THE UNIVERSITY OF
WARWICK

Library Declaration and Deposit Agreement

1.   **STUDENT DETAILS**

Please complete the following:

Full name: ..MICHAEL RICHARD ROBERT WILLIAMS..........

University ID number: ...0858319.....................................

2.   **THESIS DEPOSIT**

2.1 I understand that under my registration at the University, I am required to deposit my thesis with the University in BOTH hard copy and in digital format. The digital version should normally be saved as a single pdf file.

2.2 The hard copy will be housed in the University Library. The digital version will be deposited in the University's Institutional Repository (WRAP). Unless otherwise indicated (see 2.3 below) this will be made openly accessible on the Internet and will be supplied to the British Library to be made available online via its Electronic Theses Online Service (EThOS) service.
[At present, theses submitted for a Master's degree by Research (MA, MSc, LLM, MS or MMedSci) are not being deposited in WRAP and not being made available via EthOS. This may change in future.]

2.3 In exceptional circumstances, the Chair of the Board of Graduate Studies may grant permission for an embargo to be placed on public access to the hard copy thesis for a limited period. It is also possible to apply separately for an embargo on the digital version. (Further information is available in the *Guide to Examinations for Higher Degrees by Research*.)

2.4 *If you are depositing a thesis for a Master's degree by Research, please complete section (a) below. For all other research degrees, please complete both sections (a) and (b) below:*

(a)   Hard Copy

   I hereby deposit a hard copy of my thesis in the University Library to be made publicly available to readers (please delete as appropriate) EITHER immediately OR after an embargo period of .... months/years as agreed by the Chair of the Board of Graduate Studies.

   I agree that my thesis may be photocopied.   (YES)/ NO (*Please delete as appropriate*)

(b)   Digital Copy

   I hereby deposit a digital copy of my thesis to be held in WRAP and made available via EThOS.

   Please choose one of the following options:

   EITHER   My thesis can be made publicly available online.   (YES)/ NO (*Please delete as appropriate*)

   OR   My thesis can be made publicly available only after.....[date] (Please give date)
                                                        YES / NO (*Please delete as appropriate*)

   OR   My full thesis cannot be made publicly available online but I am submitting a   separately identified   additional, abridged version that can be made available online.
                                                        YES / NO (*Please delete as appropriate*)

   OR   My thesis cannot be made publicly available online.   YES / NO (*Please delete as appropriate*)

3. **GRANTING OF NON-EXCLUSIVE RIGHTS**

Whether I deposit my Work personally or through an assistant or other agent, I agree to the following:

Rights granted to the University of Warwick and the British Library and the user of the thesis through this agreement are non-exclusive. I retain all rights in the thesis in its present version or future versions. I agree that the institutional repository administrators and the British Library or their agents may, without changing content, digitise and migrate the thesis to any medium or format for the purpose of future preservation and accessibility.

4. **DECLARATIONS**

(a) I DECLARE THAT:

- I am the author and owner of the copyright in the thesis and/or I have the authority of the authors and owners of the copyright in the thesis to make this agreement. Reproduction of any part of this thesis for teaching or in academic or other forms of publication is subject to the normal limitations on the use of copyrighted materials and to the proper and full acknowledgement of its source.

- The digital version of the thesis I am supplying is the same version as the final, hard-bound copy submitted in completion of my degree, once any minor corrections have been completed.

- I have exercised reasonable care to ensure that the thesis is original, and does not to the best of my knowledge break any UK law or other Intellectual Property Right, or contain any confidential material.

- I understand that, through the medium of the Internet, files will be available to automated agents, and may be searched and copied by, for example, text mining and plagiarism detection software.

(b) IF I HAVE AGREED (in Section 2 above) TO MAKE MY THESIS PUBLICLY AVAILABLE DIGITALLY, I ALSO DECLARE THAT:

- I grant the University of Warwick and the British Library a licence to make available on the Internet the thesis in digitised format through the Institutional Repository and through the British Library via the EThOS service.

- If my thesis does include any substantial subsidiary material owned by third-party copyright holders, I have sought and obtained permission to include it in any version of my thesis available in digital format and that this permission encompasses the rights that I have granted to the University of Warwick and to the British Library.

