japenese proverb - "First, the man takes a drink, then the drink takes a drink, then the drink takes the man." Criticizing Vaillant's aetiological position, Peele(1983) makes the point that there is strong evidence which underlines the relatedness of different forms of substance abuse, suggesting a psychological rather than a genetic influence in addiction to alcohol. This fits in with the psychoanalytic view of addiction given above. He asks then - "What shall we call the predisposition to abuse chemically unrelated substances that these people manifest , and how may it be passed along through the genes?"37

He offers an interpretation of alcohol abuse - for him an equivalent behaviour to other substance abuse - as a reaction to personal or situational needs. He suggests that the form the pathological excess will take, whether it be alcohol or narcotic abuse, will largely depend on "social influences

emanating from cultural and ethnic, and family and peer groups."38 The role of personality is again stressed in Peele's interdisciplinary approach.

Reviewing the evidence for the concept of a prealcoholic personality Barnes(1979) states that alcoholics do have a fairly typical personality pattern when they arrive for treatment. He suggests that this common personality pattern "exists, no doubt, as a cumulative result of a prealcoholic personality and the effects of a person's drinking history on that personality pattern."39 However, in order to clarify the role of personality in alcoholism more studies, both longtitudinal and interdisciplinary are called for.

CONCLUSION

It has been shown in this section that a variety of personality factors can be at work in predisposing an individual to alcoholism. Accepting these multiple determinations a unitary aetiology does not seem likely. It would be fruitless and misleading to force a diagnoses of oral fixation or ego disturbance exclusively on the population of alcoholics regardless of their different life experiences. Blum(1968) makes the valid point that - "A dynamic diagnosis will depend upon the stage of emotional growth achieved by the individual alcoholic and upon the corresponding love choices he makes and the ego defences he has at his disposal. Psychoanalysis rests on the study of the individual history of the patient to arrive retrospectively at what might have been the particular constellation of factors which resulted in his particular symptomatology."40

While it would seem wise to avoid seeking any single cause of alcoholism, the concept of an alcoholic personality, with the disturbed personality as a predisposing factor to alcoholism, has been shown to have real meaning. The nature of this disturbance can be discovered retrospectively in the indepth analytic manner. Patterns of disturbance like oral fixation, regression, and ego impairment, have emerged over the years supplying strong evidence for the role of personality in the development of alcoholism. The variety of diagnoses of the predisposing disturbance should not take from the validity of a claim for a prealcoholic personality. If one has to make a general statement about aetiology and the personality in alcoholism it can be said

that the predisposing factor is a failure of the personality to grow normally or fully.

To conclude, in the light of the evidence gathered in this section the involvement of personality in the aetiology cannot be ignored. The nature of the involvement may be different in each individual case but there is growing evidence that developmental failure leaves the affected individual unusually vulnerable to alcoholism.

This study will deal with a number of personality characteristics mentioned in this review of the psychoanalytic model. These include, anger and frustration, impulsiveness, dependency, self-esteem, and depression. It will deal with sexual relationships, and the relation of homosexuality to alcoholism. The question of a prealcoholic personality will also be looked at.

NOTES

(1) Defence: "A general designation for all the techniques which the ego makes use of in conflicts which may lead to neurosis." Freud(1922) in Rycroft, Charles. A Critical Dictionary of Psychoanalysis, Penguin Books, Middlesex, 1968. p.28.

(2) Repression: The process (DEFENCE mechanism) by which an unacceptable IMPULSE or idea is rendered UNCONSCIOUS. Rycroft(1972) p.142.

(3) Fixation: The process by which a person becomes or remains ambivalently attached to an OBJECT, this object being one which was appropriate to an earlier stage of DEVELOPMENT. Fixation is therefore evidence of failure to progress satisfactorily through the stages of LIBIDINAL DEVELOPMENT. Rycroft(1972), p.52.

(4) Regression: In general, reversion to an earlier state or mode of functioning. Specifically, defensive process by which the subject avoids (or seeks to avoid) ANXIETY by (partial or total) return to an earlier stage of LIBIDINAL and EGO DEVELOPMENT, the stage to which the regression occurs being determined by the existence of FIXATION-POINTS. Rycroft(1972) p.138.

(5) Internalization: ...that process by which objects in the external world acquire permanent mental REPRESENTATION, i.e., by which PERCEPTS are converted into images forming part of our mental furniture and structure. Rycroft(1972) p.75.

(6) Superego: That part of the EGO in which SELF-OBSERVATION, self-criticism, and other reflective activities develop. Rycroft(1972) p.160.

(7) Splitting: A process (DEFENCE mechanism) by which a mental structure loses its integrity and becomes replaced by two or more part structures. Rycroft(1972) p.156.

(8) Denial: A process (DEFENCE mechanism) by which either (a) some painful experience is denied or (b) some impulse or aspect of the self is denied. Rycroft(1972) p.29.

(9) Projection: In psychoanalysis two sub-meanings can be distinguished: (a) the general misinterpretation of mental activity as events occurring to one, as in DREAMS and HALLUCINATIONS; and (b) the process by which specific IMPULSES, wishes, aspects of the SELF, or INTERNAL objects are imagined to be located in some OBJECT external to oneself. Rycroft(1972) p.125.

(10) Dissociation: The state of affairs in which two or more mental processes co-exist without becoming connected or integrated. Rycroft(1972) p.35.

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THE BEHAVIOURAL APPROACH TO ALCOHOLISM

John Watson(1913), one of the founders of the behavioural school described psychology as "a purely objective branch of natural science. Its theoretical goal is the prediction and control of behaviour. Introspection forms no essential part of its methods, nor is the scientific value of its data dependent upon the readiness with which they lend themselves to interpretation in terms of consciousness."1

In these early days and up to recent years behaviour theory, what existed of it, was extremely parsimonious. It did not make many assumptions beyond behaviour. It interpreted behaviour by referring only to a limited set of principles, such as, classical conditioning(a) and operant conditioning(b). The main criticisms levelled against behaviourism include - "an emphasis on superficial behaviour derived from a laboratory model of animal behaviour; a disregard of the most human of all data - cognitions (although the gathering cognitive emphasis is beginning to blunt this criticism); a very narrow focus on environmental contributors to behaviour at the expense of the ways in which we process information about that environment; the failure to incorporate systematically predispositions such as genetic endowment; problems in defining exactly what constitutes a stimulus or a response; and (especially as regards Skinner) the lack of an overall, explicitly stated theory of behaviour."2

Contemporary Social Learning Theory developed out of these perceived inadequacies. While the traditional learning theory proposed a view of the human as a passive recipient of environmental stimulation, more advanced theorists like Rotter(1950's) and Bandura(1960's) emphasized the role of both cognitive(c) and motivational(d) factors in the process of learning. There is a difference of focus between Rotter and Bandura. Rotter is concerned with "explaining how a person chooses one behaviour rather than another from an existing repertoire." Bandura places the emphasis on "the learning and acquisition of new behaviours."3 The latter's work has investigated the role of self-efficacy in both learning and behaviour. His committment to cognitive variables is evident by his belief in vicarious reinforcement(e), where a person can learn behaviour by observing another's behaviour being reinforced. He also believes that a person's behaviour is guided by expectations of reinforcement. This movement, in recent years, to include cognition and advance Behaviour Theory beyond the narrow perspectives of traditional learning theory has also had its effect on behaviour therapy.

Behaviour therapy is based directly on the learning principles of Behaviour Theory as we have seen it above. Joseph Wolpe's method of systematic desensitization(f) applies counterconditioning techniques. The aim is to "condition the individual to make responses incompatible with the undesirable ones (eg. relaxation rather than anxiety)."4 Applying the Skinnerian approach, based on operant principles, to behaviour problems, undesirable behaviour is modified by reinforcing desirable behaviour. The role of cognitive factors in behavioural psychology has also influenced therapy

techniques. Insight and understanding are now accepted as playing an important part in behaviour modification. For instance, "the cognitive restructuring(g) technique teaches individuals to reflect on how they construe certain situations so as to become emotionally upset."5 With this insight they can strengthen themselves emotionally against threatening situations.

Behaviour Principles Applied To Alcoholism

According to Behaviour Theory all drinking behaviour from social drinking to alcoholism, is governed by behavioural principles of learning and reinforcement. In the behavioural approach to alcoholism the emphasis is on antecedents and consequences of drinking. Antecedents include "the individual's past learning history, prior experiences with alcohol, and cognitive processes and expectations about the effects of alcohol."6 The consequences of drinking are evident in the reinforcing qualities of alcohol and "the social and interpersonal reactions experienced by the drinker."7 This behavioural understanding or approach to alcoholism has developed in line with the general growth of Behaviour Theory to include the cognitive aspects of social learning theory. Beginning with the early behavioural interests in alcoholism it will be useful to outline this development up to present day concerns.

Traditional Approaches

The earliest behavioural interest in alcoholism was in the area of treatment, while little attention was directed towards the aetiology of the disorder.

Within a classical conditioning paradigm the treatment of alcoholism was attempted by the use of aversive therapy techniques(h). More will be said about aversion therapy under Treatment in this section. This view of alcoholism as a disorder acquired by a classical conditioning process is founded more on attempts at treatment by aversion therapy than on any clear understanding of aetiology. Ludwig and Wikler(1974) have attempted to explain the phenomenon of craving among alcoholics by claiming that this craving "can become classically conditioned to stimuli that are related in time with the withdrawal experience. These stimuli include the physical environment, drug-using or drug dispensing associates, and certain emotional states."8

[An expansion of the classical conditioning model is found in the emphasis placed on cognitive factors by Ludwig and Wickler(1974). They suggest that the alcoholic may interpret associations and the feelings they arouse with a cognitive set (eg. the company of drinkers, a pub or social gathering, or the loneliness of a hotel room) as a craving for alcohol. As Marlatt and Donovan(1982) point out, "....a relatively straightforward attempt to explain craving for alcohol by a simple classical conditioning paradigm has thus been expanded to a more complex interpretation."9]

Another early behavioural understanding of alcoholism was based upon the apparent tension-reducing pharmacological effects of alcohol as a factor in the aetiology of problem drinking. This approach applied Hullian(1950s) learning principles such as reinforcement and was called the

Tension-Reduction Hypothesis (TRH). It was believed that alcohol relieved tension, which effect reinforced the response of drinking and led to increased drinking. However, no results unequivocally supported this view of alcohol as a tension-reducing agent and this narrow focus on overt behaviour had to be expanded to include covert cognitive factors like expectancy and anticipation. With more recent research it appears that the anticipated effects of alcohol, more than the actual effects, constitute the reinforcing effects of drinking to the alcoholic. Admitting cognitive processes the emphasis changed to how the individual interprets arousal and its alteration, and to his or her beliefs and expectations about the effects of alcohol. It is now recognized that "personal attributional processes play an important role in any hypothesis that focuses on alcohol as a tension-reducing agent."10

Skinnerian principles of operant conditioning succeeded the Tension-Reduction Hypothesis (TRH) in the mid-'60s. The focus on the consequences of drinking which characterised the TRH is maintained in the operant approach. However, the operant approach manages to combine both the classical conditioning approach and the Tension-Reduction Hypothesis. It takes account of both the focus on the antecedents and the reinforcing consequences of drinking contained separately in the other two approaches.

In the operant approach the antecedents operate as cues such as mood state cues like depression, anxiety, loneliness, boredom or simulated cues such as drinking company or pub atmosphere. These antecedents have acquired

secondary reinforcing properties in the operant approach. Again the non-mediational or traditional view which holds that reinforcement shapes behaviour directly, has been extended to include cognitive factors like the individual's perceptions, beliefs and expectations. In relation to drinking, the operant approach "suggests that the individual has developed a number of generalized and specific expectations about alcohol and its effects. For the problem drinker, drinking appears to have acquired a high level of perceived value as a reinforcer relative to other behaviours that might produce a compatible outcome".11

We can see that the early principles of learning (classical and operant conditioning) did not adequately explain the development of alcoholism in the individual, and that factors like beliefs and expectations play a key role in any comprehensive model of alcoholism. This progression in understanding which resulted in cognitive social learning approaches is based on Bandura's(1969) Social Learning Theory which asserts that alcoholics are people who have acquired, through differential reinforcement(i) and modelling(j) experiences, the maladaptive behaviour of excessive drinking in order to cope with stressful situations(k). On the question of modelling, O Leary, O Leary, and Donovan(1976) found that parents of alcoholics often failed to offer a model for social drinking since they themselves tended to use alcohol as a means of coping with life.12 It is possible that this modelling influence may also shape the individual's expectations about the reinforcing effects of alcohol. While Bandura's theory is consistent with the behavioral hypothesis that all behaviour is influenced primarily by the

external environment he himself "has recently developed a cognitive formulation of behaviour that relies heavily upon the notion of perceived self-efficacy."13

Cognitive-Behavioural Model

Marlatt and Donovan(1982) outline what they call A Cognitive-Behavioural Model of Problem Drinking. They list the following factors which appear to operate interactively and bear heavily on the probable occurence of excessive drinking:-

(a) Expectations about the effects of alcohol. They propose that where "the individual has developed the belief that drinking will increase feelings of personal power or perceived control, as well as decrease stress, alcohol becomes a prepotent source of reinforcement."14

(b) Inadequate social skills. If the individual has not developed responses alternative to drinking in high-risk situations his chances of remaining sober are decreased. Also if he "fails to perform an adequate coping response, the level of perceived self-efficacy is lowered,"15 which according to Bandura(1977) leads to a feeling of powerlessness and drink.

(c) The social environment as regards the "availability of alcohol and the constraints upon drinking in the particular situation."16

(d) Pressure from another individual or group, eg., "social pressure to conform, modeling, evaluation or criticism by others, being frustrated or angered by others....."17 Also external environmental circumstances (like

unemployment) which the individual feels are beyond his control or threatens his perception of control are high-risk situations.

The Cognitive Social Learning approach combines the early behavioural principles with cognitive factors to explain a wide range of drinking behaviour from its acquisition to its maintenance and progression. As would be expected any advances in the understanding of alcoholism are reflected in treatment procedures. It is not surprising then that the treatment of alcoholism has seen a parallel evolution from early behavioural techniques like aversion therapy to a broader spectrum package of treatment which includes social training techniques and assertiveness training.

Behaviour Therapy

In general, behavioural literature has been outcome rather than theory oriented. Contemporary behaviour therapy is more concerned with practical considerations of treating patients' problem behaviour, and it is in this area of treatment outcome that its efficacy can best be assessed. Because of its apparent debunking of the disease model of alcoholism, behaviour therapy can aim at total abstinence or controlled drinking as a treatment goal. At the initial assessment stage many behaviourally designed treatment programmes administer (a) a modified version of The Marlatts Drinking Profile Questionnaire (Marlatt 1976). This questionnaire determines basic history, drinking data, and identifies the antecedents and consequences of alcohol consumption; (b) a standard MMPI (Minnesota Multiphasic Personality

Inventory) to detect other forms of psychopathology which may exist, and (c) administer the A.E.Q. (Alcohol Expectancy Questionnaire), designed by Brown, Goldman, Inn and Anderson in 1980, which attempts to list an individual's range of expectations of reinforcement from drinking alcohol.18

After a rigorous assessment has been made treatment goals can be established. There is an increasing tendency to employ a broad-spectrum treatment package, as opposed to more traditional approaches focusing on problem behaviours, in recognition of the complexity of the problem of alcoholism. The individual components which may be used in the treatment package are varied. Davidson(1974) reports that the use of aversive therapy in the treatment of alcoholism had been reviewed positively in the literature. However, he makes the point that close analysis of the research designs and important areas of investigation reveals doubts as to the efficacy of the technique.19

More successful perhaps, are social training techniques or the development of behaviours which are incompatible with excessive drinking. Alcoholics have been described as being overly dependent and passive (Catanzaro 1967; Zwerling and Rosenbaum 1959; Within Karp and Goodenough 1959).20 The social training technique, assertive training attempts to deal with this maladaptive behaviour. Relaxation and systematic desensitization attempts to address the negative relationship between tension and alcohol abuse. Focusing on this problem Frank(1977) conducted a study on anxiety reduction in alcoholics using selected imagery techniques. Ninety alcoholics were placed in one of

three conditions: guided imagery; non-directive imagery; or no treatment. One two consecutive days for one and a half hours the experimental groups experienced progressive muscular relaxation and one of the imagery techniques. The no-treatment groups engaged in informal conservation. The results show that the experimental treatment significantly reduced the subject's level of state-anxiety when compared to the no-treatment condition.21 These techniques can be self-administered by the alcoholic.

Social learning theory suggests that the operant of drinking increases in frequency, duration and intensity accordingly as it is reinforced by the reduction in tension it affords (Conger 1956; Dollard and Miller 1950).22 Operant approaches in treatment attempt to rearrange the consequences of drinking behaviour. If the consequences are unpleasant then the drinking behaviour may be extinguished by negative reinforcement(1). Cohen et al.(1973), conducted a study in which chronic alcoholics were allowed drink, if they so chose, up to 24oz of 85 proof alcohol every day for seventeen to twenty days. Drinking 5oz or less was reinforced by being allowed stay in an enriched environment. If they exceeded this limit they were placed in an impoverished environment. The results indicate that moderate drinking is possible for alcoholics and provides support for moderate drinking as a valid therapeutic goal.23 However, it can be argued that it is not possible to extrapolate from the experimental setting to the more complex life situation outside the hospital. Consequences of drinking are not so well defined and predictable in the real world.

