IMPACT OF EARLY PARENTING ON FEMALE ALCOHOLISM

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The Research Problem

Alcohol is one of the most popular legal drugs in our society. However, for 10% of the population, the use of that drug leads to psychological and chemical dependency. Social workers are often confronted with clients whose families are fractured and contain emotionally deprived, physically abused, or neglected children due to maternal alcoholism. Often, for the female, threats by husbands, pleadings by children, sentences by judges, and exhortations by ministers do not result in a cessation of the drinking. The female, her family, and the social worker often are left pondering what there is about the drug, alcohol, that would be so impelling as to cause the female to prefer drinking to the care of her children, the love of her husband, the respect of the community, maintenance of sanity, and possible her life, Are there attributes in the personality of the alcoholic female that force her to become dependent upon alcohol and make sobriety difficult to achieve? Probably, over one million females [1] abuse alcohol and by the time a major crisis occurs, incalculable damage has been done to the female alcoholic and to her surrounding social network. The purpose of this research was to study the process of the ego's inability to tolerate and integrate ambivalent perceptions of self and others in a sample of female alcoholics. The study's questions were:

1. To what degree did the females in the sample use ego-splitting in their reporting of how they viewed others in their lives?

2. To what extent did the personality of the female alcoholic fit the pattern of the borderline personality?

3. Did ego integration or ego repair take place in the female as the period of abstinence increased?

4. As the female's period of sobriety increased, was there a change in her personality from borderline to more "normal"?

For both the pre-alcoholic, as well as the alcoholic, the literature suggests that the personality resembles that of the borderline personality. In the dynamics of both, the person experiences (a) splitting, (b) flawed interpersonal relationships, and (c) disruptive early childhood. The theory used in this study stated that the origin of these problems may develop during the first 3 years of life. [2]

The borderline personality disorder was identified as early

as 1905 by Abraham, but it was many years later before the diagnostic label for the described symptoms was applied by Knight. [3] The disorder's origin is thought to be a preoedipal fixation attributable to the failure of the child to differentiate herself from the mother at the appropriate age. [4]

The same personality development resulting from a lack of unconditional love for the child often is found to be similar to the personality of the alcoholic. Indeed, some authors consider many alcoholics to be borderline. [5]

An important factor related to the development of alcoholism in females is the prevalence of alcoholism in the family of origin. For many, early life experiences were disruptive due to parental drinking. [6]

Social workers, in many practice settings, come into contact with females who have drinking problems which may be combined with symptoms of borderline pathology. Welfare departments report that alcoholism often is an underlying condition where there is child and spouse abuse. Social workers also are often confronted by clients who are impulsive, angry, alienated, and superficial. Their interaction with their social environment is characterized by difficulty in their interpersonal and familial relationships. [7]

Corrigan [8] believed that although social workers encounter such problems, they are seriously impaired by lack of proper understanding of the disease and treatment of alcoholics. A major issue is sufficient outreach. [9] Corrigan and Anderson [10] feel that early identification of heavy drinking females through the assessment of such problems in marital counseling, medical care, and child welfare is needed if social work intervention is to succeed.

For some females, alcoholism is accompanied by the borderline personality making treatment even more difficult. Faulty perceptions of themselves and others make them unable to respond to convention problem-solving methods of treatment. Palumbo [11] suggested that different therapeutic approaches are necessary if effective treatment is to be given to borderline patients.

This study illuminated some facets of the female's personality as it interacted with her use of alcohol; moreover, it evaluated methods of diagnoses. In doing this, the study examined Gombers's [12] statement that alcoholism results from the "combined effect of childhood deprivation . . . low frustration tolerance . . . and the presence of a heavy drinker in the family."

Because of the prevalence of splitting in borderlines and the similarity in the use of this defense mechanism by alcoho-

lics, this study focused on the perceptions of the female alcoholic toward her significant others (objects) and how these faulty perceptions need to be adjusted/corrected if continuous recovery and growth are to be maintained. Second, this study focused on the impact of parenting in the early years of the female's life and its effect on the personality development of the child and its impact on her future.