5. **LEGAL INFRINGEMENTS**

I understand that neither the University of Warwick nor the British Library have any obligation to take legal action on behalf of myself, or other rights holders, in the event of infringement of intellectual property rights, breach of contract or of any other right, in the thesis.

Please sign this agreement and return it to the Graduate School Office when you submit your thesis.

Student's signature: ███████████████████████ Date: 22 July 2013

JHG 05/2011

Alcohol Dependency

And

Individual Differences

By

Michael Richard Robert Williams

A thesis submitted for the degree of Doctor of Philosophy (PhD)

University of Warwick, Warwick Religions and Education Research Unit, Institute

of Education

January 2013

Alcohol Dependency and Individual Differences

Table of Contents

TABLES

Acknowledgements

I would like to thank a number of people for their help and support during the writing of this dissertation.

First, I would like to express my appreciation to Professor L.J. Francis (University of Warwick) and Dr. M. Robbins (Glyndwr University) for their encouragement, guidance and insight throughout the process, from earliest discussions of ideas to final drafting of the finished work.

Second, I would like to thank Mr. A.G. Williams (Stauros Foundation) and Rev. Dr. A. McK. Roger who patiently and methodically proof read the dissertation.

Third, I would like to thank the Stauros Foundation for their flexibility in overseeing of my work, allowing me the opportunity carry out the research and the time to write up the findings.

Finally, I wish to thank my wife Rosemary Williams, to whom this dissertation is dedicated, for her belief in me and her consistent encouragement.

Declaration

I declare that this thesis is entirely my own work and that it has not been submitted for a degree at any other university.

SUMMARY

This research dissertation is carried out on behalf of the Stauros Foundation, a Christian agency which endeavours to offer pastoral care and support to people with an alcohol dependency problem. The sample population consisted of 207 individuals who completed a questionnaire that covered five categories of interest, for example, background biographical, alcohol and family background, drinking habits, effects of drinking habits and perceived pastoral needs.

The purposes behind the dissertation are twofold. First, it is hoped that Stauros will not only gain a more detailed understanding of the people who request help with an alcohol dependency problem, but also that they will affirm their conviction that religious belief and conversion are relevant to such people. Second, it is hoped that Stauros will benefit from the research by having clarified particular pastoral issues that will be pertinent to people with an alcohol dependency problem in their recovery process.

The first purpose is fulfilled by exploring a range of facets that constitute the beliefs and behaviour of someone who is dependent on alcohol. For example, it begins with an exploration of religious belief and conversion in relation to alcohol dependence before going on to explore behaviour in terms of drinking history, drinking practice and drinking motives. This purpose is further developed by considering primary and secondary consequences of alcohol dependency, family background and parental image, and concludes with an investigation into personality dimensions and psychological type.

The second purpose is fulfilled by maintaining a thread of continuity throughout the dissertation, one that keeps pertinent pastoral issues relevant to recovery as a recurring theme. To this end each chapter returns to this central thread by asking the question, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?'

PREFACE

The research presented in this dissertation is carried out on behalf of the Stauros Foundation. Stauros is a Christian organisation that takes its name from the New Testament word for the cross of Christ. Stauros became a registered charity in 1980 when its founder, Arthur Williams, was pastor of the Findlay Memorial Church, situated in Glasgow, Scotland. Stauros operates in the United Kingdom, the Republic of Ireland and the United States of America, with its headquarters and residential facility located in Northern Ireland.

Stauros provides pastoral care for people who request help with substance abuse issues. This care takes the form of one-to-one conversations and includes residential care for males, when this is deemed necessary. Substance abuse incorporates many substances that are psychoactive in nature and change the way a person sees, thinks, feels or behaves. In this dissertation however, the research has targeted alcohol dependency as this particular issue remains the one that is most common in the agency's experience. Stauros also offers pastoral support to the families of people with alcohol dependency. This support includes one-to-one care for spouses or partners of addicts, residential retreats for wives, partners and mothers of addicts, overnight retreats for teenagers from families where addiction exists, residential retreats for mothers and young children affected by addiction.