Controlled drinking

A number of studies conducted since 1960 have reported a return to controlled drinking for alcoholics. The first of these by D.L. Davies was published in 1962 and reported that out of ninety three reliably diagnosed alcohol addicts seven had returned to normal drinking for a minimum of seven years and ranging up to eleven years. In 1965 R.E. Kendall reported on four alcoholics who became controlled drinkers for at least three and up to eight years.24 The Rand Report published in 1976 announced "the possibility that for some alcoholics moderate drinking is not necessarily a prelude to a full relapse and that some alcoholics can return to moderate drinking with no greater chance of relapse than if they abstained."25 Sobell and Sobell(1973) conducted a follow-up study on a group of forty men who "were equally and randomly allocated to something called Individualized Behaviour Therapy (IBT) with controlled drinking as the treatment goal (CD-E group), or to conventional, abstinence oriented alcoholism treatment (CD-C group)."26 The results were in favour of the controlled-drinking-treatment approach and the difference between the two groups was maintained at the end of two years. However, Nathan(1976) found problems concerning design and data analysis in this study which make the clear interpretation of data very difficult.27 Such problems as how to ascertain the most efficacious component of a treatment package and the unreliability of self-reports are common to all studies resembling Sobell and Sobell's.

There is growing evidence of a return to controlled drinking for previously diagnosed alcoholics which questions the assumptions made by a disease concept of alcoholism. These findings have important implications for diagnosis and treatment procedures. There is, however, a cautionary word

from Heather and Robertson(1985) - "For those with serious levels of dependence and a long history of heavy drinking, a harm-free pattern of use is extraordinarily difficult to achieve and this is why such persons should typically be advised to aim for abstinence. A decision to aim for controlled drinking in someone with a serious and long-standing problem should only be made after seeking competent professional advice."28

In further response to the complexity of alcoholism, behavioural treatment has developed to include Community-Reinforcement programmes which seek to offer maximum support for the recovering alcoholic. As well as special job, family, social and recreational procedures, the Azrin(1976) study incorporated a "Buddy" system (similar to the sponsorship idea in Alcoholics Anonymous where a sober member of some years standing gives support to a new member), a daily report procedure, group counselling and a special social motivation programme to ensure the self-administration of Disulfirim (Antabuse - medication which causes an aversive reaction if alcohol is consumed). The results of this study were positive. The alcoholics who experienced the improved Community-Reinforcement programme drank less, worked more, spent more time at home and less time hospitalized than did the control groups who only received the standard hospital treatment including Antabuse. These results were stable over a two-year period.29 However the prohibitive costs of administering a programme such as this reduce its likelihood of being implemented as a matter of course.

CONCLUSION

Behaviour Theory has made very welcome advances from the parsimonious but rather limited exclusive concern with overt behaviour to include the importance of cognitive factors in human psychology. This has allayed the most serious criticisms made against Behaviour Theory, that it ignores the most human of all data - cognitions. In the behavioural approach to alcoholism these advances have meant that cognitive factors like expectations, self-efficacy, and perceived control, are considered as well as the more traditional principles of behaviour like classical and operant conditioning.

What can be said about Behaviour Theory in relation to other theoretical models of alcoholism? Since the importance of cognitive factors in any behavioural analysis is generally accepted now, Behaviour Theory has more to share with other views within the psychological approach. A contact point between the psychoanalytic and behavioural models has been suggested by Pattison(1984) - "A major area of cognitive psychology that is rapidly gaining attention (is) the study of volition. This more phenomenological approach can indeed link the psychoanalytical and behavioural perspectives in what is known in the experimental literature as "self-regulation" psychology."30 Any move to combine what is best in the different perspectives within psychology can only advance the understanding and treatment of alcoholism.

Developments in Behaviour Theory have had a parallel effect in treatment procedures. Instead of having recourse only to aversion therapy in treating alcoholism, an impressive battery of training techniques like assertiveness training, social skills learning, and cognitive restructuring are available to the alcoholic. The great advantage of Behaviour Therapy is its availability to a wide range of alcoholics who perhaps could not submit themselves to other more expensive and more protracted forms of treatment.

Behaviourists tend to use terms like alcoholism and problem drinking synonymously. This is acceptable to them since they do not consider alcoholism to be a disease and so to them the alcoholic is not set apart from other drinkers by a disease entity. Rather all drinking occurs along a continuum, from moderate social drinking at one end to problem drinking at the other. With this view of alcoholism, the aim of Behaviour Therapy can be to modify maladaptive drinking behaviour to an acceptable level or in some cases to terminate it. There is no strict delineation between normal drinking and alcoholism. This view has found quite a degree of support in studies reporting a return to controlled drinking for individuals already diagnosed as alcoholics. It is accepted that a return to moderate drinking works best for people who have not been severly affected by excessive drinking over long periods of time.

What needs to be established with more clarity in an Irish setting is how much does social learning contribute to the development of alcoholism in the individual. This is examined in the present study. Expectations about the effects of alcohol and whether they influence drinking behaviour is also looked at.

NOTES

(a) Classical conditioning(I.P. Pavlov): A process by which a response comes to be elicited by a stimulus, object or situation other than that to which it is the natural or normal response. The term was originally used of the case where a reflex, normally following on a stimulus A, comes to be elicited by a different stimulus B, through the constant association of B with A. Dreer, James. A Dictionary of Psychology, Penguin, Middlesex, 1967, p.48.

(b) Operant Conditioning(B.F. Skinner): A form of conditioning in which reinforcement is contingent upon the occurence of the response. Wolman, B.B. Dictionary of Behavioural Science, Mac Millan Press Ltd., London, 1974, p.73.

(c) Cognition: A general term for any process which allows an organism to know and be aware. It includes perceiving, reasoning, conceiving, judging. Wolman(1974), p.66.

(d) Motivation: A process (appetitive as opposed to affective) that effects changes in the environment (acts) consonant with internal representations (plans, programs). Wolman(1974), p.243.

(e) Reinforcement(I.P. Pavlov): Reinforcement takes place when the conditioned stimulus is presented simultaneously or at an effective interval before the unconditioned stimulus. Wolman(1974), p.319.

(f) Systematic desensitization(J. Wolpe): A behaviour therapy technique in which deep muscle relaxation is used to inhibit the effects of graded anxiety-evoking stimuli. Wolman(1974), p.367.

(g) Cognitive restructuring: The restructuring of an individual's cognitive structure which is his "organization of the world into a unified system of beliefs, concepts, attitudes, and expectations." Wolman(1974), p.67.

(h)Stimulus, aversive: A stimulus that, when applied after a response, decreases the tendency for that response to be activated in similar situations. Wolman(1974), p.357.

(i) Reinforcement differential: Selective reinforcement of a response to one stimulus with a greater amount of reinforcement than a response to another stimulus. This operation results in discrimination. Wolman(1974), p.320.

(j) Modelling: (1) The acquiring of behaviour through perceptual learning and through imitation, eg. the child models his behaviour on the behaviour of his parents. (2) A behaviour therapy technique designed to modify behaviour through perceptual learning and by allowing the individual to imitate. Wolman(1974), p.241.

(k) Stress: A condition of physical or mental strain which produces changes in the autonomic nervous system. Wolman(1974), p.359.

(l) Reinforcement, negative: The use of coercive stimuli for reduction or prevention of probability of reinforcement. Wolman(1974), p.320.

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THE SOCIOLOGICAL PERSPECTIVE ON ALCOHOLISM

Each of the three major sociological approaches to the understanding of alcoholism are reviewed here. These are, (a) the cultural theories, (b) the substructural theories, and (c) the labelling or deviant behavior theories. Also the Ledermann Hypothesis and the Family Systems Theory are reviewed.

An underlying assumption in most sociological investigation of alcohol addiction is that "social structure is related to the prevalence of alcoholism."1 Kessel and Walton (1965) succinctly put the case for a social dimension when they say: "Whatever the individual's psychological difficulties may be, unless the social circumstances are right he will deal with these in another way than by excessive drinking."2 It should also be recognized, therefore, that social structure is only one factor among many contributing to the condition of alcoholism. Let us proceed to examine these "social circumstances" by turning first to the cultural input in alcoholism.

Cultural Theories

Horton (1943), speaking of primitive societies, positively related the level of anxiety in a culture to the incidence of alcoholism. This anxiety had its source in insecurity about food supplies (especially when food came from hunting as opposed to crops), and also, in contact with western civilization which broke down social patterns.3 Building on these findings Field (1963) found social organization rather than anxiety per se to be the important factor in the level of alcoholism. In his view a society which is loosely organized and more individual-oriented is more prone to "drunkenness" than a society operating within well defined social controls.4

Bales (1946) outlined a social formula for alcoholism in conditions which promote guilt, unresolved tensions, unexpressed anger, sexual tension and utilitarian or self-interested attitudes to the use of alcohol.5 Similarly, Glad (1947) hypothesized that societies advocating the use of alcohol for the personal effect it affords, rather than as part of a ceremony or ritual, will have higher rates of alcoholism.6 Morton (1957) and Cloward (1959) include the frustration of failure in their concept of tension as a contributing factor in alcoholism.7 If an individual or classes of people are exposed, through television for instance, to the desirability of social advancement without the means to achieve it, they may become despairing and slide into alcoholism. Trice (1962) and Ullman (1958) found alcohol addiction to be more prevalent when ambivalence existed in the societal consensus regarding the use of alcohol.8 It should be kept in mind, however, that loose social controls may only make it possible for certain psychological or genetically predisposed individuals to become alcoholics, rather than being the cause of their alcoholism. It is a fact that only a small percentage of people living under very similar social conditions become alcoholic. What Keller (1970) calls "The Great Jewish Drink Mystery", a social phenomenon which seems to support unequivocally the notion of social structure causation for alcoholism, at least in the Jewish community, deserves special mention.9 Bales (1959) claims that "alcoholism rates are low among Jews because of their "ritual" attitude toward drinking. The frequent use of wine in religious ceremony leads the Jew to reject the use of drink for personal or hedonistic reasons."10 It could be said that the use of wine in the Christian ceremony of the mass does not prevent gentiles from becoming alcoholics.

Glad (1947) related Jewish sobriety to a need to be seen in the best social light. He also mentioned their use of alcohol for "instrumental" rather than "affective" reasons.11 Snyder (1958) saw as significant the importance of education, self-control and rational behaviour in the Jewish community.12 Keller (1970) in his article entitled "The Great Jewish Drink Mystery" claims to have produced definite clues to this "mystery". He outlines them as (a) "the banishment of the pagan gods of Canaan, to whose worship orgiastic drinking had been attached." ; (b) "the development of the religious culture with the Bible, the Torah, as Constitution, along with the institution of the local synagogue as a place of popular worship," ; and (c) "the positive integration of drinking in religiously oriented ceremonials in the home and synagogue, including meals and rites of passage."13 If Keller has discovered why Jews don't suffer from alcoholism there still remains the problem of how to convert the rest of the world to Judaism. Nevertheless, the Jewish sobriety phenomenon does supply striking evidence of the importance of attitude in the aetiology of alcoholism. Also, research into the genetic make-up of the Jewish people may help to resolve this "mystery".

Sub-structural Theories

These theories "build upon empirical findings that alcoholics are over-represented in specific age, religious, sex, ethnic, class categories, or specific family, marital, employment situations."14 Cahalan(1970) reported on a household survey which "employed a random and representative sample of 1359 adult residents of households throughout the united states interviewed initially in 1964-5 and reinterviewed three years later."15 He

asked questions dealing with about eleven specific problem areas connected with drinking. The respondents were asked whether they had experienced any of these problems during the last three years. Using a score of over seven to "demarcate a category of problem drinkers with fairly severe current problems", Cahalan found that "9% of the total sample, comprising 5% of men and 4% of women, were classified as problem drinkers," which was "equivalent to about nine million of the adult American population."16

Cahalan concluded from this study that the social environment contributes to problem drinking. The implicated socio-psychological variables include (a) attitude to drinking; (b) social support for heavy drinking; (c) impulsiveness and rebelliousness of the individual; (d) his degree of maladjustment; (e) his sense of hope or hopelessness for the future; (f) a loose-knit social pattern. Cahalan proposed two stages or conditions on the road to alcoholism - (1) heavy drinking must be indulged-in in at least some circumstances. This behaviour will of course be influenced by social variables like age, sex, ethnicity and social class; (2) next labelling occurs when the individual may "hang-out" with a heavy drinking group. Once the individual is labelled as a "heavy drinker" he may continue to drink even under social condemnation, particularly if he is impulsive or rebellious in character.17

Heather and Robertson(1985) suggest that an important finding to emerge from household survey research is the volatility of drinking problems in the natural environment, which questions the notion of a disease concept "involving an unavoidable deterioration if drinking is continued."18 For

instance, in Cahalan's study, along with the 9% who were experiencing fairly severe drinking problems there was a further 9% who had experienced serious drinking problems in the past but were now free of them. This was especially true of the young men in the study.

The Ledermann Hypothesis

Ledermann(1950's) found that the distribution of alcohol consumption, in a number of countries, followed a log-normal distribution. This is demonstrated by a "positively skewed" curve with the highest point at the left hand side and a long, progressively thinner right hand tail, which contrasts with the symmetrical bell-shaped curve in the case of a normal distribution describing natural phenomena like height. The log-normal distribution indicates that "the largest number of consumers drink nothing or a relatively small amount, a substantially smaller number drink somewhat larger amounts, and a very small number drink very large amounts."19

Ledermann made an important assumption which enabled him to predict the extent of alcohol problems in a society. This assumption was that "the dispersion, or degree of variation about the average, of consumption levels was constant across different drinking populations."20 He justified the assumption by claiming there was a biologically fixed upper limit on the amount it was possible to drink, which he estimated at one litre of pure alcohol per day. This assumption allows a prediction of the number of problem drinkers in a population based on knowledge of the average level of consumption. Consequently, "an increase in average consumption will lead to a disproportionate increase in the number of alcohol problems."21

Several empirical studies of consumption levels in large populations have supported Ledermann's ideas. However, there are also some criticisms, for instance, "the underlying assumption of a fixed upper limit to possible consumption has been criticized and, thus, the important further assumption of a constant dispersion among log-normal distributions has been thrown in doubt."22 Also, research carried out on general population samples does not agree with predictions from the Ledermann model; and there is the point that research using national statistics can fail to pick up important sub-group variations. However, it is generally agreed among specialists in this branch of epidemiology that the Ledermann hypothesis provides a sufficiently good working approximation for present uses.

The Ledermann Hypothesis suggests that, in terms of quantities of alcohol consumed, there is not a natural division between normal and abnormal drinkers. In relation to influences on the development of alcoholism, the most critical point against the disease concept is that going by the Ledermann position "the number of "alcoholics" or problem drinkers, however defined, varies closely with the average level of consumption in a society. This is further evidence that problem drinking is under environmental and not internally located control."23

The Family

A lot of attention has focussed on the families of alcoholics in the search for the cause of alcoholism. Wittman (1939) in her study of one hundred alcoholics and the same number of controls matched for age, education, and nationality found support for the typical alcoholic family, described in

much of the early literature, and comprising a "doting mother and a stern father who inspired respect, awe and fear...."24 However, several other studies, Kinsey (1966); Pittman and Gordan (1958); McCord, McCord and Gudeman (1960) have disputed these findings.25

Jackson and Connor (1953) found that attitudes of the parents towards alcohol, whether ambivalent or approving will mould the child's adult relationship with alcohol. Comparing the homes of alcoholics, moderate drinkers, and non-drinkers, they found that alcoholics "came most frequently from homes in which only one parent, usually the father, drank." Non-drinkers came from non-drinking homes and moderate drinkers from "social drinker" homes. They claim that in the "ambivalent environment" where only one parent drank, the person who later became an alcoholic found it impossible to develop consistent healthy attitudes to drink which could guide him in his adult relationship to it.26

Mac Kay(1961), drawing on data gleaned from the family histories of twenty adolescent problem drinkers constructed five aetiological hypotheses:-

1. Parental alcoholism was frequent.
2. The adolescent had ambivalent and anxiety provoking feelings about drinking based on his experience in the alcoholic home.
3. The subjects felt they had to "handle" drink in order to establish their independence from their parents.
4. Their feelings of alienation from home was assuaged by the company of their drinking peers.
5. They drank to relieve passive feeling of depression and emptiness.27

It may also be that these adolescents wished to emulate their drinking parents, a wish that even in the negative atmosphere of the home could survive as a deep need for approval. Winokur and Clayton(1968) found that problems in the home in the form of parental absence, deprivation, or pathology, may encourage the maladaptive behaviour of alcoholic drinking in the children.28

To sum up the findings in the above familial studies, the influence of parents on their children may both bring about personality problems found in many alcoholics, such as, dependency, unexpressed anger, tension, and also encourage drinking as a means of dealing with these problems which may result in alcoholism.

Family Systems Theory

Systems theorists, cyberneticists, and information theorists make the point that we are a experiencing "a scientific revolution in which we are giving up our outdated notions of causation."29 Berenson(1976) strongly suggests that a family therapist dealing with a problem of alcoholism must give up any strict causative notion of alcoholism. He must recognize that there are factors "on the biological, psychological, family, and social levels (which) all contribute toward producing an alcoholic individual or alcoholic family system, but none in themselves can be said to cause alcoholism."30

Family problem From a family systems perspective alcoholism is seen as a family rather than an individual problem. The behaviour of all members of the family maintain the drinking in an alcoholic system. Indeed, a family

may be organized around money, sex, work, death, or schizophrenia in much the same way as it is organized around alcohol. Also the parents of the adult alcoholics are seen to play an important role in the alcoholic family system by "infantalization of the alcoholic....Thus the systems approach is extended to a larger consideration of the nuclear family embedded in generational and kinship systems. The problem of alcoholism runs in families across generations and extends into the kinship system."31

The children in an alcoholic family can be the most severely victimized. They often develop emotional problems and are sometimes subject to gross neglect and child abuse. They are also part of the family system that provokes and perpetuates alcoholism. According to Kaufman and Pattison(1982), "Young children may encourage parental drinking to temporarily quiet violence or to release affection.....Children of all ages may provoke parental discord to avoid having limits set and consistently maintained."32

Family dynamics In the alcoholic family typical family dynamics are seen to exist. Female alcoholics often marry male alcoholics, but male alcoholics usually do not marry female alcoholics. It appears that some individuals "marry alcoholics or potential alcoholics to meet certain needs and preexisting traits of their own.33 The "normal" person living with an alcoholic then undergoes many personality changes. Often the alcoholic marriage becomes asexual because of the increasing inability of both partners to demonstrate affection and also because the alcoholic is progressively unable to perform sexually. As the drinking problem

deteriorates parental roles are abandoned by the alcoholic, household maintenance is neglected, and finally the job may go. The children of alcoholic families often develop alcohol and drug problems.