Beyond the female herself, the children of female alcoholics may be a high-risk group for developing alcoholism. Current estimates are that at least 12 million such children exist in the United States. [13] However, efforts directed toward prevention of these problems are limited, as only 5% of these children receive help.

General Methodology

the study's cross-sectional survey research methodology utilized a structured interview for data collection. During the interviews, the subjects responded to a series of standardized self-report instruments and open-ended questions. Tripdi [14] defined the cross-sectional survey design as having the "prime function of providing accurate quantitative-descriptive data which can be generalized to some designated population." Random sampling within defined clusters with a quota set at 52 completed interviews was used. The type of survey used in this study was a face-to-face interview with individuals drawn from a sample.

Population data was obtained by visiting each of the agencies involved in the study, it,e. Driving Under the Influence (DUI) School, Alcoholism Recovery Center, and St. Anne's Home for Alcoholic Women. Each of the Alcoholics Anonymous groups in the area estimated the number of females who attended their group regularly. The agencies gave an exact accounting of the numbers of females treated for alcoholism and/or drunk driving in the past year.

From a population of female alcoholics, a proportional number of females served by each of the groups or centers was used in determining the number of females who were included in the sample from each of them.

Measurement of Concepts

Alcoholism: A female was judged to an alcoholic from the results of the Michigan Alcoholism Screening Test (MAST). [15]

Borderline: A Self-Report Borderline Scale developed by Conte, Plutchik, Karasum & Jerrett [16] and consisting of 52 items relating to the borderline pathology was used.

Object Relations: Past object relations were tested by

asking researcher designed questions of the respondent relating to her perceptions of her parents and their care of her when she was a child. Questions also addressed her perceptions about her siblings. Present relations were tested with Hudson's [17] Clinical Measure Package using the Index of Family Relations (IFR) and Index of Peer Relations (IPR).

Self-Esteem: Hudson's Index of Self-Esteem (ISE) was used.

Depression: Hudson's Generalized Contentment Scale (GCS) was used.

Instrumentation

There were four sections to the interview, and each contained specific instruments. All four were administered to all participants; each section provided data relevant to a specific hypotheses. Instrument selection followed Bloom and Fisher's [18] proposal that they coincide with "the nature of the problem, the capabilities of the recorder, and the complexity of the situation".

Because there are so many definitions of alcoholism, it was deemed necessary to use a standardized test. The Michigan Alcoholism Screening Test (MAST) [19] has as its purpose the provision of a consistent, quantifiable structured interview instrument for the detection of alcoholism that can be rapidly administered. The test consists of 25 questions which were designed to detect denial of the problem as well.

The validity and reliability of the MAST was assessed by Selzer et al. [20] The reliability of the MAST, in terms of internal consistency, was determined by coefficient alpha, which yielded coefficients of .83 for control groups and .87 for the alcoholics, giving a .95 for the entire sample.

The first part of Section II contained a series of questions from which standard demographic data was collected. Examples of items included were: age, marital status, education, etc. These were used as independent variables and in the discussion of the characteristics of the sample of the study.

The second set of items in this section focused on the subject's experience with alcohol. These items were selected from an item pool derived from the following: (a) assessment questionnaires from a half-way house for female alcoholics; (b) assessment questionnaires interviews from the National Council on Alcoholism, (d) a review of the literature, and (e) personal experience in treating female alcoholics. The selection process retained those items which were repeatedly found and from a face validity point of view, were important for this study.

The third set of items related to family history. These items were chosen from a review of the literature about the borderline personality syndrome, but more specifically from the viewpoint of the object-relations theory of "the structural and dynamic relationships between the self-representations and objection representations". [21]

Splitting was assessed by asking each subject eight questions about the quality of her relationship with specific family members. Ten response categories from extreme disagreement (hate) to extreme agreement (love) were regrouped so that the ends of the continuum or categories 1, 2 (hate) and categories 9, 10 (love) were coded for splitting, while categories 3, 4, 5, 6, 7, and 8 were judged to be those which were indicative of milder emotions and were scored as nonsplitting.