In practice Stauros staff members draw alongside individuals with substance dependence problems and offer pastoral care using counselling skills. All Stauros staff have received elementary training in counselling skills, and most have pursued higher levels of counselling qualifications. However, the ethos of Stauros remains

decidedly pastoral in the Christian sense of this word. When it is considered

necessary men, who are alcohol dependent, may be offered a place in the Stauros

short term care home facility, located in Ballyards Castle, County Armagh, Northern

Ireland. In authorising the presentation of this dissertation Stauros has recognised

the importance of rigorous research in developing its Christian ministry, and by it

hopes to be able to maintain its Christian ethos while having academic integrity.

INTRODUCTION

The title 'Individual differences and alcohol dependency' contains three fundamental features of the research described in this dissertation. First, by referring to individuals, the research declares its interest in people and, more precisely, in the uniqueness of the individual. Second, by referring to differences, the research acknowledges that not everyone will have an identical life experience, nor will they necessarily express their alcohol dependence in identical ways. This recognition prompts the search for patterns in relation to individual life experiences and drinking behaviour, and considers if such patterns may inform good practice in pastoral care. Third, by referring to alcohol dependency, the research focuses on the specific condition that preoccupies the ministry of the Stauros Foundation, on whose behalf the dissertation is written.

Purpose

The purpose of the research, therefore, is to gather and evaluate information that relates to people who have an alcohol dependency problem and who come to the Stauros Foundation for pastoral support in recovery. By gathering and evaluating relevant information it is hoped to better inform carers about the people who request support, their drinking behaviour and their motives; and to clarify relevant issues emerging from their family background, the consequences of their drinking and their personalities.

Underlying the purpose of the research are assumptions that are both general and specific in nature. The general assumption is that a Christian pastoral care approach is a valid response to people who declare they have an alcohol dependency problem.

This assumption was explored in detail in a thesis entitled 'Pastoral care and people addicted to alcohol' completed by the author in 2006. Three specific assumptions underlie the research. First, it is assumed that better information about the people who request support leads to more effective care, by focusing attention on issues that require exploration. Second, it is assumed that the research will provide a deeper understanding of the complexity of an alcohol dependency problem, by clarifying the significance of a variety of facets of the life of people who have the condition. Third, it is assumed that patterns within the sample population's responses will inform good practice in pastoral care.

Key question and structure

The fundamental question the dissertation addresses is, therefore, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' In addressing the question the dissertation progresses through three phases.

Phase one

In the first phase, some preliminary questions are considered, questions that influence a carer's preconceptions relating to an alcohol dependency problem, pastoral care and the individual. Preconceptions that relate to an alcohol dependency problem are addressed in chapter one, which explores various models that explain and describe the condition. The chapter concludes by outlining which elements of these models are considered relevant in a pastoral context, and by identifying specific areas of interest which require further investigation and which form the structure to the rest of the dissertation.

Chapters two and three focus attention on preconceptions that relate to pastoral care. As the dissertation is written on behalf of the Stauros Foundation it is assumed that pastoral care is fundamentally Christian and evangelical in ethos. A Christian evangelical ethos, as defined here, incorporates two rudiments, a foundation in Biblical literature and an acceptance of the concept of religious conversion. To this end chapter two explores Biblical literature and language in relation to the misuse of alcohol. Chapter three investigates religious conversion and how it applies to people with an alcohol dependency problem. Chapter four focuses on people and aims at providing a general profile of those who approached Stauros for help with their alcohol dependency problem. This provides a link to the next phase by dispelling preconceptions in relation to the sample population, and by describing the methodology that is used in subsequent chapters.

Phase two

In phase two questions which relate specifically to drinking are considered. A carer needs to consider a number of aspects of individual drinking lifestyles. For example, chapter five investigates drinking behaviour by exploring both drinking history and drinking practice. Drinking history refers to how and when drinking began and includes details such as how drinking has changed over time. Drinking practice refers to the patterns and characteristics of drinking and includes details such as whether drinking is constant or episodic. Chapter six explores motives for drinking, and a motivational model for drinking is explored in some detail. Chapter seven addresses the primary consequences of a drinking lifestyle: in particular the physical, mental and emotional consequences. Chapter eight provides a link with

the next phase by focusing on secondary consequences as they relate to family issues, in particular the consequences of a drinking lifestyle on a spouse/partner and wider family.