The family members of the alcoholic develop patterns that have been labelled the disease of co-alcoholism. These patterns range from early phases of denial and rationalization "with the hope that the alcohol-related behaviour will improve."34 There are also feelings of responsibility and guilt for the alcoholic's behaviour, and some withdrawal. Next comes the middle stage in which there is "hostility, disgust, pity, preoccupation with protectiveness, and shielding of the alcoholic."35 These negative feelings of suspicion and hostility then become generalized to the total environment. In the final stages there is total preoccupation with the alcoholic manifested in responsibility for and quarrelling with him or her. The co-alcoholic loses interest in the outside world and also in the self. Psychosomatic illness or drug and alcohol dependence may occur. The co-alcoholic has also been called an "enabler" because he or she enables the alcoholic to continue drinking. It is often at these final stages when detachment by the co-alcoholic occurs with treats or demands of separation, that treatment is sought.

Treatment Accepting alcoholism as a family system problem "the attitudes, structure, and function of the family system" have been shown to be a crucial variable in successful treatment outcome.36 Berenson(1976) makes the point that "the therapist must also be alert not to accept cessation of drinking as the only measure of outcome. A.A. has long recognized that

there is a difference between being "dry" and being "sober".37 Merely taking away the alcohol and not allowing an expression of bottled-up behaviour means that "the individual or family has only a partial repertory of behaviour and feelings."38 It must be remembered that the alcoholic entering treatment belongs to a family system and will return to that system. If a dysfunctional system is unchanged then the treatment gains may be vitiated. However if the whole family adopts more appropriate behaviour then the chances of successful treatment outcome are enhanced.

Deviant Behaviour Theory

This theory is based on the belief that an individual is labelled an alcoholic, and therefore deviant, depending on his "social status, visibility, locale, age, and the juncture in time."39 Alcoholism is not seen as existing within the parameters of a physical or psychological dependency. Rather it is seen as a life-style moulded by deviance -producing relationships with people (family etc.) and institutions, including helping agencies. Becker(1963) reveals a prevailing sociological approach to alcoholism when he states, "I will be less concerned with the personal and social characteristics of deviants than with the process by which they come to be thought of as outsiders and their reactions to that judgement."40

The individual, then, mainly through negative social relationships, has embarked on a life of deviant behaviour and so becomes labelled as deviant

by public reaction which reinforces him in this role. Once labelled an alcoholic the individual's self-perception and other's perception of him can lead to further alienation. In a defensive manner he may reject the norms of society and resort to various forms of "retreat, aggression, manipulation of reality, and unity with other deviant subcultures."41

Remarking on this "spiral of deviancy amplification", Robinson(1976) makes the point that "it is not being suggested that the deviant group is inexorably propelled, as if by magic, along such a path. For, of course, man creates as well as reacts to his circumstances."42 Having a sociological perspective on alcoholism Robinson does not refer to the disease concept which could also account for the rapid or gradual social decline of the alcoholic.

CONCLUSION

Arguing in the most general way for a social influence in alcoholism, one can refer to the truism, "no man is an island", and it follows that alcoholics like everybody else are open to the advantages and disadvantages of social interaction. It has been shown in this section that certain cultural attitudes to alcohol and drinking have an influence on the prevalence of alcoholism in a society. The disease model of alcoholism was questioned by Cahalan's(1970) household survey of drinking behaviour which demonstrated the volatility of drinking problems. This finding undermines the notion of disease involving an inevitable detioration with continued drinking. The

Ledermann Hypothesis argued for a social influence in alcoholism by showing that there is a correlation between the number of drink-related problems and the level of alcohol comsumption in a society.
Focussing on subgroups within a society we have seen that specific family settings , where an "ambivalent" attitude to alcohol, or problems in the home exist, appear to encourage the development of alcoholism in certain family members. Family Systems Theory stressed the importance of seeing the alcoholic as part of an alcoholic family system, not an isolated individual. This view was said to be crucial for successful treatment outcome.

However, although social factors appear to play an important role in the development of alcoholism, when it comes to define the mechanisms of that influence the complexity of the situation is striking. It seems to be that "social and psychological elements are intertwined in ways that are neither simple nor obvious."43 It appears from some studies reviewed here that certain environmental conditions especially foster the expression of personality problems in the form of alcoholism. It is generally accepted that the role played by the environment is in supplying the "right" social circumstances for the development of alcoholism.

What needs to be established more clearly in an Irish setting is the extent of social influence on alcoholism. This study deals with such social factors as attitudes to drinking, support for heavy drinking, parents' drinking, and problems in the home.

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PROCEDURE

Description of sample

The sample consists of two groups of twenty eight people, an alcoholic group and a non-alcoholic or control group. Of the alcoholic group eighteen were E.S.B. employees who had received treatment through the E.S.B. Employee Assistance Programme and all but one were stopped drinking at the time of interview. The remaining ten alcoholics were receiving treatment at Stanhope St. Social Service Centre for Alcoholics and were sober at the time of interview. Of the non-alcoholic group twenty were E.S.B. employees and eight others were from various walks of life. None of this group had ever been diagnosed as alcoholics or had ever received treatment for alcoholism. All of them could be termed "social drinkers". When asked whether they drank to excess (Q46.), twenty four replied they never did and four said they occasionally did.

Sex

The two groups were predominantly male. Two alcoholics and four controls were females.

Age

The alcoholic group was slightly older than the control. The average age for both groups was, 37.89 for the alcoholics and 31.13 for the controls. This difference was not found to be significant in a Chi-Square test.

Marital Status

Eleven of the alcoholics were single, fifteen were married, and two were separated. Sixteen of the controls were single and twelve were married. The fact that more of the controls were single is probably explained by the younger average age of this group. The difference between the two groups was not found to be significant.

Occupation

Both groups were fairly equally represented in the Professional, Managerial, and Inspectional Classes of occupation as outlined in the Hall-Jones Scale of Occupation.(see Appendix B) In the Skilled, Semi-Skilled, and Routine Manual Classes, the alcoholics were better represented than the controls. A similar pattern emerged in the occupation of the fathers of the two groups. The vast majority of the mothers of the sample were housewives, with four of the mothers of the alcoholic group in the Inspectional, Supervisory, and other non-manual (higher-grade) Class. There was no significant difference found between the two groups in either the respondents' occupation or that of their parents.

Rural/Urban

Both groups were well represented in the rural and urban categories. Fifteen alcoholics and twenty controls came from the country, while thirteen alcoholics and eight controls came from the city. The difference between the two groups was not found to be significant.

Level of education

The control group overall had attained a higher level of education than the alcoholic group. Sixteen of the controls had finished Secondary school and seven had attended University compared with seven alcoholics finishing Secondary school and three attending University. The parents of the control group had also attained a slightly higher level of education than the parents of the alcoholics. The difference between the two groups on the level of education of the respondents was found to be significant. Also the difference in the level of education of the fathers, but not the mothers, of the two groups was significant.

Design of Study

Because the aetiology of alcoholism in Ireland has not been examined in detail it was thought best to conduct an exploratory study before undertaking larger scale work at a later stage; - "Lazarsfeld (1944) has proposed that the development of a closed-question interview schedule be preceded by more intensive, freer interviews with a subsample of the population in order to discover the range of probable responses, the dimensions that are seen as relevant, and the various interpretations that may be made of the question wording. On the basis of such preliminary exploration, more meaningful closed questions can be formulated".1

For the purposes of this study then, it was decided to test the theories which have emerged from the literature review, in an Irish context. This will indicate both whether these theories are relevant to the Irish

alcoholic problem, and allow additional factors peculiar to the Irish situation to emerge. An alcoholic group consisting of 28 alcoholics and a control group consisting of 28 social drinkers was used in the study.

Data collection plan

A qualitative approach was adopted which would best suit the exploratory nature of the study. The great advantage of qualitative data for a study such as this is that they "consist of detailed descriptions of situations, events, people, interactions, and observed behaviour; direct quotations from people about their experiences, attitudes,, beliefs and thoughts.." 2 As Lofland (1971) succinctly puts it - "In order to capture participants "in their own terms" one must learn their categories for rendering explicable and coherent the the flux of raw reality. That, indeed, is the first principle of qualitative analysis".3 For instance, it was considered important to obtain data rich in depth and detail on the childhood experiences and family background of the respondents. With this objective in mind open-ended questions were posed such as - How would you describe yourself growing up?, or - Could you describe your father to me? Detailed information gathered on these questionnaire items allowed categories of personality and family background to emerge rather than having them imposed on the respondents.

The Interview: It was decided to interview the respondents using a standardized questionnaire. All of the subjects were interviewed by the same person and an average time for each interview was an hour and a quarter. The

interviewer wrote down each response verbatim in the relevant space provided in the questionnaire. The respondents were assured of confidentiality and were told that the responses were expected to be conversational and detailed within the limits of the time allowed for each interview. This time was limited because most of the interviews were conducted in the work place and subjects were allowed only a certain amount of time off from work. The field work extended over a period of six months. This time was spent designing the structured interview, gaining access to the ESB (Electricity Supply Board), and Stanhope St. Social Service Centre for Alcoholics,and arranging interview schedules with volunteer respondents.

Questionnaire design: The structure of the questionnaire is as follows:-
Description of sample - Qs1-3; Q23; Q25; Q27; Qs34-35; Q37; Qs41-42; Qs45-46.

Early drinking experience - Qs4-6; Q9.

Medical model - Q13; Q32; Q50.

Psychoanalytical model - Qs11-12; Qs15-19; Qs21-22; Q24; Q28; Q33; Q39; Qs47-49; Qs51-53.

Behavioural model - Qs7; Q13.

Sociological model - Q8; Q10; Qs14-15; Q20; Q26; Qs29-31; Qs36-38; Q40; Qs43-44.

The questionnaire consists of two kinds of questions - (a) "fixed-alternative" questions; and (b) "open-ended" questions.

"Fixed-alternative" questions: These are questions in which "the responses of the subject are limited to stated alternatives. These alternatives may be simply 'yes' or 'no', or they may provide for indicating various degrees of approval or agreement".4 For example, Q2 - Did you ever drink alcohol? Yes/No, or Q31 - What were your parents' attitudes to you drinking?

Strongly approve	moderately approve	Neither approve nor disapprove	Moderately disapprove	Strongly disapprove

"Open-ended" questions: These questions are "designed to permit a free response from the subject rather than one limited to stated alternatives ... the respondent is given the opportunity to answer in his own terms and in his own frame of reference".5 For example, Q11 - How do you get on with women? or Q36 - How would you describe your home life growing up? When asking the open-ended questions, "the interviewer is given freedom to repeat the question if the reply is not to the point and to use at his discretion such non-directive probes as - "Wont you tell me more." "What makes you think ...?" "Why?" "In what way...?" etc. The task of the interviewer is to encourage the respondent to talk freely and fully in response to the questions included in the interview schedule and to make a verbatim record of his replies".6

A number of the open-ended questions are dichotomous response questions in that they "provide the interviewer with a grammatical structure suggesting a 'yes' or 'no' answer".7 For example, Q48 - Would you describe yourself

as a perfectionist? To avoid the likelihood of a respondent answering a bare 'yes' or 'no' to any of the open-ended questions the interviewer explained in advance that he was looking for some depth and detail in the responses. In the case of a respondent just answering 'yes' or 'no' to a question the interviewer asked for an elaboration and had recourse to probe questions.

Closed questions have been used "where the possible alternative replies are known, limited in number and clear cut".8 Open-ended questions have been used when what is important is the respondent's personal experience, his own frame of reference and concepts in which he perceives the event.

Time frame of questions: The emphasis in the questions is on the past experience of the subjects, in an attempt to construct a picture of the individual in terms of personality, family background and social environment. With questions that are worded in the present tense, e.g. Q47 - Would you describe yourself as a dependent kind of person?, the respondent is encouraged to give an overall account of his degree of dependency, past and present. The meaning of dependency is explained where necessary.

Data Analysis Plan

The responses to fixed alternative questions provide little difficulty when it comes to analysis. They are succinct, parsimonious and easily aggregated for analysis. By contrast the responses to the open-ended questions are longer, more detailed and variable in content, and so analysis of this raw data is more difficult.

Categories: The first stage in the analysis of qualitative data is an inductive perusal of the responses in a search for emergent patterns. Guba (1978) mentions the problem of convergence which is "figuring out which things fit together. This leads to a classification system for the data ..... the evaluator/analyst begins by looking for 'recurring regularities' in the data. These regularities represent patterns that can be sorted into categories".9

Tabulation: When the categories for each open-ended question have been formulated the next stage is the tabulation of the responses which is part of the technical process in the statistical analysis of data. The "essential operation in tabulation is counting to determine the number of cases that fall into the various categories".10 At this stage the responses to each open-ended question are represented in categories. For example, Q8 - Can you describe the occasion on which you took your first drink?

With friends in a pub	With friends in a field	With friends at a party	alone

The alcoholics and non-alcoholics who fall into these categories are represented in numerical form. The responses to the fixed-alternative questions also appear in numerical form in the pre-determined categories.

Statistical treatment: The statistical method used to analyse the results is the Chi-Square test in the case of this study. This test is used to "determine the significance of differences between two independent groups ...

The hypothesis under test is usually that the two groups differ with respect to some characteristic and therefore with respect to the relative frequency with which group members fall into several categories."(11) This statistical method is explained in detail in the results section of the study.

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STATISTICAL TREATMENT

The hypothesis under test using the Chi-Square is usually that the two groups differ with respect to some characteristics and therefore with respect to the relative frequency with which group members fall into several categories. The hypothesis is tested by comparing the proportion of cases from one group in the various categories with the proportion from the other group. The null-hypothesis would be that the distribution of group members is independent of the categories into which they fall. For example, in Q53. Do you find it difficult to deal with authority figures?, the null-hypothesis would be that the proportion of alcoholics who had difficulty with authority figures is the same as the proportion of non-alcoholics who had difficulty. For a Chi-Square with more than two categories the null-hypothesis is stated in terms of the non-independence of the groups in relation to all categories.

The rejection of the null-hypothesis indicates that there is a significant difference in the pattern of responses of alcoholics and non-alcoholics to the particular question. While this may not allow a fine-grained analysis of intercategory differences, it can indicate the particular factors which discriminate between the two groups. The alternative strategy of collapsing categories was rejected on the grounds that it would lose qualitative information which was felt to be important. Thus it was decided to retain the categories which emerged from the responses to each question and to discuss the results in terms of the numbers of both groups which fell into each category.

This entailed a series of fifty four Chi-Square tests. A .01 level of significance was chosen in order to maintain a reasonable degree of experiment- wide Type 1 error which occurs if we reject the null-hypothesis when, in fact, it is true. On the basis of this alpha level, less than one of the significant results would be considered to have occured at random.

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RESULTS

Description of Sample

	Male	Female	Average age	Rural	Urban
Alcoholics	26	2	37.890	15	13
Non-alcoholics	24	4	31.135	20	8

Questionnaire Results

The following questions in the results section are in the same order as in the questionnaire.

Q4. How old were you when you took your first drink?

	10-15yrs	16-20yrs	21-25yrs	25-30yrs	31-35yrs
Alcoholics	8	15	3	1	1
Non-alcoholics	3	21	3	1	

Q5. Can you describe the occasion on which you took your first drink?

	With friends in a pub.	With friends in a field.	With friends in a house.
Alcoholics	16	8	4
Non-alcoholics	18	3	7

Ho = There is no difference between the alcoholics and non-alcoholics on the occasion on which they took their first drink.

Chi-Square = 3.206

Ho is accepted at .05 level of significance.

Typical Responses

With friends in a pub: 1."In a hotel with friends, I decided to experiment with cider."(Alcoholic) 2."In a pub with friends, part of a social work group."(Non-alcoholic)

With friends in a field: 1."Drinking cider and wine with friends in a field."(Alcoholic) 2."At fifteen in fields with friends drinking cider and sherry.(Non-alcoholic)

With friends in a house: 1."A birthday party of the brother's and the whole family were there."(Alcoholic) 2."At a 21st. party with friends in a G.A.A. club at a bar."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the Alcoholics and Non-alcoholics it is noted that more of the alcoholics than the controls had their first drink in a field which suggests that they have experienced greater peer group support for heavy drinking. Also three of the alcoholics had their first drink alone. The categories "With friends in a field" and "Alone" should be considered in any further research.

Q6. Did you begin to drink regularly from the time you took your first drink?

Within five years.

	Social drinking occasionally.	Social drinking at weekends.	Heavy drinking.
Alcoholics		8	20
Non-alcoholics	9	19	

Ho = There is no difference between the alcoholics and non-alcoholics on the pattern of drinking from the time they took their first drink.

Chi-Square = 56.0

Ho is rejected at .01 level of significance.