This section also contained instruments used to measure:

1. Length of Sobriety--measured by the number of months at the interval level. This was a major independent variable as it was predicted that those whose sobriety was the longest would exhibit less ego-splitting, borderline personality and higher self-esteem scores.

2. Level of Adult Adjustments--results from questions on employment and marital history were evaluated for evidence of splitting and for comparison with the entire sample.

Section II contained A Self-Report Borderline Scale (BSI) constructed by Conte et al., and published in The Journal of Nervous and Mental Disease and was used to determine whether or not the respondents could be classified as having borderline personality disorder. This 52-item scale was formulated on the basis of a selected review of some :important theoretical discussions and empirical investigations of patients characterized as borderline." It is a questionnaire requiring true or false answers that are concerned with "impaired object-relations, impulsivity, emptiness, depression, depersonalization, and lack of self-identity." [22]

Section IV focuses on present feelings about the self, particularly self-esteem and on relationships with family and peers. The first set of instruments used was from The Clinical Measurement Package and was developed by social workers for social workers. [23] This section measured the changes in the perception of alcoholic females toward themselves and others.

The data collected are first coded and then entered into a format compatible with the UNIVAC 1100 version of the Statistical Package for Social Sciences. [24] The data analysis performed conformed to the respective level of measurement of the data. The analysis included the use of appropriate test of statistical

significance, measures of correlation, direction, and degree of change in the variables. [25]

For tests of statistical significance used to determine the extent to which the results are due to randomness or sampling error, the level of probability used to reject the null hypothesis was $p<.05$.

For measures of association/measures of correlation used to determine the strength of the relationship Contingency Coefficient, Wild's Lambda, or Pearson product-moment correlation coefficients were used.

The direction of the relationship was determined by either the sign of the correlation coefficient, measure or association or the direction of the trends in the data.

The degree of change was measured by either an inspection of the percentage table or where linearity was possible by the use of the regression equation.

Results

A proportional sample of 52 females was drawn from a population of females from the researcher's county who were: in treatment at (a) Alcoholism Recovery Center - 9; or St. Anne's Home - 8; (b) AA members - 27; or (c) attending DUI classes - 8.

Each female was interviewed once by the researcher. The interviews lasted from 50 minutes to 3 hours with a mean of 1.5 hours. The pace and length of the interview was influenced by the respondent. The interviews were conducted either at the agency or a place convenient to the respondent and to the researcher. One-half of the DUI sample used alcohol during the interview.

The age range of the sample was from 20 to 67 years with a mean age of 42.4 years, a standard deviation of 13.9, and a median of 38 years.

Twelve subjects (23%) had never been married. Thirty-one respondents (60%) of the females were separated from their husbands, divorced or widowed when interviewed. Nineteen (37%) were married.

Corrigan [26] believed that the female's drinking has a direct impact on the people living with her. Forty of the respondents that were married or had been married were asked to designate the extent to which they thought their drinking affected their marriages. Twenty-seven (68%) of the females in the sample described their drinking as adversely affecting their marriages. All the females who had been married had at least one child, and

3 females had 6 children each, making a total of 86 children born to the sample.

Object relations theory states that the presence of family dysfunctioning in the family of origin (parent and sibling) may provide a fertile milieu for the development of alcoholism in the females in the sample. [27] Therefore, the family background of the sample was explored.

Thirty-seven (71%) of the subjects reported that their mothers and/or fathers drank to excess or abused drugs. Twenty-nine (56%) perceived their mothers and/or fathers to have been emotionally or mentally ill. In addition, 16 (31%) of the females experienced divorces in their families of origin.

Object relations theory also suggests that being either abused or experiencing a prolonged illness as a child may result in having impaired object relations. Thirty (58%) of the 52 females reported they experienced abuse as children. A statistically significant correlation (Chi-square = 3.44, p = .03) was found in the analysis of the variables of abuse as a child and scoring on the BSI in the cAtegory of being borderline. In the case of the borderline scores, 23% of those classified as being border-line had been abused, and 4% of those not classified as being borderline had not been abused. Twenty-four (46%) of the sample described themselves as being a "sickly baby".