Phase three

In phase three questions which relate to a drinker's family background and personality are considered. A carer needs to gain as clear an understanding of the individual as possible, so as to appreciate the specific challenges he or she will have to meet. To this end chapter nine inquires about the individual's family background, with a particular focus on alcohol abuse within that background. Chapter ten targets more specifically the individual's relationship with his or her parental figures: a further step in developing a clear understanding of the individual's life experience and emotional stability. Chapter eleven explores the three-dimensional model of personality, as described by Eysenck, in an attempt to inquire how personality dimensions are reflected within the sample population. Chapter twelve explores the idea of psychological type, proposed by Jung (1990), and operationalised by Francis (2005) in the Francis Psychological Type Scales.

Each chapter begins by setting the theoretical context before describing and presenting the research findings for the topic under investigation. Where it is deemed appropriate profile patterns in relation to sex and age are included, and later, in chapters eleven and twelve, patterns in relation to drinking motives are explored. A summary of the main findings within each chapter is included and a conclusion incorporates a reflection on the key question running throughout the dissertation.

The concluding chapter is a summary of what a carer needs to consider when he or she is asked to help a person who has an alcohol dependency problem.

<center>**Chapter One**</center>

<center>**Alcohol dependency**</center>

Chapter Outline

Introduction

The words 'alcohol dependency problem' can mean different things to different

people because it is a complex and heterogeneous disorder (Kuo, Aggen, Prescott,

Kendler and Neale, 2008). Elementary thought may elicit unhelpful stereotypical

images of homeless people. Political or social reflection on the condition may

prompt theories and strategies that are as diverse as creating employment

opportunities, carrying out housing rejuvenation or implementing adult learning

initiatives. Employ the words in a health care context and general practitioners may

think of examining an individual's physical condition, giving specific attention to

liver function (Williams, 2008) and vitamin deficiency (Tsiaousi, Hatzitolios,

Trygonis and Savopoulos, 2008), while psychologists may think of assessing a

patient's motivation to change and consider cognitive behavioural therapy (Lee and

Rawson, 2008). But what of carers faced with the task of supporting people with

this condition: what does a carer need to consider in helping a person who has an alcohol dependency problem?

Chapter one addresses this question by providing a theoretical discussion of four models of an alcohol dependency problem, a description of the characteristics of an alcohol dependency problem and a clinical explanation of how the condition develops. It is intended that the theoretical discussion will direct a carer to consider the concept of responsibility. Various models suggest differing levels of responsibility on the part of a person with an alcohol dependency problem for both the development of the condition and deliverance from its influence. The models included in this chapter are the moral model, the medical model, the enlightenment model and the compensatory model. The description of the characteristics of an alcohol dependency problem each model contains, will help the carer to consider the variety of issues incorporated in the condition. A clinical explanation of how the condition develops will inform a carer about the cognitive processes that influence drinking behaviour. The chapter ends with a conclusion that summarises the key considerations necessary for effective pastoral care and that ascertains topics for further investigation.

Theoretical models

A model of an alcohol dependency problem is a construct aimed at helping people conceptualise the complexities of the condition. Models change over time, because they are subject to the social processes concurrent to them, processes that influence the creation of developing concepts and their acceptance as credible and valid (Room, 2001, p 35). Gusfield (1967) traced some changes in the terms used to

describe and define people with an alcohol dependency problem up to the latter part of the nineteenth century. For example, the term deviant drinker was replaced with repentant drinker, which gave way to the enemy drinker. All of these terms preceded the phrase sick drinker, a term that emerged in the first half of the twentieth century. Contemporary terms include alcoholic, alcohol dependent or a person with an alcohol dependency problem.

Different models not only reflect social processes, however, they also reflect differing opinions relating to aspects of an alcohol dependency problem. Opinions vary on many different topics relating to an alcohol dependency problem, but two areas are worthy of further consideration. According to the answers to two key questions, four models of an alcohol dependency problem have been highlighted by Brickman, Rabinowitz, Karuza, Ajzen, Cohn and Kidder (1982). The two questions concern the issue of responsibility. First, who is responsible for the development of an alcohol dependency problem: second, who is responsible for changing an alcohol dependency problem lifestyle? The combinations of answers to these questions steered Brickman, Rabinowitz, Karuza, Ajzen, Cohn and Kidder (1982) towards four possible models of an alcohol dependency problem, models they designated as the moral model, the enlightenment model, the compensatory model and the medical model.