Typical Responses

Social drinking occasionally: 1."Yes, I suppose so, off and on once a month."(Non-alcoholic) 2."No, except an odd glass of wine. I didn't like the taste of alcohol."(Non-alcoholic)

Social drinking at weekends: 1."On and off. Moderate, social drinking at weekends until twenty seven. Then heavy."(Alcoholic) 2."No, I went to Rathmines College of Commerce when I was nineteen. I started to drink at weekends at that time and sometimes during the week. But now mainly weekends."(Non-alcoholic)

Heavy drinking: 1."Yes, at weekends. After fifteen it was regular, every night."(Alcoholic) "The following summer at weekends for about a year. Then from Thursday to Sunday. It stayed at from Wednesday to Sunday mostly."(Alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - Social drinking at weekends; and Heavy drinking. Questions derived from it for futher research are suggested along the lines of drinking practice, eg., frequency, amount, occasion.

Q7. What effect did you think alcohol would have on you?

	I didn't think much about it.	Make me feel happy and relaxed.	Make me feel grown up.	A bad effect.
Alcoholics	13	10	4	1
Non-alcoholics	13	12	1	2

Ho = There is no difference between the alcoholics and non-alcoholics on their expectations about the effect of alcohol.

Chi-Square = 2.16

Ho is accepted at .05 level of significance.

Typical Responses

I didn't think much about it: 1."I didn't give it any thought. It wasn't an issue, it just happened.(Alcoholic) 2."I never thought about how it would effect me. I was curious about the effect it would have."(Non-alcoholic)

Make me feel happy and relaxed: 1."Make me feel happier, have a bit of crack."(Alcoholic) 2."I thought it would me feel merry, in good form going to a dance."(Alcoholic) 3."I expected to be more relaxed, to lose control both physically and mentally slightly." (Non-alcoholic)

Make me feel grown up: 1."I expected a certain high. There was a macho bullshit associated with it. I was a real man."(Alcoholic) 2."Make me feel more grown up, boost my confidence."(Non-alcoholic)

A bad effect: 1."I thought it would have a bad effect because of bad home experiences."(Alcoholic) 2."I was afraid of alcoholism because I knew people who were alcoholics."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the two groups the expectations of a small number of the alcoholics seem to be related to negative feelings about themselves, eg., not feeling grown up or perhaps lacking in confidence. This item may be useful in dealing with the psychological needs of the individual in relation to alcohol and should not be discarded in any further research.

Q8. What were your main reasons for drinking?

	For social reasons	To overcome shyness	To kill loneliness	To escape reality	I liked the pub	To feel grown up
Alcoholics	14	5	2	2	2	3
Non-alcoholics	27	1				

Ho = There is no difference between the alcoholics and non-alcoholics on their main reasons for drinking.

Chi-Square = 15.346

Ho is rejected at .01 level of significance.

Typical Responses

Social reasons: 1."To be the same as the rest of them, to mix in."(Alcoholic) 2."To be like everyone else. Get in on what was popular, I wanted to experience what was going on. All my mates were heavy social drinkers. Part of the ritual to go for a few pints every day after work."(Alcoholic) 3."Looking forward to breaking the pledge. To join in with friends who were drinking."(Non-alcoholic)

To overcome shyness: 1."Through shyness about women. To get false courage to go to dances. Helped me to mix with people."(Alcoholic) 2."Company, shyness, in order to mix in with people."(Non-alcoholic)

To kill loneliness: 1."To kill loneliness, to be in a social scene."(Alcoholic) 2."It became my main social outlet. I was a very lonely character. There was a desire to belong to a particular group. I was happy with the drinking friends I'd found. There was a certain amount of rebellion against a strict upbringing."(Alcoholic)

To escape reality: 1."I thought it would do away with all my worries. Make me feel carefree, to escape."(Alcoholic)

I liked the pub: 1."Just passing the time, just a casual social outlet. I liked the atmosphere in the pub. Just the same as watching T.V."(Alcoholic)

To feel grown up: 1."The in thing to do with everybody else, to fit in with the older crowd. To feel more grown up like smoking."(Alcoholic)

Utility of Item

This item distinguishes well between the Alcoholics and Non-alcoholics, therefore questionnaire items derived from it are suggested for further research. These would deal with the areas of - shyness; loneliness; adjusting to reality; and self-confidence.

Q9. What was your capacity for alcohol like?

At first:

	Very high (10+ pints)	High (8 pints)	Average (4-5 pints)	Small (0-3 pints)
Alcoholics		9	11	8
Non-alcoholics		1	8	19

Within five years:

Alcoholics	15	8	5	
Non-alcoholics		3	15	10

Ho = There is no difference between the alcoholics and non-alcoholics in their capacity for alcohol when (a) they first started to drink and (b) within five years.

At first.
Chi-Square = 11.52

Within five years.
Chi-Square = 32.272

Ho is rejected in (a) at .01 level, and in (b) at .01 level.

Utility of Item

This item distinguishes well between the Alcoholics and Non-alcoholics so questionnaire items derived from it are suggested for further research. These would be along the lines of - capacity for alcohol at first; increase in capacity.

Q10. With whom did/do you drink most frequently?

	Personal friends.	Work mates.	Wife.	Pub acquaintances.	Alone.
Alcoholics	6	4		12	6
Non-alcoholics	22	2	4		

Ho = There is no difference between the alcoholics and non-alcoholics in the people they drank with.

Chi-Square = 26.526

Ho is rejected at .01 level of significance.

Typical Responses

Pub acquaintances: "Shift-workers in the newspapers. People I'd meet in the pubs - other heavy drinkers."(Alcoholic) "Misfits of society. I'd go to certain pubs where people didn't care what you were."(Alcoholic)

Alone: "On my own mostly. I wouldn't like to be tied down."(Alcoholic) It didn't matter. Whoever happened to be in the pub. In the latter end of my drinking, I drank by my self."(Alcoholic)

Utility of Item

This item distinguishes well between the Alcoholics and Non-alcoholics so questionnaire items derived from it are suggested along the lines of drinking company - whether it is, close friends; pub acquaintances and other heavy drinkers; or just alone.

Q11. How do you get on with women?

	Get on well (married)	Get on well (single)	Difficulties (married)	Difficulties (single)	Homosexual
Alcoholics	10	2	8	7	1
Non-alcoholics	12	14		2	

Ho = There is no difference between the alcoholics and non-alcoholics on how they get on with women.

Chi-Square = 16.005

Ho is rejected at .01 level of significance.

Typical Responses

Get on well: 1."Very well, I think. I'm quite relaxed in their company and I like their company. I'm married to the same woman for the last twenty-eight years."(Alcoholic) 2."Great. I can have easy conversation with women. I feel reasonably confident talking to them."(Non-alcoholic)

Difficulties: 1."Very bad. Always did. Couldn't mix with them. Feeling shy was a stumbling block. Not able to build up relationships. Mainly one-night stands with prostitutes."(Alcoholic) 2."Not very well. Relationships have been casual. Shy with women and nervous. Not a good mixer with women, and drink helped enormously. Given the right circumstances sexually I would be fine."(Non-alcoholic)

Utility of Item

This question distinguishes well between the two groups so questionnaire items derived from it are suggested along the lines of - lasting or casual relationships; sexual problems; anger towards women.

Q12. How do you get on with men?

	Get on well	Lack confidence	Homosexual experience	Keep to myself
Alcoholic	18	5	3	2
Non-alcoholic	27			1

Ho = There is no difference between alcoholics and non-alcoholics on how they get on with men.

Chi-Square = 9.127

Ho is rejected at .01 level of significance.

Typical Responses

Get on well: 1."I get on well with men. I always had a couple of good buddies."(Alcoholic) 2."O.K. I can talk to them at any level. I can enjoy a joke. Wide interests in sport so I meet a lot of men."(Non-alcoholic)

Lack confidence: 1."On the one to one relationship I'd dry up."(Alcoholic) 2."I feel inadequate with some guys, a little jealous."(Alcoholic) 3."I needed drink to have sex."(Female alcoholic)

Homosexual experience: 1."O.K. I don't know where I stand sexually at the moment. Probably homosexual."(Alcoholic) 2."I don't know, you can keep your distance with men. I had two sexual relationships with men."(Alcoholic)

Keep to myself: 1."I never get very close to anybody."(Alcoholic) 2."I spend a lot of time on my own. I'm not sure of the nature of the difficulties."(Non-alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, so questionnaire items derived from it are suggested along the lines of - comfortable with men; lacking in confidence with men; fearful of men; and homosexual experiences with men.

Q13. How would you describe your family as drinkers?

ALCOHOLICS

	Alcoholic	Heavy drinker	Moderate drinker	Light drinker	Non-drinker	Don't know
Father	11	5	5	3	3	
Mother	2	3		10	13	
Brothers	12	11	23	6	13	
Sisters	5	1	23	17	24	
Father's side						
Uncles	8	12	21	1	11	31
Aunts	1	1	4	25	33	9
Grandfather	5	2	4	3		14
Grandmother		1		4	7	16
Mother's side						
Uncles	16	5	29	10	5	2
Aunts	3	1	15	29	34	1
Grandfather	7	2	6	3	1	9
Grandmother			1	5	13	9

NON-ALCOHOLICS

	Alcoholic	Heavy drinker	Moderate drinker	Light drinker	Non-drinker	Don't know
Father	1	3	9	10	5	
Mother			2	11	15	
Brothers		5	31	19	11	
Sisters		5	11	17	11	
Father's side						
Uncles	4	6	37	10	12	7
Aunts		3	5	26	16	5
Grandfather	2	3	3	4	4	12
Grandmother			1	4	13	10
Mother's side						
Uncles	5	12	31	12	13	4
Aunts	2	3	16	19	23	2
Grandfather	1	4	3	5	2	13
Grandmother			1	4	11	12

Ho = There is no difference between the alcoholic and non-alcoholic groups in the drinking behaviour of (a) their fathers, (b) their mothers, and (c) their brothers.

Chi-Square = (a) 14.328

" " = (b) 5.532

" " = (c) 16.360

Ho is rejected in (a) at .01 level of significance.

Ho is accepted in (b) at .05 level of significance.

Ho is rejected in (c) at .01 level of significance.

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics so further questionnaire items derived from it are suggested along the lines of - family drinking history; alcoholism in the family.

Q14. Were any of your immediate family ever hospitalized for depression, nervous breakdown, or other such problems?

	No	Depression	Nervous breakdown	Schizophrenia
Alcoholics	16	6	5	1
Non-alcoholics	21	4	3	

Ho = There is no difference between the alcoholics and non-alcoholics on their family experience of depression, nervous breakdown, or other such problems.

Chi-Square = 1.977.

Ho is accepted at .05 level of significance.

Utility of Item

Although this questionnaire item does not distinguish well between the two groups it is noted that there are more incidents of mental illness in the families of the alcoholics than in the families of the controls. This may be an important difference and should be considered further.

Q15. Did you have any bad experiences when you were growing up?

	No	Father's death	Father's alcoholism	Emotional trauma
Alcoholics	14	5	5	4
Non-alcoholics	22	1	2	3

Ho = There is no difference between the alcoholics and non-alcoholics on the bad experiences they had growing up.

Chi-Square = 4.976

Ho is rejected at .05 level of significance.

Typical Responses

Emotional trauma: 1."My parents fought a lot which caused a lot of anxiety in myself. My father was away from home a lot working. When he came home at weekends I was afraid of him."(Female alcoholic) 2."Yes, I was beaten a lot by my mother up to fourteen years of age. I was molested by a babysitter when I was seven."(Non-alcoholic)

Utility of Item

This item distinguishes well between the alcoholic and non-alcoholic groups so further questionnaire items derived from it are suggested along the lines of - parental alcoholism; parental absence; sexual abuse; violence in the home; emotional deprivation.

Q16. Do you ever feel that you have anger and frustration bottled-up inside you?

	No, I'm easy going	Yes, I often feel anger and frustration	Yes, I sometimes feel anger and frustration	Yes, in the past but not now
Alcoholics	4	17	7	
Non-alcoholics	20	4	2	2

Ho = There is no difference between the alcoholics and non-alcoholics on the amount of anger and frustration they feel bottled-up inside them.

Chi-Square = 18.28

Ho is rejected at .01 level of significance.

Typical Responses

Easy going: 1."No, I was always fairly easy going, always achieved what I set out to achieve. I dealt with anger and frustration on the spot."(Alcoholic) 2."I'm generally regarded as being placid, occasionally let anger out."(Non-alcoholic) 3."Very seldom. Generally very relaxed, confident and good-humoured."(Non-alcoholic)

I feel anger and frustration: 1."Yes, I get angry for no reason at all and frustrated. I can't pin it down to anything."(Alcoholic) 2."Yes I sometimes rear-up on my mother and older brothers. I had a lot of anger growing up."(Alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the "No, I'm easy going", and "Yes, I often feel anger and frustration", categories. Questionnaire items derived from it are suggested along the lines of - feeling relaxed; being able to express anger; feeling pent-up.

Q17. Would you describe yourself as an impulsive person? (eg. that you act or speak before you think.)

	No, I think first	When I was younger, yes but not now	When I was drinking, yes but not now	Yes I am impulsive
Alcoholics	7	1	7	13
Non-alcoholics	21	3		4

Ho = There is no difference between the alcoholics and non-alcoholics on the personality characteristic of impulsiveness.

Chi-Square = 16.332

Ho is rejected at .01 level of significance.

Typical Responses

Think first: 1."No, definitely not. I'm generally rather cautious. I would tend to sit back and think about things first."(Non-alcoholic) 2."No, I'd work out what I was going to say. I'd count to ten."(Alcoholic)

Impulsive: 1."Yes, I got married after a year and a half. I've bought cars on the spur of the moment."(Alcoholic) 2."Yes I don't stop and think, I just lose the head there and then."(Non-alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "No, I think first"; "When I was drinking, yes but not now"; and "Yes, I am impulsive". Questionnaire items derived from it are suggested along the lines of - stopping to think; letting emotions take over; impulsive acts of buying, eating, speaking.

Q18. Do you see yourself in a good or bad light?

	In a good light	In a bad light	In a bad light due to drinking	In a bad light growing-up, now in a better light
Alcoholics	9	6	7	6
Non-alcoholics	25	2		1

Ho = There is no difference between the alcoholics and non-alcoholics on whether they see themselves in a good or bad light.

Chi-Square = 19.164

Ho is rejected at .01 level of significance.

Typical Responses

Good light: 1."In a good light. In general things were very happy and I saw myself in a good light growing up."(Non-alcoholic) 2."On the whole I have a good opinion of myself. I've never done anybody harm. I've no deep resentment against anyone, except about the job. I always tried to earn on honest shilling."(Alcoholic)

Bad light: 1."I used to feel that if people really knew me they wouldn't like me. That's a long standing feeling."(Alcoholic) 2."I've very low self-esteem. I always had an inferiority complex, that is still there. So I would have seen myself in a bad light always."(Alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "In a good light"; "In a bad light due to drinking"; "In a bad light growing up, now in a better light". Further questionnaire items derived from it are suggested along the lines of - low self-esteem; feelings of inferiority; feeling optimistic or pessimistic about life; self-acceptance and self-hatred.

Q19. How do you get on with other people? (eg. you like their company or you prefer to be on your own.)

	I like company	I like company and time to myself	I'm more of a loner
Alcoholics	6	7	15
Non-alcoholics	10	16	2

Ho = There is no difference between the alcoholics and non-alcoholics on whether they like company or prefer to be on their own.

Chi-Square = 15.085

Ho is rejected at .01 level of significance.

Typical Responses

Like company: 1."I like company, always did. Since I've stopped drinking I like family company mostly."(Alcoholic) 2."I like company of different ages. I like to mix in a mixed age group."(Non-alcoholic)

Loner: 1."A lot of time I like to be left alone. I get on with people but I like to be on my own a lot."(Alcoholic) 2."Most of the time I'd rather be on my own. I'd be more of a loner. I feel self-conscious going to people's houses."(Alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "I like company and time to myself"; "I'm more of a loner". Further questionnaire items are suggested along the lines of - mixing in well; liking or disliking own company; feeling isolated; not able to mix.

Q20. How did you feel about alcohol and drinking before you started to drink?

	No strong feelings either way about it	Anti-drink at first	Wary of it	Approved of it
Alcoholics	16	7	1	4
Non-alcoholics	9		17	2

Ho = There is no difference between the alcoholics and non-alcoholics on the way they felt about alcohol and drinking before they started to drink.

Chi-Square = 23.848

Ho is rejected at .01 level of significance.

Typical Responses

No strong feelings: 1."I didn't know anything about it. It was just something I tried."(Alcoholic) 2."I'd no experiences of it's abuses so it didn't effect me. It didn't cross my mind."(Non-alcoholic)

Anti-drink at first: 1."I hated the idea of it because of the home situation (alcoholic father). I used to drink orange at first but then I saw how my friends got on with women after a few drinks."(Alcoholic)

Wary of it: 1."I think I was against it. My mother was anti-drink. I was one of the last of the gang to drink. I was a bit wary of it."(Non-alcoholic)

Approved of it: 1."It was quite acceptable. I wasn't anti-drink. I was all for it, I was curious about it. I couldn't wait until I could join in and be chatting away and drinking."(Alcoholic) 2."It was just the thing to do. It was a sign of being grown up."(Alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "No strong feelings either way about it"; "Anti-drink at first"; "Wary of it". Further questionnaire items derived from it are suggested along the lines - didn't think much about it; was against it; was wary of it's effects; thought it was a grown-up thing to do; hated it because of home experiences.

Q21. Did you use drugs other than alcohol?

	No	Tranquillizers	Cannabis occasionally	L.S.D., Cocaine infrequently	Heroin
Alcoholics	20	3	3	2	
Non-alcoholics	21		5	1	1

Ho = There is no difference between the alcoholics and non-alcoholics in their use of drugs other than alcohol.

Chi-Square = .090

Ho is accepted at .05 level of significance.