In addition to exploring dysfunctioning in the parent subsystem, this research investigated the sibling subsystem. The literature suggested [28] that siblings of the female alcoholics are likely to reveal similar dysfunctional patterns. An analysis of the responses corroborates this belief. Twenty-three (50%) of the sample adjudged their siblings as having alcohol problems. Sixty-one percent were addicted to drugs/alcohol. Along with addiction, 19 (41%) of the females considered their siblings as having emotional/mental problems.

Since the study was about female alcoholics, all of the females were tested using the Michigan Alcoholism Screening Test (MAST) to se if the label was an accurate description. The results indicated that the DUI's had a problem with alcohol they did not report.

Forty-four (85%) of the respondents felt that family concern about the drinking may have crystallized their perceptions that the drinking was not normal. The realization that the drinking could not be limited to one or two drinks for 40 (77%) of the females may have added to the belief that their drinking was abnormal. Blackouts, a physiological manifestation of addiction, were experienced by 46 (88%) of the females.

Forty-one (79%) of the females said they used alcohol before

noon in an attempt to self-medicate to alleviate both physical (hang-overs) and mental pain. A large portion of the mental pain was reported to rest on drunken fights. Moreover, 37 (71%) of the subjects said they neglected their families. The shame referred to by Kurtz [29] may have become chronic for many of the respondents.

Thirty-eight (73%) of the respondents began drinking between the ages of 13 and 18 years old. Four before they were 12 years old and 10 at age 19 or over. The occasion for the first drink was a party for 25 (46%) of the respondents. A family celebration was the second most frequent occasion when drinking began for 11 (21%) of the subjects. Six (12%) respondents started drinking with their husbands, and it is interesting to note that all 6 of these respondents are now divorced from those some husbands.

Demographic and social history data on the sample revealed that many of the females had been drinking for a number of years, and they reported many problems both in their families and work/peer relationships.

The effect of the alcohol on the females by their first drink varied: 12 (23%) reported no effect; 12 (23%) enjoyed their first drink and it's effect; 14 (26%) got sick or hated the effect. Almost 50% of the females had been drinking 10 years or less. Nineteen (37%) had been drinking 11 years and over with 9 (17%) of these females using alcohol for over 21 years. The DUI's were not included in the data.

All of the females, including the DUI's, were given a list of 23 reasons for continuing their use of alcohol. Multiple responses were permitted. The list was compiled from a review of literatures and the researcher's clinical experience. The most frequent response for the total sample given by 41 (79%) of the respondents was "to have a good time." However, when the DUI's were eliminated from the sample, the primary reasons for drinking were tied between "frustration" and "stresses of living" by 38 (73%) of the 44 women. Frustration is an affect frequently mentioned in the literature by those with a borderline personality disorder. [30]

"Depression" and "a desire to escape reality" were second in order of frequency of responses for all 52 subjects for continuing to use alcohol (26, 69%). Depression may be reflected further in the frequency of subjects checking "coping with low self-esteem" (59.6%), stresses of living (73%) and loneliness (67%).

Thirty-four (65%) of the females reported that they drank to "feel normal". The females spoke of thinking of themselves as being less attractive or intelligent than their peers unless they drank. The literature contained references to the alcoholic who

is frequently the scapegoat of the family. [3 1] This study's theory suggests that a lack of positive parental feedback in the early stage of personality development of children can result in an unrealistic view of themselves and others.

Along with the feeling of being "abnormal" as a reason for drinking, 34 (64%) of the subjects checked "fear", "Anger", "worry", and "nervousness", all destructive affect states, were checked by 33 (64%) of the females as the reasons they drank alcohol.

Drinking had been a problem in their lives for several years. Twenty-seven (52%) said that drinking had been a problem for 1 to 5 years. An additional 15 (29%) females said the problem had lasted for 6 to 10 years. Only 2 females had difficulties with alcohol for more than 16 years. In order of importance, the problems experienced by the females drinking alcohol were: psychological and physical deterioration; lowered self-esteem; financial problems; problems in school; and problems with law-enforcement agencies.