Moral model

According to the moral model the drinker is responsible for the development of his or her alcohol dependency problem and is also responsible for changing his or her drinking lifestyle. In the moral model the drinker is characterised as being lazy and

is required to strive to change his or her behaviour; helpers can only exhort or encourage drinkers to act and make a change. Levine (1978) explains that, prior to the eighteenth century; it was assumed that people got drunk because they wanted to, and that they were fully responsible for their actions by virtue of reason and freewill. Barber (2002), commenting on Levine's work, states, 'Drunkenness was a choice made for pleasure' (Barber, 2002, p 13). One expression of this moral model has some proponents today, mostly from religious fundamentalist traditions, who advocate that an alcohol dependency problem 'begins with the sin of drinking alcohol, progresses to the greater sin of excessive use and ends as a sinful habit' (Clinebell, 1998, p 287).

Discussion

There are several principles within the moral model that warrant exploration. First, is it justifiable to accept, without qualification, that everyone with an alcohol dependency problem is solely responsible for the development of his or her dependency? For many the answer to this question is 'no,' because there are factors that appear to influence the development of an alcohol dependency problem, factors that contribute to individual vulnerability. Vulnerability to an alcohol dependency problem is influenced by various facets summarised as the biopsychosocial background to dependency (Donavan, 1988).

The word biopsychosocial captures three influences that impact on individuals thereby making them more likely to develop an alcohol dependency problem. The three influences include genetic vulnerability (the biological element), personal characteristics and coping skills (the psychological element) and family history, peer

influence and cultural background (the sociological and cultural element). These are the 'multiple determinants in systematic interaction during its [alcohol dependence] development, maintenance and treatment' (Parks, Marlatt and Anderson, 2001, p 559). These factors demonstrate that an individual's development of an alcohol dependency problem is not always the black and white choice implicit within the moral model. Yet neither do these factors absolve individuals of personal responsibility in the way proponents of a disease model, for example, might suggest.

Second, if an alcohol dependency problem is caused by moral turpitude, the implication is that those who succumb to its power are more morally weak than those who do not. Surely such an implication must be challenged. May (1991) would indeed challenge this view because he is convinced of the equal moral need in all people. He writes,

> I also learned that all people are addicts, and that addictions to alcohol and other drugs are simply more obvious and tragic addictions than others have. (May 1991, p 11)

If, on the other hand, an alcohol dependency problem is related to moral plight, is the implication that those who succumb to it are demonstrating a moral need? Such an implication has some evidence when those with an alcohol dependency problem express attitudes of remorse for their continued drinking, guilt for the behaviour they display and shame at the person they feel they have become. The vocabulary of remorse, guilt and shame is the vocabulary of morality. And this implication is further supported by the observation that spiritual experience seems to play a role in the recovery of many people with an alcohol dependency problem. Again May

writes,

> I identified a few people who have overcome serious addictions to alcohol
> and other drugs, and I asked them what had helped them turn their lives
> around so dramatically. All of them described some sort of spiritual
> experience. (May, 1991, p 6-7)

In this viewpoint, morality and spiritual experience, although not necessarily
philosophically linked, are seen to be associated in application.

Third, the moral model asserts that a drinker's choice to drink is free, that this choice
is based on reason and that it is motivated by pleasure. Assertions such as these
appear to take no cognisance of the real compulsion expressed by people with an
alcohol dependency problem. Collins and Bradizza (2001) prefer to describe
compulsion, or craving, using the generic term 'urges', a feature that typifies any
substance dependency.

In classical conditioning models, craving is a recurring theme. Conditioning
models, as the name suggests, emerge from classical conditioning theories where
alcohol-related cues become conditioned stimuli when repeatedly paired with
alcohol consumption. These cues elicit the same response as alcohol itself, namely
the release of neurotransmitters in the brain. If alcohol is not ingested immediately
then craving develops. As Field and Cox (2008) explain, through classical
conditioning, substance related stimuli elicit expectancy of substance availability
and this expectancy causes both attentional bias and subjective craving. In the light
of the brain activity that corresponds to the experience of urges for alcohol
ingestion, is a drinker with an alcohol dependency problem truly free to choose to

drink or not, based solely on reason and motivated purely by pleasure?