Typical Responses

Tranquillizers: 1."Yes, I took pills, prescribed medicine like Largactal and Nobrium."(Alcoholic) 2."I took pills, Valium and Mandrax, before I drank at all. Then infrequently over the years hash and tablets."(Alcoholic)

Heroin: 1."Yes, heroin,cocaine, speed, hash, pills, for a period of about three years on a fairly regular basis. I stopped short of addiction, just about."(Non-alcoholic)

Utility of Item

This question does not distinguish well between the alcoholics and non-alcoholics so it does not seem likely that further questionnaire items derived from it will show a significant difference between the two groups.

Q22. Do you have any problems such as gambling or eating disorders?

	No	Gambling problem	I eat too much
Alcoholics	21	4	3
Non-alcoholics	27	1	

Ho = There is no difference between the alcoholics and non-alcoholics on whether they have problems such as gambling or eating disorders.

Chi-Square = 5.218

Ho is accepted at .01 level of significance.

Utility of Item

Although there is not a significant difference between the two groups on this item the alcoholics are better represented than the controls in two categories. It is suggested that this item should not be disregarded in any future large scale study.

Q23. What age are you?

	10-20yrs	21-30yrs	31-40yrs	41-50yrs	51-60yrs	61-70yrs
Alcoholics		8	8	7	5	
Non-alcoholics	4	13	4	4	2	1

Ho = There is no difference in the ages of the alcoholics and non-alcoholics.

Chi-Square = 5.890

Ho is accepted at .05 level of significance.

Q24. Have you ever suffered from depression?

	No	Yes, during drinking period	Yes, before and during drinking period	Yes, since I've stopped drinking	Yes, for a time
Alcoholics	11	9	7	1	
Non-alcoholics	25				3

Ho = There is no difference between the alcoholics and non-alcoholics in their experience of depression.

Chi-Square = 21.181

Ho is rejected at .01 level of significance.

Typical Responses

Depression: 1."Yes, I've felt very depressed after a bout of drink."(Alcoholic) 2."Yes, during a drinking bout I ended up with the Samaritans and ended up in St. Vincents hospital for depression."(Alcoholic) 3."Yes I was treated once for depression. After I started to drink the depression was more acute."(Alcoholic) 4."Yes, I was depressed as a kid. When I was twenty-two I was under a doctor for depression. I had the same depression when I was young."(Alcoholic) 5."Yes, I had three bouts of depression since I stopped drinking in 1977."(Alcoholic) 6."Yes, most of my life I have felt depressed. I was never hospitalized but I was sent to the doctor as a kid to have a talk about it."(Non-alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "No"; "Yes, during drinking period"; and "Yes, before and during drinking period". Further questionnaire items derived from it are suggested along the lines of - incidence of depression during childhood and adolescence; depression brought on by alcohol; medication and hospitalization for depression; drinking as a direct result of depression caused, for example, by bereavement.

Q25. Are you single, married, separated, divorced?

	Single	Married	Separated	Divorced
Alcoholics	11	15	2	
Non-alcoholics	16	12		

Ho = There is no difference in the marital status of the alcoholics and non-alcoholics.

Chi-Square = 1.175

Ho is accepted at .05 level of significance.

Q26. Did/do you feel it necessary to drink to be accepted and liked by people?

	Yes, I drank to fit in	No, I get on with people with or without drink	No, I didn't care what people thought
Alcoholics	20	5	3
Non-alcoholics	6	21	1

Ho = There is no difference between the alcoholics and non-alcoholics on whether they found it necessary to drink to be accepted and liked by people.

Chi-Square = 14.070

Ho is rejected at .01 level of significance.

Typical Responses

No I drank to fit in: 1."Yes, I felt I would fit in better with the older crowd, grow up fast."(Alcoholic) 2."Yes, if you didn't drink you weren't accepted into company."(Alcoholic) 3."Yes, I needed drink to get courage to be more accepted by people."(Alcoholic)

I get on with people: 1."No, I got on well with everybody and drinking was just part of growing up."(Alcoholic) 2."No, a good few of my friends don't drink so I don't have to drink."(Non-alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "Yes, I drank to fit in"; "No, I get on with people with or without drink". In the first category five alcoholics felt group pressure to drink, and fifteen felt pressure from a lack of confidence to drink to fit in. Questionnaire items derived from this question would deal with areas like - drinking because of social pressures; drinking because of personal pressures; feelings within the individual like inadequacy, inferiority.

Q27. What is your occupation?

	Classes 1-2	Classes 3-4	Classes 5-6	Classes 7-8
Alcoholics	4	7	5	12
Non-alcoholics	7	9	10	2

Ho = There is no difference between the alcoholics and non-alcoholics in their class of occupation.

Chi-Square = 9.900

Ho is accepted at .05 level of significance.

Q28a. Do you have any children?

	Yes	No
Alcoholics	16	12
Non-alcoholics	11	17

Ho = There is no difference between the alcoholics and non-alcoholics in the number of children they have.

Chi-Square = 1.786

Ho is accepted at .05 level of significance.

Q28b. If yes, how do you get on with them?

	Get on well	Some difficulty	No children
Alcoholics	13	3	12
Non-alcoholics	11		17

Ho = There is no difference between the alcoholics and non-alcoholics on how they get on with their children.

Chi-Square = 4.278

Ho is accepted at .05 level of significance.

Typical Responses

Get on well: 1."Great, even when I was drinking I got on well with them. Good relationship with them all."(Alcoholic) 2."Great, I've a good relationship with the kids. I bring them out at the weekends."(Non-alcoholic)

Some difficulty: 1."I get on fairly good with them, but I think they are afraid of their lives of me.(Alcoholic) 2."I haven't seen him (son) for five and a half years."(Alcoholic)

Utility of Item

Although this question does not distinguish well between the alcoholics and non-alcoholics show a little more difficulty in dealing with their children than the control group. This item may be useful in dealing with the issue of object relationships in a larger study.

Q29. Could you describe your father to me?

	I felt close to him	I felt distant from him	Mixed feelings	He died when I was young
Alcoholics	6	13	4	5
Non-alcoholics	20	6	1	1

Ho = There is no difference between the alcoholics and non-alcoholics in their relationships with their fathers.

Chi-Square = 14.582

Ho is rejected at .01 level of significance.

Typical Responses

Close to him: 1."Very casual, easy going. We got on fine together, went to football matches together. Growing up we weren't distant. No great tensions."(Alcoholic) 2."He's very helpful, always doing jobs at home, he's very cheerful. He's a good singer. He'd do anything for you if you asked, he's a good father. He's dogmatic, my relationship with him is very good."(Non-alcoholic)

Distant from him: 1."I never felt close to him. He is extremely selfish and this drove me away from him. I suppose I never felt I had a father."(Alcoholic) 2."I was afraid of him. He was aggressive. It wasn't a great relationship, I couldn't feel close to him."(Alcoholic)

Mixed feelings: 1."Very much a love/hate relationship from my end. He can't express emotion. I had a conversation with him for the first time recently..... Growing up I felt he didn't give me enough attention."(Alcoholic) 2."I got on well with him. I felt a bit aggrieved when he left. At the moment I can take him or leave him....at one time close, distant now."(Non-alcoholic)

Utility of Item

This question distinguishes well between the alcoholics and non-alcoholics,the significant difference appearing in the categories - "I felt close to him"; "I felt distant from him". Further questionnaire items derived from it are suggested along the lines of - getting on well and feeling close to the father; feeling rejected by him; feeling afraid of him; ambivalent feelings for him; feeling his absence in the home through his death or separation from family.

Q30. Could you describe your mother to me?

	I felt close to her	Not so close to her	I felt distant from her	I was too close to her
Alcoholics	19	3	4	2
Non-alcoholics	20	6	1	1

Ho = There is no difference in the way alcoholics and non-alcoholics felt about their mothers.

Chi-Square = 2.8

Ho is accepted .05 level of signifigance.

Typical Responses

Felt close to her: 1."Very close to my mother. I could talk to her. We've both confided in each other. My father was more remote, an authority figure. She was more understanding and sympathetic than my father."(Alcoholic) 2."She wasn't as strict as my father. A shy person, very understanding, helpful and supportive. Hardworking, I really did idolize my mother. I was very close to her."(Non-alcoholic)

Not so close to her: 1."My mother died when I was seventeen years old. She was a very good mother. Most of the time I was out in the fields playing football. I would have liked to have been closer to her. She was probably also sick because of the home situation." - Father was alcoholic and violent. - (Alcoholic) 2."She must have been strong-willed. It wasn't a bad relationship. She respected my independence and we worked well in that way. We were more distant than close but a respectful distance."(Non-alcoholic)

Felt distant from her: 1."I was afraid of her. She was the boss there. She used to work partime. I never felt close to her. I could never tell her anything. She couldn't show affection."(Alcoholic) 2."I felt distant from her always. I don't communicate with her. Never felt very close to her."(Non-alcoholic)

Too close to her: 1."The brothers said I was too close to her. She used to do everything for me. I was very close to her."(Alcoholic) 2."I was too close to her. An unhealthy closeness to her. She was a complex person completely dominated by my father."(Non-alcoholic)

Utility of Item

Although this item does not distinguish well between the two groups further research on the nature of the close relationship between alcoholics and their mothers might be fruitful as alcoholism has been explained by some psychoanalytic theorists as fixation at the oral stage of development.

Q31. What were your parents' attitudes to you drinking?

	Strongly approve	Moderately approve	Neither approve nor disapprove	Moderately disapprove	Strongly disapprove	Don't know
			ALCOHOLICS			
Father	1	6	5	3	9	4
Mother		5	3	6	12	2
			NON-ALCOHOLICS			
Father	1	6	10	6	5	
Mother		6	8	8	6	

Ho = There is no difference between the alcoholics and the non-alcoholics on their parents' attitudes to them drinking.

Chi-Square = 3.808 (Father); and 2.646 (Mother)

Ho accepted at .05 level of significance.

Utility of Item

Although this item does not distinguish well between the two groups it is noted that twice as many alcoholic group parents strongly disapprove of their offspring drinking,- (particularly the mothers disapproved) - as control group parents. On this basis it may be useful to question further the effect of disapproving attitudes to drink of parents on their offspring.

Q32. Have you had any illnesses in your life?

	Yes	No
Alcoholics	16	12
Non-alcoholics	12	16

Ho = That alcoholics have not experienced more illness in their lives than non-alcoholics.

Chi-Square = 1.132

Ho accepted at .05 level of significance.

Utility of Item

This item does not distinguish well between the alcoholics and non-alcoholics. It is not likely that further research along these lines would be useful.

Q33. Do you find that you are impatient? (eg. you find it hard to put up with delays in people turning up, or when queuing for buses or in the bank.)

	Yes, I'm very impatient	Yes, a little bit at times	No, I'm generally easy going
Alcoholics	17	5	6
Non-alcoholics	8	9	11

Ho = That alcoholics are not any more impatient than non-alcoholics.

Chi-Square = 5.852

Ho is accepted at .05 level of significance.

Typical Responses

Very impatient: 1."Yes, waiting for somebody is unbearable. It is a major source of tension."(Alcoholic) 2."Yes, I can't wait on queues, or for people turning up."(Non-alcoholic)

A little bit at times: 1."No, I wouldn't say I'm overly impatient. If I'm late I'm impatient."(Non-alcoholic) 2."At times only. I can be patient when I want to."(Non-alcoholic)

Generally easy going: 1."No, by in large I take delays in my stride."(Non-alcoholic) 2."Very occasionally, as a general rule I'm extremely patient."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the two groups it is noted that twice as many alcoholics as non-alcoholics are in the "very impatient" category. This suggests that the "impatience" variable may be a useful item for further research, so it should not be discarded at this stage of inquiry.

Q35. What place do you come in the family?

1st.	2nd.	3rd.	4th.	5th.	6th.	7th.	8th.	9th.	10th.
				ALCOHOLICS					
10	3	4	4	3	2	2			
				NON-ALCOHOLICS					
11	7	5	1	2	2				

Q36. How would you describe your home life growing up?

	Happy	Reasonably happy	Very unhappy
Alcoholics	11	8	9
Non-alcoholics	20	6	2

Ho = There is no difference in the home life growing up of alcoholics and non-alcoholics.

Chi-Square = 7.350

Ho is rejected at .05 level of significance.

Typical Responses

Happy: 1."Very good, very happy. We never wanted for anything. We all had the opportunity of going to college. We were never deprived of affection."(Alcoholic) 2."It was happy, whole family is fairly close. My parents were always there if there was anything wrong. I felt good about going home."(Non-alcoholic)

Very unhappy: 1."Brutal all the fighting in the house. Always rows and police up to the house. My mother attempting suicide."(Alcoholic) 2."Bad, a lot of tension and aggression and fear in the home. I can't remember any happiness much when I was growing up."(Non-alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "Happy"; and "Very unhappy". Further questionnaire items derived from it are suggested along the lines of - atmosphere in the childhood home; whether there was violence in the home; did the respondents feel secure or anxious; alcoholism in the home.

Q37. How would you describe your home life now?

	Very good	Reasonably good	I live alone it's fine	I live alone it's not great	Bad
Alcoholics	16	1	3	4	4
Non-alcoholics	21	3	3		1

Ho = There is no difference in the present home life of the alcoholics and non-alcoholics.

Chi-Square = 6.388

Ho is accepted at .05 level of significance.

Typical Responses

Very good: 1."Great now. I wouldn't change it for all the beer in Guinnesses."(Alcoholic) 2."Very good, its a busy place. A lot of cooperation between the wife and kids. No hastle, so far so good.(Non-alcoholic)

Bad: 1."There are problems with my wife - sexual problems. There is some aggression in the home."(Alcoholic) 2."A bit bad a the moment over the drink and trouble. My wife cut her wrists and tried suicide."(Alcoholic) 3."Much the same, a lot of aggression, shouting and screaming everyday."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the two groups it is noted that for eight of the alcoholics their present home life is unhappy compared to one non-alcoholic. It is suggested therefore that further consideration of this variable may be useful.

Q38a. What part does/did alcohol play in your home life?

	No part	A small part	A large part
Alcoholics	9	1	18
Non-alcoholics	22	3	3

Ho = There is no difference in the part alcohol played in the home lives of the alcoholics and non-alcoholics.

Chi-Square = 17.102

Ho is rejected at .01 level of significance.

Typical Responses

No part: 1."It played no part. There was a subtle taboo on drinking"(Alcoholic) 2."We never had alcohol in the house. It played no part at all. No interest in it."(Non-alcoholic)

A small part: 1"An odd time we might have a drink looking at T.V., or wine with the Sunday dinner."(Non-alcoholic)

A large part: 1."My father was an alcoholic and my grandfather. The uncle(alcoholic) used to come for a few months now and then."(Alcoholic) 2."A large part mainly centred around my father who was an alcoholic."(Non-alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "No part"; and "A large part". Further questionnaire items derived from it are suggested along the lines of - alcoholism in the home; drinking practice in the home.

Q38b. What part does/did alcohol play in your work life?

	A large part	A small part	No part
Alcoholics	15	6	7
Non-alcoholics	3	10	15

Ho = There is no difference in the part alcohol plays/played in the work life of the alcoholics and non-alcoholics.

Chi-Square = 11.908

Ho is rejected at .01 level of significance.

Typical Responses

A small part: 1."A certain amount of social drinking was encouraged."(Alcoholic) 2."I'd go out about once a week or once a fortnight with girls from work."(Non-alcoholic)

A large part: 1."Travelling around the country you'd get expenses. There was a lot of money and a lot of dos."(Alcoholic) 2."I drank a lot through the job, drinking with work mates."(Alcoholic) 3."Working in cabaret as a doorman there is a lot of drinking after hours."(Non-alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "A large part"; and "No part". Further questionnaire items derived from it are suggested along the lines of - presence of drink during working hours; encouragement to drink from work colleagues; drinking with people from work.

Q38c. What part does/did alcohol play in your social life?

	Large part	Large part once now small part	Medium part	Small part
Alcoholics	28			
Non-alcoholics	3	4	9	12

Ho = There is no difference in the part alcohol plays/played in the social life of the alcoholics and non-alcoholics.

Chi-Square = 33.30

Ho is rejected at .01 level of significance.

Typical Responses

Large part: 1."My whole social life was drink. When I was drinking I knew no other social life."(Alcoholic) 2."Almost exclusively to do with drinking. From the time I went to college my social life was dominated by alcohol."(Alcoholic)

Medium part: 1."Every weekend I drink at least once in a pub or disco. I drink moderately."(Non-alcoholic) 2."We'd have a couple of drinks at weekends - Friday, Saturday, and Sunday. A drink or two after bowling or ice-skating, and three or four if we stay in the pub."(Non-alcoholic)

Small part: 1."Not a major role, parties or seasonal events. The occasional weekend drink."(Non-alcoholic) 2."The odd drink after training."(Non-alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "Large part"; "Medium part"; and "Small part". Further questionnaire items derived from it are suggested along the lines of - drinking practice in social life; amount of social activity connected with drinking; social activities independent of drinking.

Q39. How would you describe yourself growing up?

	Happy and mixed in well	Shy but happy in myself	Shy with feelings of inferiority	A loner
Alcoholics	11	2	10	5
Non-alcoholics	11	15	2	

Ho = There is no difference between alcoholics and non-alcoholics as children.

Chi-Square = 20.260

Ho is rejected at .01 level of significance.