All the subjects except the DUI's were asked for the reasons they stopped drinking from a list similar to the previous one. For 37 (71%) of the females currently not drinking, the most frequent response was that they "wanted a better life". The second most frequently checked response was "self-disgust" (31, 59.6%).

Twenty-five (48%) of the females checked "fear of losing my mind" as one of the reasons for stopping drinking. When this number is examined in the light of the number who used prescribed or illegal psychotropic substances (29, 56%), the frequency of giving this reason is validated. In addition, twenty-six (50%) of the females were sent to psychiatrists which reinforced their suspicions that something was wrong.

Social pressure played a minimal role for the respondents in stopping drinking. Only 2 (3.8%) reported pressure by a husband/boyfriend, 2 (3.8%) by a mother, 3 (5.8%) by children, and 4 (7.7%) by a judge. Four (7.7%) females stopped drinking to "hold the family together."

Thirty-two (62%) of the females had been or were currently in a 28 day treatment program. Thirteen (25%) had been treated at an outpatient clinic; 19 (37%) were in a halfway house twenty-two (42%) had been treated by a mental health professional, while 14 (27%) had received family treatment. No DUI's experienced treatment.

The independent variable, length of sobriety, was measured in months since the last use of alcohol. The DUI's had 0 months of sobriety while the other subjects in the sample ranged from 1

to 85 months of sobriety and over. An analysis of variance indicated that there was a statistically significant difference in the mean months of sobriety between the three groups.

Seven alternative hypotheses were generated for this study. The first two hypotheses stated that there is a relationship between the length of sobriety to the scores on the Conte et. al. BSI [32] and to the researcher's own instrument measuring ego splitting in the perception of the parent. The third hypothesis examined the relationship between the scores of the BSI and ego splitting scales. The fourth through the seventh hypotheses examined the relationship of the length of sobriety to the four Hudson [33] CMP scales used. Each of the alternative hypotheses stated that with an increase in the length of sobriety there would be a lowering in the proportion of subjects who reported being depressed, an increase in the number reporting themselves as having higher self-esteem, and a decrease in the number of subjects who reported interpersonal, family, or peer relationships problems.

All of the null hypotheses, with the exception of the second and third were rejected based on the magnitude of the statistic used to appraise the statistical relationship in the data. The statistical results were similar both with he DUI's included in the analyses and when they were excluded from the analyses.

The results of the study are interpreted within the object relations theoretical perspective. This theory is an amplification of the psychoanalytic theory. The findings of the study suggest that further research is needed to understand the impact of the early years on the development of personality disorders and alcoholism in the adult female. Social work practitioners may utilize the findings of this study in social work practice with alcoholic females and in related curricula.

Implications for Social Work Theory, Practice, and Education

This study contributes to Social Work's understanding of female alcoholism as it was found that with increased periods of sobriety, ego repair takes place as those with longer periods of sobriety appeared to have improved object relations.

The theoretical basis of the study stated that female alcoholics may have experienced a defective personality development which resulted in an inaccurate perception of themselves and their social relationships. Such a process contributed to the development of alcoholism and borderline in the female. The study's results, therefore, may support the theoretical basis for practice as reasons for drinking and the clinical problems females experience after they stop drinking may be understood from this theoretical position. The female's reason for pursing treatment, staying in treatment, or remaining sober may stem from

internal experience. Taking these facets into consideration may guide the social worker to helping the female alcoholic maximize the benefits from growth producing experiences.

The study provided a test for a number of clinical assessment instruments which might assist the clinician in diagnosing alcoholism (MAST) and borderline personality (BSI) in females. [34] The use of Hudson's Clinical Measurement Package was found useful in assessing the perceptions of self-esteem, depression, and family/peer relationships.

One finding of note was the AA meetings were found to have a positive effect on the feelings and social interactions of the female alcoholic. Therefore, when treating female alcoholics, AA participation by the recovering female needs to be considered as beneficial to this process. King et al. state that "for the newly sober alcoholic, AA is a powerful provider of . . . caring and support." [35]

Social work curricula for female alcoholics has not been developed as extensively as has the curricula in other problem areas. Corrigan and Anderson [36] maintained that the problem of female alcoholism needs to be taught in the schools of social work if there is to be a greater commitment by the profession to treat them They believed that stereo-types will persist and expand, and that treatment will be based on distorted knowledge.