Medical model

The medical model, according to Brickman, Rabinowitz, Karuza, Ajzen, Cohn and Kidder (1982), is at the opposite end of the responsibility spectrum from the moral model. In relation to the two questions of developing an alcohol problem and implementing a solution, the medical model holds that someone with an alcohol dependency problem has a low level of responsibility in both areas, contrasting with the high level of responsibility purported in the moral model. The medical model suggests that a drinker with an alcohol dependency problem is ill, not lazy, and that he or she needs first to accept the condition rather than striving to change behaviour. This is a foundational belief within Alcoholics Anonymous, that dependency upon alcohol is a disease.

The concept of an alcohol dependency problem being a disease can be traced specifically to the writing of Benjamin Rush (White, 2000). Recognising dependency as a disease placed it into the realm of being a medical condition. The early studies of mental illness, including an alcohol dependency problem, followed a medical approach aimed at precise diagnosis of specific conditions. In this medical context of psychiatric disorders the approach to diagnosing mental illness began by examining conditions in order to establish 'common aetiologies, symptom profiles and course' (Epstein, 2001, p 48). After classification of such criteria, it was hoped that a definition would become clear and a precise diagnosis possible and that this would lead in turn to an appropriate treatment.

The disease model gave rise to a classification system of people suffering from an alcohol dependency problem, one that was initially based on criteria such as physiological consequences, but that later developed by taking cognisance of drinking patterns, aetiology, comorbid disorders and ability to abstain. Later, this development was elaborated by Jellinek (1960) into his five species of alcoholism, which were his five types of alcoholic, alpha, beta, gamma, delta and epsilon. He also outlined the phases through which an individual's drinking career passed from non-alcoholic to alcoholic drinking. According to Barber, his understanding represented an eclectic canon of truth drawn from pseudo-medical, psychological and religious ideas (Barber, 2002, p 18). Not all would agree, however, with Barber's view.

In a discussion of an alcohol dependency problem being a disease, colloquialisms such as 'One does not become an alcoholic, one is born an alcoholic' are affirmed by data that demonstrates the link between genetics and vulnerability to the condition. Mayfield, Harris and Schuckit (2008) provide a summary of the evidence supporting genetic influences and highlight specific genes that contribute to a vulnerability to an alcohol dependency problem, although they also include other considerations such as environmental influences. In an overview of gene identification strategies applying candidate genes for an alcohol dependency problem, Köhnke (2008) declares, 'Alcoholism is a disease with an underlying complex biochemical pathophysiology.' The complexity is demonstrated in the range of determinants that influence vulnerability to the condition, determinants that include, for example, the alcohol dehydrogenase (ADH) and aldehyde dehydrogenase ALDH-systems, both of which influence an individual's ability to

metabolise alcohol. Other determinants include the dopamine and opioid systems which have an influence on the way the disease of an alcohol dependency problem develops, the gamma-amonibutyric acid (GABA) system which has an influence on the behavioural and withdrawal effects of alcohol and the neuromodulator NPY which has an influence on behavioural and psychological processes including anxiety.

Nevertheless, Jellinek's work came under increasing pressure from researchers who began to investigate further the nature of an alcohol dependency problem and to question the conclusions he drew. The result was that Jellinek's scientific approach to understanding an alcohol dependency problem was found to be flawed because the research audience he had used had been exclusively members of the Alcoholics Anonymous movement. Furthermore, the phases that he had presented as the typical progression from social drinking to an alcohol dependency problem were found not to represent the patterns of heavy drinking that appeared in national surveys in the late 1960's. In Fingarette's view, it would seem that from the outset of serious attempts to understand scientifically the nature of an alcohol dependency problem that a wrong turn had been taken (Fingarette, 1989).

Discussion

In the context of treatment there are several advantages in associating an alcohol dependency problem as a medical condition linking it to the disease model. First, this approach helps people who suffer from an alcohol dependency problem to accept that they have such a condition and to seek help. Second, it is good to approach an alcohol dependency problem from a scientific perspective and to apply

empirically-based procedures to discover the exact nature of the condition and so aid treatment strategies. Third, funding for research into the condition is more likely if it is viewed in the same way as other medical conditions that have a negative impact on individuals and society. Fourth, understanding an alcohol dependency problem as a medical condition professionalises treatment agencies and approaches, which in turn build a confidence base for those who attend them for help.