Typical Responses

Happy and mixed in well: 1."I got on with people. Always involved in sport, the Legion of Mary, St. Vincent de Paul. School was a happy time. Happy enough kid growing up."(Alcoholic) 2."Usually out of the house with friends. I was a member of a few clubs, went swimming. I mixed in well with others."(Non-alcoholics)

Shy but happy in myself: 1."I'd say I was shy and a bit self conscious. I always had a gang of friends."(Alcoholic) 2."I was always very quiet, not very extrovert. I was quite happy being quiet. I always had one or two good friends. I was very happy growing up."(Non-alcoholic)

Shy with feelings of inferiority: 1."I was shy, with an inferiority complex. Very nervous growing up."(Alcoholic) 2."I was shy. Although I mixed successfully with people. I always had friends. There was a deep feeling of inferiority or self-contempt behind the public image. I identified a lot with city interests like music."(Non-alcoholic)

A loner: 1."Insecure, self-conscious, very shy - unhappy because I felt lonely. Through lack of confidence I didn't take part in sport, debates."(Alcoholic) 2."A bit of a loner, never on the football team. I'd only have one or two friends. Shy, very unhappy. I never liked being me. I wanted to be more extroverted, have a sense of humour."(Alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in the categories - "Shy but happy in myself"; "Shy with feelings of inferiority"; and "A loner". Further questionnaire items derived from it are suggested along the lines of - feeling happy and well integrated; feeling shy ; feeling inferior; feeling isolated; lacking in confidence.

Q40. Did you ever feel there was pressure on you to drink?

	Yes, pressure from friends	Yes, internal pressure	No, I just felt like it
Alcoholics	5	5	18
Non-alcoholics	17		11

Ho = There is no difference in the pressure to drink that alcoholics and non-alcoholics felt.

Chi-Square = 13.232

Ho is rejected at .01 level of significance.

Typical Responses

Pressure from friends: 1."Yes, a certain amount of peer group pressure."(Alcoholic) 2."Yes, a subtle pressure to fit in from friends who were drinking."(Non-alcoholic)

Internal pressure: 1."I felt pressure from within, from my own thinking."(Alcoholic) 2."Yes, sexual problems in marriage put pressure on me to drink as a form of escape."(Alcoholic)

Just felt like it: 1."No, it suited me to drink. I liked the drinking environment."(Alcoholic) 2."No, I just wanted to drink. I'd blame the job on my drinking but it wouldn't be the job."(Alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference appearing in at least the two categories - "Yes, pressure from friends"; and "No, I just felt like it". Further questionnaire items derived from it are suggested along the lines of - personal decision to drink; peer group pressure; internal pressure from emotional conflict; desire to escape through drink.

Q41. What is your father's occupation? (If he is retired, out of work, or deceased, what was his principal former occupation.)

Classes 1-2	Classes 3-4	Classes 5-6	Classes 7-8
	ALCOHOLICS		
2	4	13	9
	NON-ALCOHOLICS		
5	6	12	5

Ho = There is no difference in the occupations of the fathers of the alcoholics and non-alcoholics.

Chi-Square = 2.866

Ho is accepted at .05 level of significance.

Utility of Item

Although this item does not seem to distinguish well between the two groups it is noted that the fathers of the alcoholics are better represented in the Manual Classes than the fathers of the non-alcoholics. It is suggested therefore that family occupation may be usefully looked at in any later stage of research.

Q42. What is your mother's occupation? (If she is retired, out of work, or deceased, what was her principal former occupation.)

	Classes 1-2	Classes 3-4	Classes 5-6	Classes 7-8	Housewife
ALCOHOLICS	4				24
NON-ALCOHOLICS					28

Ho = There is no difference in the occupation of the mothers of the alcoholics and non-alcoholics.

Chi-Square = 2.629

Ho is accepted at .01 level of significance.

Utility of Item

This item does not seem to distinguish well between the alcoholics and non-alcoholics. However since four of the mothers of the alcoholics had an occupation outside of the home compared to none of the mothers of the control group it is suggested again that family occupation might be usefully looked at in any further research.

Q43. When you were a teenager, what did the people you were closest to do in their spare time?

	Sports, dances and other non-drinking pastimes	Sports, dances and social drinking	Sports, dances and heavy drinking
Alcoholics	8	4	16
Non-alcoholics	11	14	3

Ho = There is no difference in the pastimes of the teenage friends of the alcoholics and non-alcoholics.

Chi-Square = 14.920

Ho is rejected at .01 level of significance.

Typical Responses

Other non-drinking pastimes: 1."A bit of cycling, a lot of dances. Football matches, catching rabbits, shooting, hunting."(Alcoholic) 2."Watched T.V., played football, read books and played with computers."(Non-alcoholics)

Heavy drinking: 1."They drank and went to dances and robbed cars, got into fights. 2."Soccer, dances, then at sixteen you met in the pub before anything."(Alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics so further questionnaire items derived from it are suggested along the lines of - drinking practices of teenage friends; interests and activities of teenage friends.

Q44. What social outlets were available in your community when you were a teenager?

	Various outlets	Some outlets	Very few outlets	No outlets
Alcoholics	6	10	6	6
Non-alcoholics	10	7	5	6

Ho = There is no difference in the community outlets available to the alcoholics and non-alcoholics when they were teenagers.

Chi-Square = 1.618

Ho is accepted at .05 level of significance.

Typical Responses

Various outlets: 1."As a boy, school sports mainly. In the Navy, clubs, swimming pools, drama, etc."(Alcoholic) 2."A youth club, discos, hiking outings, cinema. Pitch and put, swimming pools and pubs.

Some outlets: 1."Not that many. Football and handball, pubs, cinema and dances."(Alcoholic) 2."Football, sports, swim in the river."(Non-alcoholic)

Very few outlets: 1."Very little, except a handball alley, cinema in the local hall, and dance. Pubs."(Alcoholic) 2."Weren't any for girls. It was mainly football clubs and pubs. It was a developing area then."(Non-alcoholic)

No outlets: 1."Local school team. The pub. Damn all."(Alcoholic) 2."None in the local community. Pubs and a cinema."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the two groups it is noted that the control group had more access to organized activities like youth clubs than the alcoholic group. The fact that this provides alternatives to drinking should not be overlooked in any further research.

Q45. What level had you reached when you finished your full-time education? And what level had your parents reached?

	Self		Father		Mother	
	Alc.	N.Alc.	Alc.	N.Alc.	Alc.	N.Alc.
National education only - Incomplete	3	-	4	1	4	1
- Complete	6	1	19	14	16	17
1-2 Secondary School	1	1	-	3	-	2
3-4 Secondary School	4	3	2	3	3	2
Finished Secondary School	7	16	-	5	3	5
Some Vocational Education	2	1	1	-	-	-
Completed Vocational Education	2	-	1	-	-	-
Some University Education	2	1	-	1	-	1
Completed University Education	1	4	1	1	2	-
Post Graduate (M.A., Phd., etc.)	-	2	-	-	-	-

1. Ho = There is no difference in the level of education of the alcoholics and non-alcoholics.

Chi-Square = 11.380

Ho is rejected at .01 level of significance.

2. Ho = There is no difference in the level of education of the fathers of the alcoholics and non-alcoholics.

Chi-Square = 8.114

Ho is rejected at .05 level of significance.

3. Ho = There is no difference in the level of education of the mothers of the alcoholics and non-alcoholics.

Chi-Square = 2.170

Ho is accepted at .05 level of significance.

Utility of Item

It appears that the control group reached a higher standard of education overall than the alcoholic group, while the parents of both groups had a similar level of education. Education may be an important factor in alcoholism and should be included in any further research.

Q46. Would you say you drink to excess?

	Yes(occasionally)	No
Alcoholics		28
Non-alcoholics	4	24

Utility of Item

This question was asked to establish the drinking behaviour of the non-alcoholics to ensure that they were "social drinkers" and so would be accepted as a control group. The results indicate that they were acceptable.

Q47. Would you describe yourself as a dependent kind of person?

	Yes, I lean on people	Yes, while drinking	No, I'm self-reliant
Alcoholics	13	4	11
Non-alcoholics	5		23

Ho = That alcoholics are no more dependent than non-alcoholics.

Chi-Square = 7.639

Ho is rejected at .01 level of significance.

Typical Responses

Lean on people: 1."Yes, dependent, I tend to rely on stronger people."(Alcoholic) 2."Yes, I need a lot of encouragement from others. A lot of things are done for me at home."(Non-alcoholic)

Yes, while drinking: 1."Yes, I was dependent while I was drinking, but I'm more independent since I've stopped."(Alcoholic)

No, I'm self-reliant: 1."Very independent, I emigrated to England and made my own life."(Alcoholic) 2."I'm independent, I can take the initiative. I do my own thing. I had to take the role of the father, being the eldest."(Non-alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference occurring in the categories - "Yes, I lean on people"; and "No, I'm self-reliant". Further questionnaire items derived from it are suggested along the lines of - relying on others; making decisions; dependency in relationships; problem solving.

Q48. Would you describe yourself as a perfectionist?

	Yes, I am a perfectionist	No, but I like to do things well	No, I just do my best
Alcoholics	7	7	14
Non-alcoholics	2	12	14

Ho = There is no difference between the alcoholics and non-alcoholics on the characteristic of perfectionism.

Chi-Square = 4.090

Ho is accepted at .05 level of significance.

Typical Responses

Perfectionist: 1."Yes I would. I get tensed up if a job is not right."(Alcoholic) 2."Yes, I knock myself if I make mistakes. I'm hard on myself. If I don't get a job done perfectly I blame myself for it."(Alcoholic) 3."Yes, and have been described as such by others. I like to take time and do things right."(Non-alcoholic)

Do things well: 1."In a lot of areas like my work I like to do a good job. It's not a problem, I'm not obsessional about it."(Alcoholic) 2."I like to do things very well. I'd accept it if it didn't work out perfectly."(Non-alcoholic)

Do my best: 1."No, I'll do my best. I like to get work satisfaction. If it suits me I'll take a short cut."(Alcoholic) 2."No, I wouldn't go overboard. I'd do my best."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the alcoholics and non-alcoholics seven alcoholics describe themselves as perfectionists compared to only two controls. It is suggested then that this personality trait should not be dismissed too lightly from any further research.

Q49. Would you describe yourself as a domineering person? (eg. you need to be in a position of power.)

	Yes	No
Alcoholics	9	19
Non-alcoholics	2	26

Ho = There is no difference between the alcoholics and non-alcoholics on the characteristic of being domineering.

Chi-Square = 5.515

Ho is accepted at .01 level of significance.

Typical Responses

Yes: 1."Yes, I would tend to. I bullied my girlfriend."(Alcoholic) 2."Yes, I'm either totally dependent or domineering. I used money to dominate people."(Alcoholic)

No: 1."No, I wouldn't try to impose my will on anybody."(Non-alcoholic) 2."No way, I'd stick back in a group and let others do the shouting or whatever."(Non-alcoholic) 3."I'd usually let others dominate me."(Alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the two groups it is noted that nine of the alcoholics compared to only two controls admit to being domineering. It is suggested therefore that this personality trait may be useful at a further stage of research.

Q50. Would you say you were a hyperactive child?

	Yes	No
Alcoholics	3	25
Non-alcoholics	1	27

Ho = There is no difference between alcoholics and non-alcoholics on hyperactivity in childhood.

Chi-Square = 1.057

Ho is accepted at .05 level of significance.

Typical Responses

Yes: 1."Yes, I used to get the fidgets a lot, jumpy."(Alcoholic) 2."Yes, even as a kid I couldn't sit still."(Alcoholic) 3. "Yes I was always in trouble in the class for messing."(Non-alcoholic)

Utility of Item

Although this item does not distinguish well between the alcoholics and non-alcoholics there is some evidence that alcoholics may be more prone to hyperactivity in childhood. It is suggested that this variable should not be dismissed in any later research.

Q51a. Have you experienced tragedy in your life?

	Yes	No
Alcoholics	18	10
Non-alcoholics	13	15

Ho = There is no difference in the extent of tragedy experienced by alcoholics and non-alcoholics.

Chi-Square = 1.806

Ho is accepted at .05 level of significance.

Typical Responses

Yes: 1."Yes, my sister died of cancer, and my father died."(Alcoholic) 2."Yes, my whole childhood, and my brother died."(Alcoholic) 3."Yes, my father died when I was young, and friends were killed in car crashes."(Non-alcoholic)

Utility of Item

There does not appear to be any significant difference in the extent of tragedy experienced by both groups. However it is in the reaction of the alcoholics and non-alcoholics to the tragedy that an interesting difference occurs, as we can see below.

Q51b. If yes, did you drink more as a result of this?

	Yes	No	No tragedy
Alcoholics	12	6	10
Non-alcoholics	1	12	15

Ho = There is no difference in the drinking practice of alcoholics and non-alcoholics when they experience tragedy.

Chi-Square = 10.306

Ho is rejected at .01 level of significance.

Typical Responses

Yes: 1."Yes, I drank more as a result of my wife dying. Then I really hit the bottle."(Alcoholic) 2."The biggest tragedy of my life is my lack of a relationship with my father. This caused my isolation which contributed to my drinking."(Alcoholic)

Utility of Item

This item distinguishes well between the alcoholics and non-alcoholics, the significant difference occurring in the categories - "Yes; and "No". Further questionnaire items derived from it are suggested along the lines of - reaction to tragedy; ability to express grief; alternative reaction to drinking.

Q52. As a teenager, did you ever run into trouble with the law?

	Yes	No
Alcoholics	3	25
Non-alcoholics	2	26

Ho = There is no difference between alcoholics and non-alcoholics in their experience of trouble with the law.

Chi-Square = .211

Ho is accepted at .01 level of significance.

Typical Responses

Yes: 1."Yes, robbing cars and getting drunk."(Alcoholic) 2."Yes, I was arrested a few times but I was only charged once. I was arrested for things I didn't do. I wasn't into crime."(Non-alcoholic)

Utility of Item

Although this item does not distinguish well between the two groups it is suggested that this study is dealing with a limited sample and therefore delinquent behaviour should not be dismissed from any larger future study.

Q53. Do you find it difficult to deal with authority figures?

	Yes	No
Alcoholics	10	18
Non-alcoholics	4	24

Ho = There is no difference between alcoholics and non-alcoholics in whether they find it difficult to deal with authority figures.

Chi-Square = 3.408

Ho is accepted at .01 level of significance.

Typical Responses

Yes: 1."Yes, very difficult. I'm inclined not to recognize most people's authority. In the simplest ways it gives me problems. I don't like calling people mister or doctor."(Alcoholic) 2."I do, I'm basically anti-authoritarian. I'm a non-conformist which brings me into conflict with authority."(Non-alcoholic)

No: 1."No, in the Navy I found no difficulty in taking orders."(Alcoholic) 2."Not really, they are there to do a job. I've no resentment against them."(Alcoholic) 3."No, I get on well with most people. I don't have a fear of authority. When it comes down to it they're just human beings."(Non-alcoholic)

Utility of Item

Although this item does not seem to distinguish well between the two groups it is noted that more of the alcoholics than the controls had difficulty with authority figures. It is suggested then that further research on this item might be useful in determining an alcoholic personality trait.

Q54. Is there anything you would like to add?

This question was intended to give the respondents an opportunity to talk about anything not covered in the previous questions. In all cases they either had nothing further to add or reiterated points they had already made. It was decided to check any comments against the responses already made. For example, John, a thirty four year old alcoholic said in reply to Q54. - "Yes, people pleasing has always been there. I was always afraid of offending people. This is related to my low self-esteem. I always put on a mask." John had already spoken of having low self-esteem in Q18., so his comment reinforced his previous response. The same procedure applied to the other relevant comments.

TABLE 1.

Questions showing a difference between the alcoholics and non-alcoholics at .01 level of siginficance.

Q.	ITEM	MODEL	Level of Sig.
13.	Family drinking history	Medical Model	.01
11.	Relationships with women	Psychoanalytic Model	.01
12.	Relationships with men	Psychoanalytic Model	.01
16.	Anger and frustration	Psychoanalytic Model	.01
17.	Impulsiveness	Psychoanalytic Model	.01
18.	Self-esteem	Psychoanalytic Model	.01
24.	Depression	Psychoanalytic Model	.01
39.	Childhood personality	Psychoanalytic Model	.01
47.	Dependency	Psychoanalytic Model	.01
13.	Social learning	Behavioural Model	.01
20.	Attitude to drink	Sociological Model	.01
29.	Relationship with father	Sociological Model	.01
38a.	Alcohol and the home	Sociological Model	.01
38b.	Alcohol and the job	Sociological Model	.01
38c.	Alcohol and social life	Sociological Model	.01
40.	Pressure to drink	Sociological Model	.01
43.	Pastimes of teenage friends	Sociological Model	.01

Questions showing a difference between the alcoholics and non-alcoholics at .05 level of significance.

10.	Drinking company	Sociological Model	.05
15.	Bad childhood experiences	Psychoanalytic Model	.05
26.	Drinking to be accepted and liked by others	Sociological Model	.05
36.	Home life growing up	Sociological Model	.05
51b.	Drinking as a result of tragedy	Psychoanalytic Model	.05

DISCUSSION OF RESULTS

This chapter consists of a discussion of the findings on questions dealing with (a) the early drinking experience of the respondents and (b) the various theories of aetiology in the order of the literature review.

EARLY DRINKING EXPERIENCE

Age: On the question dealing with the age of the respondents when they first started to drink (Q.4), we can see from the raw data that ten alcoholics compared to five controls began drinking at the early age of ten to fifteen years old. The rest of the sample began drinking at what could be called a usual age - from late teens on. A statistical test using the Chi-Square showed no significant difference between the two groups.

Occasion: Looking at the sample on the questionnaire item covering the occasion on which they took their first drink (Q.5) the vast majority of the respondents were with friends. The two groups differ in that seven of the alcoholics compared to three controls had their first drink in a field with friends and three of the alcoholics compared to none of the controls drank alone. It was found however, that these differences between the two groups were not significant.