One implication of the results is that such information can be woven into a course which discusses object relations theory. Special attention may be given to the personality development of the female and the roles parents play in the possible development of pathology in a child. Although there are many areas of knowledge needed in the diagnosis and treatment of female alcoholics, the schools of social work could stress the involvement of the parents during the early phases o f personality development through courses in object relations theory, especially the implications for prevention.

The findings revealed a tie between drinking and child abuse, an area familiar to social workers. Prevention in this area is crucial and the abuse potential needs to be investigated by social workers with alcoholic females in the caseload.

The literature [37] further indicates that children of alcoholic females are at risk for developing alcoholism by the nature of the parenting and of the environment. Social workers who have long treated the bulk of the nation's alcoholic females could be invaluable in helping to prevent the child from developing a similar pathology through early identification and intervention of the mother.

The results of the study show that abstinence has a positive

effect on the reduction of the negative influences of both the early parenting and present drinking in the female adult. Preventing relapse through maintenance in the female alcoholic is suggested as a viable goal in the treatment process.

The study builds on the literature that examines simultaneously, the concepts of borderline personality, ego splitting, and alcoholism. However, few researchers and clinicians have attempted to explain the variability in one concept through variability in the other. Where this has been done, alcoholism is described as a subsystem of the borderline condition.

In addition, further research may indicate that such continuing problems as divorce, family violence, misbehavior of the children, and "behavioral, emotional, and cognitive disorder" [39] can be better understood and treated through an understanding of the dynamics of the female alcoholic. Anderson and Henderson [39] concluded that it is imperative to research the problem and to devise effective methods for treatment.

REFERENCES

1. Barbara S. McCrady, "Women and Alcohol Abuse," in M. T. Notman and C.C. Nadelson, Eds., The Woman Patient: Aggression, Adaptations and Psychotherapy (New York, Plenum Press, 1982) pp. 217-244.

2. Margaret S. Mahler, Fred Pine and Anni Bergman, The Physchological Birth of the Human Infant: Symbiosis and Individuation (New York, Basic Books, 1975).

3. Robert Knight, "Borderline States," Bulletin of the Menninger Clinic 17 (January 1953) pp. 1-12.

4. Mahler, et al., op. cit.

5. Jesse M. Hellman, "Alcohol Abuse and the Borderline Patient," Psychiatry (November 1981) pp. 307-316: and Otto F. Kernberg, "Borderline Personality Organization, Journal of the American Psychoanalytic Association 15 (July 1967) pp. 614-685.

6. Vasanti Burtle, "Development/Learning Correlates of Alcoholism in Women," in Vasanti Burtle, ed., Women Who Drink (Springfield, Ill.: Charles C. Thomas Publishers, 1979) pp. 145-174: Edith S. Gomberg, "Risk Factors Related to Alcohol Problems Among Women: Proneness and Vulnerability," in Research Monograph No. 1, Alcoholism and Alcohol Abuse among Women: Research Issues (proceedings of a Workshop: Department of Health, Education and Welfare, 1978) pp. 83-118; John Lancone and D. Lacone, Women Who Drink (Reasing, Mass,: Wesley Publishing Co., 1980) and Joan Volpe, Advances in Alcoholism Treatment Services for Women VIII Research Observer's Report, NIAAA (Washington: U.S. Department of Health and Human Services, Public Health Service; Alcohol, Drug Abuse and Mental Health Administration , 1983) pp. 41-50.

7. Terry Eisenberg Carrillo, "Testing a Theory of the Borderline-Narcissistic Personality," Social Work 26 (March 1981) pp. 107-112.

8. Eileen M. Corrigan, "Alcohol Knowledge and Practice Issues," Health and Social Work 4 (November 1979) pp. 9-40.

9. Sheila B. Blume, "Diagnosis, Casefinding, and Treatment for Alcohol Problems in Women," Alcohol Health and Research World (Fall, 1978) pp. 10-22.