There are also a number of problems, however, with the details of the disease model that weaken its acceptance as a valid model for understanding an alcohol dependency problem. First, the loss of control argument raises a number of issues (Jellinek, 1962). For example, the first step to recovery, according to the medical model, is considered to be that a drinker confesses his or her powerlessness over alcohol. The phrase 'loss of control' endeavours to capture the truth, often observed in an alcohol dependency problem, that there is a powerful momentum driving a drinker to keep drinking long after he or she has had enough. Alcohol has become a dominating necessity (Fingarette, 1989 p 32). According to the disease model someone with an alcohol dependency problem has physiological and neurological abnormalities which constitute an allergy in the body (The Twelve Steps, 1979, p 22), an allergy that determines drinking behaviour. This cannot mean, however, that a drinker has no control at all over the amount of alcohol consumed, because not everyone with an alcohol dependency problem drinks to oblivion. Some control the amount they drink so as to maintain a certain level of alcohol in the blood, and do so with great skill (Mello and Mendelson, 1978). Furthermore, using Jellinek's alcoholic species as a model, loss of control is exhibited differently by differing types. In delta alcoholics it is seen in their inability not to drink, to resist the first

10

drink, whereas in gamma alcoholics loss of control is exhibited by their inability to stop drinking once they have ingested the first. There is an obvious contradiction here in relation to gamma alcoholism. If compulsion and loss of control are only exhibited after the first drink, then surely the problem can be solved by an individual not taking the first drink (Fingarette, 1989).

Second, research has demonstrated that people diagnosed with an alcohol dependency problem do not always have loss of control (Jellinek, 1962) in the way the disease model depicts. Sensible self-control is a phenomenon among some with an alcohol dependency problem who may moderate their drinking, or even abstain, for reasons that are important to them, and at times they choose. Furthermore, drinking behaviour may be informed by the drinker's subjective expectations of his or her drinking (Waller and Rumball, 2004, p 249). It has been demonstrated often that drinking behaviour depends upon what a drinker believes he or she is drinking, disproving the myth that when someone with an alcohol dependency problem ingests alcohol, it triggers an irresistible urge to drink more. There is little doubt that heavy drinkers can control their drinking and indeed frequently do (Fingarette, 1989).

Third, there is always some degree of choice: impulse and compulsion influence decisions, but do not remove the necessity of choice entirely. To remove choice completely is to accept that someone with an alcohol dependency problem has no responsibility whatsoever in his or her drinking behaviour and this makes change impossible. Such a drinker may use the belief he or she has a disease as a way of absolving himself or herself from the responsibility to stop drinking.

Fourth, to continue to pursue this line of enquiry may be to create blind-spots in which valuable research may be carried out. For example, a preoccupation with the condition can detract from the other aspects of the life of people who suffer from an alcohol dependency problem, aspects that may warrant research attention. For example, are there patterns to be observed in the way people with an alcohol dependency problem perceive their parents or parental figures?

Finally, it is questionable whether or not an alcohol dependency problem, as a behaviour pattern, truly belongs in a medical framework when it is compared to other compulsive behaviour patterns. For example, do compulsive gamblers have a disease?

Enlightenment model

Falling between the two extreme positions of the moral and medical models lay the remaining two models, the enlightenment and compensatory models. These differ from one another in regard to the answers to the questions of responsibility for the cause and solution of an alcohol dependency problem.

The enlightenment model proposes that the individual has a high level of responsibility for the cause of an alcohol dependency problem: the individual is guilty on this count. Cook (2008) explains that the guilt is derived from the individual's loss of contact with his or her God, or higher power (Alcoholics Anonymous, 1979, p 25), and that it is this loss of contact that causes dependency upon substances such as alcohol. This model further proposes that the individual has a low level of responsibility in finding a solution to his or her alcohol

dependency problem, suggesting that the action expected is submission to the truth of their condition, namely loss of contact with their higher power. Their responsibility for changing their behaviour is low because they cannot do it without the aid of their higher power. The individual must submit to God, the God of their understanding, because only through the intervention of a higher power will the desire to use alcohol be removed. Therefore, it becomes clear why the enlightenment model is associated with a spiritual outlook on the issue of an alcohol dependency problem, and is sometimes called the spiritual model. Some of the tenets of teaching in Alcoholics Anonymous are grounded in this understanding of recovery from an alcohol dependency problem.