Drinking pattern: On the question dealing with the drinking pattern for the first five years (Q.6) a significant difference was found between the two groups. Within five years twenty of the alcoholics were drinking heavily while nine of the controls were having an occasional social drink and the remaining nineteen were drinking socially at weekends.

Drinking capacity: At first :- straight away nine of the alcoholics were in the 'high' (8 pints of beer) category. Eleven of the alcoholics compared to eight of the controls were in the 'average' (4-5 pints) category. Eight of the alcoholics compared to nineteen controls were in the 'small' (0-3 pints) category (Q.9). These findings were significant on the Chi-Square test. Within five years:- There was a dramatic increase in the level of consumption for the alcoholic group. Within five years of first starting to drink fifteen of the alcoholics were in the 'very high' (10+ pints) category; eight were in the 'high' (8 pints) category compared to three controls; five were in the 'average' (4-5 pints) category compared to fifteen controls; and none were in the 'small' (0-3 pints) category compared to ten controls. This difference between the two groups was found to be significant.

Summary

The early drinking experience of the sample shows us that on the age and on the occasion on which they first started to drink there was no significant difference between the two groups. That the alcoholic group drank greater amounts of alcohol and more frequently than the control group suggests they

had a pronounced need and a high tolerance for alcohol. This need or desire for alcohol may arise from the emotional or social conditions of the individuals - a point which will be taken up respectively in the psychological and sociological models sections later on in this discussion. The high tolerance finding may indicate an inherited physiological difference between the two groups. This is looked at in the medical model section in the discussion.

MEDICAL MODEL

Family disease: Responses to Q13. dealing with the family incidence of alcoholism, indicated that most of the alcoholic group had an alcoholic parent, usually the father, compared to only one of the control group. This finding strongly suggests that alcoholism is a family condition and goes further than N.S Cottons (1979) who reviewed studies conducted in the last forty years and found that almost one-third of any group of alcoholics will have at least one alcoholic parent.

Comparing the drinking behaviour of the families of the alcoholics and non-alcoholics, eleven fathers were alcoholic and six were heavy drinkers in the alcoholic group, compared to one alcoholic father and three heavy-drinking fathers in the control group. This difference between the two groups on the fathers' drinking behaviour was found to be highly significant on a Chi-Square test. Looking at the drinking behaviour of the mothers of the two groups - five mothers in the alcoholic group were alcoholic compared to none in the control group. This difference was not significant. Twelve brothers in the alcoholic group were alcoholics and eleven were heavy drinkers compared to no alcoholic brothers in the control group and five heavy drinkers, - a difference which was highly significant. Overall, the families of the alcoholic group, going back to grandparents on both sides, had a lot more incidents of alcoholism than had the families of the control group.

While there is convincing evidence in this questionnaire item to suggest that alcoholism is a family disease it is not possible to say unequivocably, whether the condition is inherited through the genes or whether it is a learned behaviour. It has been found that the transmission of "alcoholic genes" is strongest in men, so if the inheritance of alcoholism is genetic we would expect there to be more alcoholics among the male members of the families of the alcoholic group. This is in fact the case:- twelve brothers compared to five sisters were alcoholic; twenty-four uncles compared to four aunts were alcoholics; and twelve grandfathers compared to no grandmothers were alcoholic. These findings still do not allow a categorical statement on the genetic influence in the aetiology of alcoholism to be made. Short of conducting adoption or twin studies it is not possible to rule out a social learning influence in the "inheritance" of alcoholism.

What can be said is that from these findings alcoholism appears to be a family disease which manifests most strongly among the male members of alcoholic families.

Hyperactivity: To examine this variable the respondents were asked whether they were hyperactive in their childhood (Q50). Three of the alcoholics said yes, they couldn't sit still compared to one non-alcoholic. The difference between the two groups was not significant in a Chi-Square test. These findings do not support Tarter et al (1976) who found more symptoms of

childhood hyperactivity and other indices of minimal brain dysfunction among severe drinkers than among less severe drinkers.

Physical illness: On this question the respondents were asked whether they had any illnesses in their lives (Q32). Sixteen of the alcoholics said yes compared to twelve of the non-alcoholics. The purpose of this question was to determine whether the alcoholics as a group had perhaps more childhood or adolescent illnesses than the control group, which might have contributed to their excessive drinking. However, the difference between the two groups was not found to be significant. There was no great difference between the two groups on the range of illnesses they had, - listed in both groups are bronchitis, pneumonia, asthma, jaundice. However, the alcoholics did have four incidents of illnesses directly related to their drinking. These were pancreatitis, gastroenteritis, heart attach, liver and kidney trouble.

Summary

The most impressive results in this section have been those related to the family incidence of alcoholism, for instance, the difference between the fathers' drinking behaviour of both groups was significant at .01 level of significance. There is strong evidence to suggest that alcoholism is a family condition which manifests most often in the male members of the family. The nature of the "inheritance" of alcoholism cannot be ascertained in this study, it may be inherited through the genes or it may be a learned behaviour.

In the responses to the questions dealing with hyperactivity in childhood, and physical illness, the two groups did not differ greatly. It is reasonable to say that in this study, at least, these two variables do not play an important role.

PSYCHOANALYTIC MODEL

Relationships:- In developing relations with the opposite sex (Qs.11 & 12), the alcoholic group manifested more difficulties, both when married and single than did the control group. Fifteen alcoholics had difficulties relating to women compared with two controls. These difficulties were of a chronic nature and existed before the onset of alcoholism in ten of the alcoholics. For example, John, a 27 year old alcoholic said in reply to the question "How do you get on with women?" - "Very bad, always did, couldn't mix with them. Feeling shy was a stumbling block. Not able to build up relationships. Mainly one night stands with prostitutes." The problem for these alcoholics was an inability to form close attachments or to be intimate with women. Of the two women alcoholics in the study, one found it difficult to relate to men and could only be intimate when she had alcohol taken.

In relating to men the alcoholic group had again more problems than the control group. Ten alcoholics compared to one control spoke of problems such as lacking confidence, keeping their distance and homosexual encounters.

The difference between the two groups on Qs 11 and 12 were significant on a Chi-Square test and show some support for Glover's (1932) proposal of a "psychic condition in the alcoholic which is dangerous and which manifests in the individual's ambivalent identification with objects. Alcohol is used

in an attempt to cure the underlying disorder but results only in self-destruction." Chodorkoff (1963) also emphasizes "disturbances in object relationships as significant in the alcoholic personality".

Questioning the respondents on their relationships with their children (Q.28) it was found that both groups got on well with them. There was no significant difference between the groups which indicates that the alcoholic group could have successful object relationships. However, as would be expected the alcoholics who had difficulties relating to the opposite sex didn't have any children.

Anger and frustration: Seventeen of the alcoholic group said they often feel anger and frustration compared to four of the control group (Q.16). Overall the alcoholics appeared to have suffered more from anger and frustration and the difference between the two groups was found to be significant. This finding lends support to Khantzian's (1982) view that alcoholics are less able to achieve "affect regulation" because of disturbances in ego structures which are responsible for regulating behaviour and feelings.

Khantzian believes that the alcoholic's use of regression diminishes his capacity for affect regulation resulting in an influx of unbearable feelings. To avoid extreme affective discomfort the alcoholic resorts to the use of denial and/or alcohol. An example of bottled-up anger and frustration, perhaps leading to alcoholism, is Jack, a thirty-four year old alcoholic who

replied to this item - "Yes, all the time. It goes back to when I was a kid. I felt hatred for my father, bottled up."

This inability to deal with anger and frustration manifested in the alcoholic group is supported by the findings of both Kernberg (1975) and Klein (1975) who propose a positive relationship between difficulties in affect regulation and alcoholism.

Impulsiveness: On this question of impulsiveness (Q.17) the alcoholic group scored significantly higher than the control group. Twenty alcoholics said they were impulsive compared to four controls. Seven out of the twenty alcoholics said they were impulsive while drinking but not since they have stopped. This suggests that their impulsivity was due to drinking and was not an integral part of their personality. It is still a high score on impulsivity for the alcoholic group compared to the control group. An example of impulsiveness in the alcoholic group was Tom, a forty year old alcoholic who responded to the question on whether he regarded himself as impulsive- "Yes, quite often I shoot from the hip. I am guarding against the impulsiveness in me."

There is support in these findings for Khantzian's (1982) claim that the pre-alcoholic personality is impulsive. Other characteristics of the pre-alcoholic personality proposed by Khantzian were restlessness, and delinquent, aggressive and/or violent behaviour. On the questions dealing with restlessness (Q.50) this study found no significant difference between

the two groups - three of the alcoholics compared to one of the controls admitted to feelings of restlessness in childhood. On the question dealing with delinquent behaviour no significant difference was found between the two groups - three alcoholics compared to two controls admitted to robbing cars and vandalizing property.

These findings indicate that impulsiveness may be related to alcoholism, but restlessness and delinquent behaviour do not appear to be.

Dependency: A basic concept of psychoanalysis sees dependency as the key to psychic development. Human beings spend a large part of their early life dependent on others. Because of this, the emotional relationships which prevail in these early years set the pattern for adult interpersonal relationships. If we accept that alcoholism can be a symptom of a failure in emotional growth we would expect the alcoholic group in this study to be more dependent than the control group. This is, in fact, the case.

A significant difference on the Chi-Square test was found between the two groups on the question dealing with dependency (Q.47). Seventeen of the alcoholic groups compared to five of the control group said they were dependent emotionally on other people. Four of the seventeen alcoholics said they were dependent while drinking but were becoming more independent since they stopped drinking. This high level of dependency in the alcoholics may be indicative of problems in the development of self-structures as suggested by Khantzian (1982). Self-structures are important in maintaining self-esteem

and inner states of comfort and well-being. A balanced 'sense of self' is achieved by internalizing qualities and attitudes from parents who are seen to care for the child.

If we look at the relationships between the respondents and their parents in this study we find that there was no significant difference between the two groups in their relationships with their mothers; both groups were close to their mothers. However, there was a significant difference between the two groups in their relationships with their fathers - seventeen of the alcoholics had difficulties relating to their fathers compared to seven of the controls, and five alcoholics were bereaved of their fathers when they were young compared to one control. This pronounced difficulty among the alcoholics in relating to their fathers may be as a result of the high level of paternal alcoholism in the alcoholic group.

This negative parent/child relationship evident among the alcoholics could lead to impairment in self-structures which, in turn, would result in the unhealthy dependency found in the alcoholic group in this study.

Low Self-Esteem: Nineteen of the alcoholic group saw themselves in a bad light compared to only three of the control group (Q.18). With six of the nineteen alcoholics this feeling of low self-esteem was a long-standing feeling. With another six they felt bad about themselves growing up but were improving in their own self estimation. Seven others saw themselves

in a bad light due to their drinking. Of the three controls who saw themselves in a bad light, two said it was a long-standing feeling and one used to see himself in a bad light, but now sees himself in a better light.

These differences between the two groups which were significant on a Chi-Square test, indicate that the alcoholic group had suffered more emotional damage caused by poor self-opinion than had the control group. Being unhappy with themselves they would have a greater need for a mood-altering chemical like alcohol than would the control group. Pat, a 28 year old alcoholic, in reply to the question "Do you see yourself in a good or bad light?" said, "Now in a good light. Growing up, I felt bad about myself. I gave an image of being happy but inside I felt inferior and lonely."

These findings coincide with Khantzian's (1982) view, relating impairment in self-structures and alcoholism. One result of this impairment is faulty ego-ideal formation (the self's conception of how he wishes to be), which, in turn, results in low self-esteem. Williams (1965) and McCord (1972) also found evidence of poor self-esteem in alcoholics.

Homosexuality: Only one of the alcoholic group compared to none of the control group stated he was exclusively homosexual (Q.11). However, two other alcoholics had homosexual experiences but were convinced that their sexual preference lay with the opposite sex. For example, John, a thirty year old alcoholic with feelings of 'attraction and fear' for women, had two sexual

relationships with men 'at an experimental stage' in his life. At present he would 'not be interested again'.

These homosexual episodes can be explained with reference to Hartman's (1925) study in which he discovered that homosexuality was often acquired as an effect of taking a drug which caused regression. The drug in question here was cocaine but a similar situation may obtain with alcohol which also invites regression.

Depression: There were significantly more incidents of depression among the alcoholics than among the controls (Q.24). Seventeen of the alcoholic group suffered from depression compared to three of the control group. Nine of these alcoholics related their depression to their drinking while seven others experienced depression before they started to drink and one since he stopped drinking. There is evidence here that alcoholism causes depression, a finding that is supported in the longtitudinal study of Hoffman et al (1974, 78).

There is also the finding that seven of the alcoholic group compared to three of the control group suffered depression before they started to drink, which suggests that depression may be a predisposing factor in alcoholism. Cooney (1971) found a relationship between depression and alcoholism in St Patrick's Psychiatric Hospital in Dublin.

Chodorkoff (1963) relates depression to early object loss or never possessing objects - "In an attempt to avoid the severe depression attendant on the loss of object early in life, the alcoholic often destroys himself". Looking at the seven alcoholics who suffered from depression prior to their drinking history there is a clear pattern of disturbances in object relationships. Six of the seven people describe themselves as loners and six also admit to having difficulties relating to the opposite sex. All of the seven had difficulties relating to their parents, - feeling distant or fearful of one or other of the parents, more usually the father. These findings indicate a strong correlation between disturbances in object relationships, depression, and alcoholism and suggest that further research on the questionnaire item would be useful.

Summary

The alcoholics, in contrast to the control group, appeared to find it difficult to build up intimate relationships with the opposite sex. It is suggested that the difficulties may have stemmed from problems in developing object relationships, a finding which is reported in other studies. The alcoholic groups also appeared to experience significantly more anger and frustration than the control group resulting, it is suggested, from an inability to regulate feelings and behaviour. These were also much more impulsive than the control group.

The alcoholics were considerably more dependent than the non-alcoholics, a factor which may be related to problems in maintaining self-esteem and inner

states of well-being. These problems may have originated in the negative relationships which a majority of the alcoholics had with their fathers. Problems in maintaining self-esteem manifested again in the alcoholics with a large number of them seeing themselves in a bad light in contrast to the control group who generally saw themselves in a good light. The sexual preferences of both groups was overall heterosexual and although one alcoholic was exclusively homosexual and two others had homosexual experiences this did not appear to be a significant factor in the make-up of the alcoholic group.

Experiences of depression were much more frequent among the alcoholics than among the controls. The depression was related to drinking by some alcoholics and was a long-standing feeling in others. So there is evidence here that depression may sometimes cause alcoholism and sometimes may be a result of alcoholism. It was suggested that there may be a connection between disturbances in object relationships, depression and alcoholism. On the question of the addictive personality, alcohol appeared to be the only drug of addiction for the alcoholics, and the use of other drugs for both groups was minimal. However, speaking of addiction in psychoanalytic terms, which explain addiction as dependence on a substance, an activity or a person, the alcoholics in contrast to the controls, showed a dependency on a substance (alcohol), and a tendency to depend on other people.

It was found that both groups suffered tragedy in their lives, but they differed in that the alcoholics reacted to the tragic events by resorting to

alcohol. The alcoholic group frequently reported incidents of an unhappy childhood and specifically referred to feelings of inferiority and loneliness as a cause of their unhappiness. The control group had overall happier childhoods. Questioned on specific personality traits the alcoholics were not found to be overly impatient, domineering, rebellious, and did not show any significant signs of perfectionism.

The findings of this section indicate a strong correlation between psychological influences and the development of alcoholism. All of the variables looked at in this section, with the exception of homosexuality which was not well represented in either group, showed a difference between the alcoholics and non-alcoholics at .01 level of significance. It was noted that a number of the alcoholics saw drinking as a cause of their problems, such as impulsiveness, or low self-esteem. The idea that excessive drinking in itself can bring about a personality change is something that should be considered when drawing conclusions about the aetiology of alcoholism particularly in relation to psychological causes.

BEHAVIOURAL MODEL

Expectations: Dealing with the factor of expectations about the effects of alcohol the respondents were asked, - What effect did you think alcohol would have on you? (Q7) It was found that there was no significant difference between the two groups at .05 level. The same number of alcoholics and non-alcoholics (thirteen), didn't think much about the effect alcohol would have on them. Seven alcoholics and eight non-alcoholics thought it would make them feel "happy and relaxed". Three alcoholics thought it would alleviate anxiety and four controls thought it would make them less inhibited. One alcoholic compared to two controls were cautious about the bad effects of alcohol, and four alcoholics compared to one control thought it would make them "feel grown up".

These findings indicate that the alcoholic group did not expect anything significantly different from alcohol than the control group. However, the findings, to a small degree, support the view that expected relief from "negative emotional states such as anger, tension, anxiety and depression, represent frequently reported reasons given for drinking by both social drinkers and alcoholics". (Marlatt and Donovan, 1982, pp565-66) Of those who expected anything from alcohol, three alcoholics thought it would alleviate anxiety, - for instance, John, a thirty-nine year old alcoholic expected alcohol to "do away with all worries - make me carefree - to escape".

There is very little evidence to suggest that expectations about the effects of alcohol will influence initial drinking behaviour in any major way.

Social learning: There is strong evidence in this study to suggest that alcoholism is a family condition, i.e. it runs in families. In the medical model section of this discussion it was shown that the alcoholic group had a far greater number of alcoholic parents (eleven fathers and two mothers), than the control group (one father). Also alcoholism appeared mainly among the male members of the families of the alcoholic group. We can assume from this that the condition is either passed on through the genes, is a learned behaviour, or is a combination of both.