10. Eileen M. Corrigan and Sandra C. Anderson, "Training for Treatment of Alcoholism in Women," Social Casework 59 (January 1978) pp. 42-50.

11. Joseph Palumbo, "Theories of Narcissism and the Practice of

Clinical Social Work," Clinical Social Work Journal 4 (January 1976) pp. 51-59.

12. Gomberg, op. cit., p. 105.

13. National Institute of Alcohol Abuse and Alcoholism (NIAAA), Information and Feature Service (October 1981).

14. Tony Tripodi, "The Logic of Research Design," in R. M. Grinnell, Jr., ed. Social Work Research and Evaluation (Itasca, Illinois: F.E.Peacock Publishers, 1981) p. 213.

15. Melvin L. Selzer, "The Michigan Alcoholism Screening Test: The Quest for a New Diagnostic Instrument," American Journal of Psychiatry 127 (June 1971) pp. 1653-1658.

16. Hope R. Conte, Robert Plutchik, Toksoz Karasum, and Inez Jerrett, "A Self-Report Borderline Scale: Discriminative Validity and Preliminary Norms," Journal of Nervous and Mental Disease 169 (July 1980) pp.428-435.

17. Walter W. Hudson, The Clinical Measurement Package (Illinois: The Dorsey Press, 1982).

18. Martin Bloom and Joel Fischer, Evaluating Practice: Guidelines for the Accountable Professional (Englewood Cliffs: Prentice-Hall, 1982) p. 109.

19. Selzer, op. cit.

20. Melvin L. Selzer, Amiram Vinokus, and Louis Van Rooijen, "A Self-Administered Short Michigan Alcoholism Screening Test (SMAST), Journal of Studies on Alcoholism 36 (January 1975) pp. 117-125.

21. Althea J. Horner, Object Relations and the Developing Ego in Therapy (New York: Jason Aronson, 1979).

22. Conte, Et. al., op. cit., p. 428.

23. Hudson, op. cit.

24. Norman N. Nie, C. Hadlai Hull, Jean F. Jenkins, Karin Steinbrenner, and Dale H. Brent, eds., Statistical Package for the Social Sciences 2nd ed. (New York: McGraw Hill, 1975).

25. Hubert M. Blalock, Jr., Social Statistics, Revised Second Edition, (New York: McGraw Hill, 1979).

26. Eileen M. Corrigan, "Alcoholic Women in Treatment; A Summary of Findings," in Dave Cook, Christine Fewell, and John Riolo, eds., Social Work Treatment of Alcohol Problems (New Brunswick;

Rutgers Center for Alcohol Study, 1983) pp. 109-118.

27. Otto F. Kernberg, Borderline Conditions and Pathological Narcissism (New York: Jason Aronson, 1975).

28. Lacone, op. cit.

29. Ernest Kurtz, "Why A.A. Works: The Intellectual Significance of Alcoholics Anonymous," Journal of Studies on Alcohol 43 (January 1982) pp. 38-80.

30. Peter Hartocollis, Borderline Personality Disorders: The Concept, the Syndrome, the Patient (New York: International Universities Press, 1977).

31. McCrady, op. cit.

32. Conte, et al., op. cit.

33. Hudson, op. cit.

34. Stuart Kirk and Aaron Rosenblatt, "New Applications of Research to Clinical Practice," in Aaron Rosenblatt, Diana Waldfogel, and general editors, eds., Handbook of Clinical Social Work (Washington: Jossey-Bass Publishers, 1983) pp. 549-559.

35. Barbara Lee King, LeClair Bissell, and Peter O'Brien, "Alcoholics Anonymous, Alcoholism Counseling, and Social Work Treatment," Health and Social Work 4 (November 1979) p. 194.

36. Corrigan, op. cit.

37. Nady El-Guebaly and David R. Offord, "The Offspring of Alcoholics: A Critical Review," The American Journal of Psychiatry 134 (April 1977) pp. 357-365.

38. Sandra C. Anderson and Donna C. Henderson, "Family Therapy in the Treatment of Alcoholism," Social Work in Health Care 8 (Summer 1983) pp. 79-94.

39. Anderson, op. cit.