As a learned behaviour it may be that the alcoholics in this study acquired the behaviour of excessive drinking through a modelling experience, i.e. they learned their drinking behaviour by observing their parents. Parents, of course, are not the only models, and the fact that the alcoholic group received more social support for heavy drinking than the control group - fourteen of the alcoholics had teenage friends who drank a lot compared to one control(Q43.) - suggests that social learning may be an important factor in the onset of alcoholism. This complies with Bandura's (1969) view that behaviour is learned through observation, using a variety of models whose behaviour we imitate. It may be that social learning theory rather than genetics explains the development of alcoholism in the individuals in this study. However, further research is necessary to establish this.

Summary

It was not found that the alcoholics differed in any significant way from the control group in their expectations about the effects of alcohol when they first started to drink. However, there is some difference between them in that a small number of the alcoholics had more urgent expectations that alcohol would relieve painful emotional states of anxiety and lack of confidence. The control group on the whole seemed to have less urgent expectations.

It may be that social learning theory can explain the acquisition of excessive drinking behaviour. Certainly there is strong evidence to show that alcoholism runs in families where the alcoholic parents present a model for excessive drinking. It may be, also, that the heavy drinking of friends which is observed by the potential alcoholic, is imitated by him and contributes to his own alcoholism.

SOCIOLOGICAL MODEL

Attitude to drinking: This variable was examined by asking each respondent - How did you feel about alcohol and drinking before you started to drink? (Q20). The difference between the two groups on this variable was significant on a chi-square test. The most striking difference between them was the number of non-alcoholics (seventeen) who were wary of the bad effects of alcohol compared to only one of the alcoholics .... A typical control group reply was from Jim, an eighteen year old non-alcoholic, - "I was aware of its bad effects, so I was wary of it. I felt I would be in perfect control. I wasn't anti-drink". The majority of the alcoholic group (sixteen) either had no strong feelings one way or another about alcohol, or were anti-drink at first (seven).

It appears that the control group overall had a healthy respect for alcohol, whereas the alcoholic group had extreme views about it ranging from being uninformed to feeling negative towards it. These findings support Cahalan's (1970) view that the socio-psychological variable of attitude to drinking will influence the individual's drinking behaviour.

Social support for heavy drinking: The questions dealing with social support for heavy drinking asked the respondents, (a) What were the pastimes of the people they were closest to when they were in their teens (Q43); (b) What social amenities were available in their communities when they were growing up (Q44).

(a) On this question it was found that fourteen of the alcoholics had friends, or people they were close to, who played sport, went to dances,, and drank a lot in their spare time, compared to one person in the control group. Heavy drinking was a regular activity in the social groupings of alcoholics, whereas moderate drinking at weekends or other non-drinking pastimes was the norm for the control group. The difference between the two groups was found to be significant on this item.

(b) The control group were only marginally better off than the alcoholic group on the question of social amenities. Ten non-alcoholics had access to youth clubs growing up compared to six of the alcoholics. There was no significant difference found between the two groups on this item. It was found that overall there was a dearth of social alternatives to drinking particularly on the lower end of the socio-economic scale. Respondents from working class backgrounds reported there was nothing for them to do besides drink cider in the fields and later in the pubs. Alternatives to drinking seem to be linked to class, middle-class respondents being better off with access to more youth clubs and other organized facilities.

It is sometimes said by people working in the field of alcoholism in Ireland that excessive drinking is related to a lack of alternative social outlets. It appears from the findings of this study that there is a lack of social amenities, particularly in working class areas, which would ensure that the social conditions were 'right' for a vulnerable individual to develop alcoholism.

The finding of a significant difference between the two groups on the variable, social support for heavy drinking, agrees with Cahalan (1970) that the social environment plays an important role in how the individual will approach the behaviour of drinking and how he will establish himself in a drinking pattern.

Parents' drinking: Looking at the drinking behaviour of the parents of alcoholics compared to non-alcoholics, specifically to discover whether the alcoholics came from a home where an ambivalent attitude to drinking might prevail because only one parent drank, the respondents were asked to describe their families as drinkers (Q13). It was found that in the alcoholic group twenty five fathers drank (eleven were alcoholics) and fifteen mothers drank (two were alcoholics). This difference between the fathers and mothers of the alcoholic group on their drinking behaviour was significant on a Chi-Square test. While almost all of the fathers drank in the alcoholic group, half of the mothers didn't drink.

There is support in these findings for Jackson and Connor (1953), who compared the homes of alcoholics, moderate drinkers, and non-drinkers, and found that alcoholics "came most frequently from homes in which only one parent, usually the father, drank". They claim that in the "ambivalent environment" where only one parent drank the prealcoholic would fail to develop consistent, healthy attitudes to drink.

They also found that moderate drinkers came from "social drinker" homes.

In the present study, of the control group twenty three fathers drank (one was an alcoholic), and thirteen mothers drank (none were alcoholics). Overall the parents of the control group were moderate to non-drinkers. Only four of the fathers exceeded the 'moderate' category - three were heavy drinkers and one was an alcoholic. These findings again support Jackson and Connor (1973).

Bound up with the parents' drinking behaviour is the parents' attitude to drinking. This was examined in this study (Q31) and no significant difference was found between the two groups. The parents of both groups were not over-represented at any particular point on a five point scale ranging from Strongly Approve to Strongly Disapprove. Unlike the studies of Jackson and Connor(1973) and Joyce O Connor(1978) this finding does not show a correlation between attitudes of parents to alcohol and the drinking behaviour of their offspring.

Problems in the home: A study undertaken by Winokur and Clayton (1968) found that problems in the home in the form of parental absence, deprivation, or pathology may encourage the maladaptive behaviour of alcoholic drinking in the children. The present study, testing this hypothesis, questioned the respondents on, (a) the incidence of mental illness in the immediate family (Q14); (b) whether they had traumatic experiences in childhood (Q15); and (c) the atmosphere in the childhood home (Q36).

On the question of mental illness in the family there was no significant difference between the two groups. Twelve alcoholics compared to seven controls reported incidents of depression, nervous breakdown, or schizophrenia in the family. On the question dealing with bad experiences in childhood there was a significant difference between the two groups. Fourteen alcoholics compared to six controls reported experiences like fathers' deaths, fathers' alcoholism, and emotional trauma. On the question dealing with the atmosphere in the childhood home it was found that nine alcoholics came from a very unhappy childhood home compared to one of the control group. For example, John, a thirty-four year old alcoholic described his home life growing up as - "Very unhappy. The home was always tense, always anger in the air. My father was a lunatic when I think of it". The findings on this questionnaire item were significant on a Chi-Square test.

Overall the alcoholics had more problems in the home life growing up than the control group. This finding supports Winokur and Clayton's (1968) finding of a correlation between problems in the home and drinking problems in the offspring.

Social pressure to drink: This variable was examined by asking the respondents (a) Whether they ever felt there was pressure on them to drink (Q40); and (b) Whether they felt it was necessary to drink to be accepted and liked by people (Q26).

(a) On this question a significant difference was found between the two groups on a Chi-Square test. Seventeen of the control croup compared to only five of the alcoholics felt peer group pressure. Eighteen of the alcoholics compared to eleven controls said they drank because they just felt like it, and the remaining five alcoholics drank because of pressure from the way they felt emotionally. From these findings it appears that the control group felt more peer group pressure to drink than the alcoholic groups.

(b) Responding to this question twenty-one of the control group said - they get on with everybody whether they are drinking or not, compared to five alcoholics. Fifteen of the alcoholics compared to six of the controls felt they would have been outsiders if they didn't drink. Five of the alcoholics felt they would be more confident and therefore more acceptable to people if they drank compared to none of the controls. This difference between the two groups was significant on a Chi-Square test. Overall the findings show that the alcoholic groups were under more pressure both socially and personally to drink to feel accepted by others.

At first there appears to be a contradiction in the findings on these two questionnaire items dealing with social pressure to drink. On item (a), the findings indicate that the alcoholic group felt very little social pressure to drink, and on item (b) fifteen of the same group said they felt it was necessary to drink to be accepted and liked by people, so admitting to feeling social pressure to drink. It is suggested by the author that peer group pressure existed for the alcoholic group, (see Q43, which shows that for sixteen of the alcoholics their friends as teenagers, "drank a lot"), but they did not see it as pressure since they "wanted to drink anyway".

Joyce O'Connor (1978), in her study of drinking among young Irish people, found that overall peer group support for drinking was important in shaping the drinking behaviour of young people. The findings of the present study would support this view. The moderate drinking behaviour of the control group was shaped by the peers of this group, for example, on the question asking the respondents whether they found it necessary to drink to be accepted and liked by people, John, a twenty-two year old non-alcoholic, said, "No, but if I overdrank I think they would reject me". On the other hand, the peers of the alcoholic group showed a significant degree of heavy drinking.

The difference between the two groups on this variable of social support for heavy drinking is illustrated clearly in the question dealing with the part alcohol played in the social life of the respondents (Q38). It was found that alcohol played a large part in the social life of the twenty-eight

alcoholics, whereas the control group had alternative social activities to drinking. It was also found that alcohol played a large part in the work life of the alcoholics, e.g. "I drank a lot through the job, drinking with work mates".

These findings indicate that the social support for teenage heavy drinking, evident among the alcoholic group in Q44, was carried through into adult life as a pattern of drinking behaviour was established. The alcoholic group appeared to be more exposed to social support for heavy drinking. As the process of alcoholism set in the alcoholics tended to move away from friends and work mates and find support for excessive drinking among pub acquaintances or drank alone.

Summary: Questioned on their attitude to alcohol before they started to drink the alcoholic group appeared indifferent to or ignorant of the dangers of alcohol, even though they quite often came from alcoholic homes. They seemed to receive more support for heavy drinking as their teenage friends frequently indulged in excessive drinking compared to the moderate drinking of the peers of the control group. The alcoholics often came from alcoholic homes and from homes where there was an ambivalent atmosphere regarding drink, caused by the excessive drinking of the fathers and the little or no drinking of the mothers. The attitude of the parents of the alcoholic group to their offspring drinking was often disapproving compared to the more moderate attitude of the control group's parents. This is

further evidence of an ambivalent attitude to alcohol in the alcoholics' homes.

The alcoholic groups appeared to suffer more from problems in the home growing up, in the form of fathers' deaths, fathers' alcoholism, and other emotional trauma. They frequently described their childhood home as unhappy and tense whereas the control group overall came from happy homes. Peer group pressure existed for both groups but it was not so explicit for the alcoholic group since a large number of them said they wanted to drink anyway. However, it is suggested that the pressure did exist implicitly and would have been an issue for many of the alcoholics had they not wanted to drink.

Of the thirteen items looked at pertaining to a sociological influence seven of them turned up a difference between the two groups at .01 level of significance; three others showed a difference at .05 level; and the remaining three showed a difference which was not significant at .05 level. It appears from these findings that there was a considerable sociological influence and that the alcoholics were disadvantaged in many ways which may have led them to alcoholic drinking.

CONCLUSIONS

The results of this study provide support in varying degrees for the four models tested. They indicate that alcoholism is a family condition; that there is a strong correlation between psychological influences and the development of problem drinking; that it may arise as a result of social learning; and that the social environment plays an important role. The strongest correlation was seen between psychological factors and alcoholism, followed by sociological and medical factors. This suggests that people who develop alcohol problems are disadvantaged psychologically and socially, these two areas of influence being interrelated. Added to this is the possibility that they may also be genetically vulnerable.

It is a feature of the complexity of alcoholism that the models sometimes overlap which makes it difficult to estimate their exact degree of influence. For instance, in the sociological model there are family studies which describe the personality of parents in an attempt to define a typical alcoholic family. Also the incidents of mental illness and emotional deprivation in the home are included in a sociological model. There is an obvious need to separate sociological from psychological variables to arrive at meaningful models. In the medical model it is not clear that the significant difference between the two groups on family drinking history is attributable to a genetic influence. The importance of social learning in these results must also be recognized.

Implications for future research.

As the findings of this study indicate, a unitary cause of alcoholism does not seem likely. It is therefore recommended that an interdisciplinary approach to the problem be adopted. It should first be attempted to disentangle the various models so that the relative contribution of each can be assessed. In the case of the medical model there is a need in Ireland for twin and adoption studies to tease out the genetic influence in alcoholism. Also a battery of psychological tests should be applied to establish the psychological influence. With the different models well defined a large scale study can better determine the weight of each influence.

An attempt should be made to distinguish between the personality of the individual before he developed alcoholism and his personality when he presents for treatment. This will allow an assessment of the degree of emotional damage caused by the drinking behaviour itself. In order to do this it would be necessary to conduct longtitudinal studies. Such studies would also help to establish the existence or non-existence of an alcoholic personality.

This is an exploratory study of the influences on the development of alcoholism in an Irish context. As such it is intended to lay the groundwork for larger scale research which would build on the findings of the study.

APPENDIX A.

QUESTIONNAIRE

No._____

THE AETIOLOGY OF ALCOHOLISM 1985

Q1. Male/Female.

Q2. Did you ever drink alcohol? Yes/No.

Q3. Are you an alcoholic? Yes/No.

Q4. How old were you when you took your first drink? _____

Q5. Can you describe the occasion on which you took your first drink?

_____ _____

_____ _____

_____ _____

_____ _____

Q6. Did you begin to drink regularly from that time on?

_____ _____

_____ _____

_____ _____

_____ _____

Q7. What effect did you think alcohol would have on you?

_____ _____

_____ _____

_____ _____

_____ _____

Q8. What were your main reasons for drinking?

Q9. What was your capacity for alcohol like?

Q10. With whom did/do you drink most frequently?

Q11. How do you get on with women?

Q12. How do you get on with men?

Q13. How would you describe your family as drinkers?

	Alcoholic	Heavy dr.	Moderate dr.	Light dr.	Non-dr.	Don't know
Father						
Mother						
Brothers						
Sisters						
Father's side						
Uncles						
Aunts						
Grandfather						
Grandmother						
Mother's side						
Uncles						
Aunts						
Grandfather						
Grandmother						

Q14. Were any of your immediate family ever hospitalized for depression, nervous breakdown, or other such problems?

_____ _____

_____ _____

_____ _____

_____ _____

Q15. Did you have any bad experiences when you were growing up?

_____ _____

_____ _____

_____ _____

Q16. Do you ever feel that you have anger and frustration bottled-up inside you?

Q17. Would you describe yourself as an impulsive person? (eg. that you act or speak before you think).

Q18. Do you see yourself in a good or bad light?

Q19. How do you get on with other people? (eg. you like their company or you prefer to be on your own).

Q20. How did you feel about alcohol and drinking before you started to drink?

Q21. Did you use drugs other than alcohol?

Q22. Do you have any problems such as gambling, eating disorders, or depression?

Q23. What age are you? _____

Q24. Have you ever suffered from depression?

Q25. Are you single, married, separated, divorced? _____

Q26. Did/do you feel it necessary to drink to be accepted and liked by people?

Q27. What is your occupation?

Q28. Do you have any children? Yes/No.
If yes, how do you get on with them?

Q29. Could you describe your father to me?

Q30. Could you describe your mother to me?

Q31. What were your parents' attitudes to you drinking?

	Strongly approve	Moderately approve	Neither approve nor disapprove	Moderately disapprove	Strongly disapprove
Father					
Mother					

Q32. Have you had any illnesses in your life?

Q33. Do you find that you are impatient? (eg. you find it hard to put up with delays in people turning up, or when queuing for buses or in the bank).

Q34. Would you describe yourself as a city or country person?_____

Q35. What place do you come in the family?

1 2 3 4 5 6 7 8 9 10

Q36. How would you describe your home life growing up?

Q37. How would you describe your home life now?

Q38. What part does/did alcohol play in your home, job, and social life?

Home_____

Job_____

Social life_____

Q39. How would you describe yourself growing up?

Q40. Did you ever feel there was pressure on you to drink?

Q41. What is your father's occupation? (If he is retired, out of work, or deceased, what was his principal former occupation.)

Q42. What is your mother's occupation? (If she is retired, out of work, or deceased, what was her principal former occupation.)

Q43. When you were a teenager, what did the people you were closest to do in their spare time?

Q44. What social outlets were available in your community when you were a teenager?

_____ _____

_____ _____

_____ _____

_____ _____

Q45. What level had you reached when you finished your full-time education? And what level had your parents reached?

	Self	Father	Mother
National education only - Incomplete	1	1	1
- Complete	2	2	2
1-2 Secondary School	3	3	3
3-4 Secondary School	4	4	4
Finished Secondary School	5	5	5
Some Vocational Education	6	6	6
Completed Vocational Education	7	7	7
Some University Education	8	8	8
Completed University Education	9	9	9
Post Graduate (M.A., Phd., etc.)	0	0	0

Q46. Would you say you drink to excess?

_____ _____

_____ _____

_____ _____

_____ _____

Q47. Would you describe yourself as a dependent kind of person?

_____ _____

_____ _____

_____ _____

Q48. Would you describe yourself as a perfectionist?

Q49. Would you describe yourself as a domineering person? (eg. you need to be in a position of power).

Q50. Would you say you were a hyperactive child?

Q51. Have you experienced tragedy in your life?
If yes, did you drink more as a result of this?

Q52. As a teenager, did you ever run into trouble with the law?

Q53. Do you find it difficult to deal with authority figures?

Q54. Is there anything you would like to add?

Thank you for your cooperation.

APPENDIX B.

Class 1: Professionally Qualified and High Administrative.

Class 2: Managerial and Executive (with some resposibility for directing and initiating policy).

Class 3: Inspectional, Supervisory, and other non-manual (higher grade).

Class 4: Inspectional, Supervisory, and other non-manual (lower grade).

Class 5: Routine grades of non-manual work.

Class 6: Skilled manual.

Class 7: Manual semi-skilled.

Class 8: Manual, routine.

This Ordinal Occupational Scale is an adaptation for an Irish context of the Hall-Jones Scale. (Adapted by M. Mac Greil, 1973).