Discussion

For some people belief in God or a higher power may be problematic. First, for those holding atheistic or agnostic beliefs the concept of believing in a higher power comparable, for example, to a Judeo-Christian understanding of a deity, may prove to be a step too difficult. Attempts at navigating around this obstacle, by designating one's belief in a higher power as a being of one's own understanding (The twelve steps, 1979, p 35), allows some individualistic nuances in the concept. However, this jeopardises any cogent objectivity by reducing the higher power to being a construct of an individual's own mind. Can such a construct really be an objective higher power?

Alternatively, if this process of identifying a power that is the construct of an individual's own understanding is valid, then the responsibility for recovery must still lie at the feet of the person with an alcohol dependency problem. It is his or her

responsibility to construct such a higher power and implement the process. However, if this is not the postulation, and if there is a keen adherence to belief in the power of a being greater than the drinker, then someone with an alcohol dependency problem is at liberty to remain passive towards making any attempt to secure sobriety, by simply stating that their God has not answered his or her pleas for help.

Second, in the context of an alcohol dependency problem, how does one submit to one's higher power in order to obtain sobriety? Submission may mean implementing changes to one's belief about one's use of alcohol, one's attitudes to life and one's behaviour. However, implementations such as these are possible through logical thought and choice. Perhaps in conversation with a carer help may be obtained in the process of thinking things through to appropriate decisions, for example, using Pita's (2004) developmental process model. Submission may mean receiving power from an external source to enable an individual to implement the necessary changes and, presumably this power comes in answer to prayer or some other form of communication with the higher power.   But if one's higher power is a being of one's own construct, what meaning does prayer have?

Compensatory model
The compensatory model reverses the place and weight of responsibility found in the enlightenment model. In this understanding individuals have little responsibility in the development of their alcohol dependency problem because they are characterised as being deprived. Their alcohol dependency problem is a response to complex influences that are both personal and environmental, and the development

of their dependency is a learned response to such stressors. Dawson, Grant and Ruan (2005) demonstrated that there was a positive relationship between the number of stressors experienced by respondents in the year previous to the research, and all measures of heavy drinking.

In the compensatory model there is a high level of responsibility for the individual, however, in ensuring recovery, because he or she must work at understanding their alcohol dependency problem, and take steps to combat the negative patterns that have been allowed to develop. Often, at this point, there can be an overlap with the spiritual model because, for some people, their understanding of their condition incorporates a spiritual perspective on life and experience. This model recognises individual differences and allows for consideration to be given to the individual and to the unique distinctions that characterise people with an alcohol dependency problem.

Discussion

Some may question the suggestion that people with an alcohol dependency problem have little responsibility in the development of their drinking problem. To suggest that there is a wide variety of factors that contribute to the development of dependency is helpful in that it recognises the complexity of the condition. Nevertheless, it may also contribute to a victim mentality within the drinker, one that is far from conducive to achieving a full recovery. An over emphasis on contributing factors insinuates a deterministic philosophy that absolves the drinker unnecessarily (Mercadante, 1996, p 135), and one that sits uncomfortably alongside the responsibility that the drinker has to take action and assert the desire to change.

This theoretical discussion of four models of alcohol dependency is intended to direct a carer to consider the concept of responsibility. This is important as a carer's beliefs about whether or not a drinker is responsible for the development of their dependency, and for recovery, will have a profound influence on the approach a carer adopts.

There are partial truths to be found in each of the four models and these need not be mutually exclusive. For example, first, the carer may agree with the moral model that people with an alcohol dependency problem are to be held responsible for the development of their dependency and for their recovery from its influence. Second, the carer may appreciate the truth expressed in the medical model that specific genes contribute to a vulnerability to an alcohol dependency problem, especially if they coincide with other considerations and environmental influences. Third, the carer may believe the truth conveyed in the enlightenment model where only through submission to God will the desire to use alcohol be removed. Fourth, the carer may recognise the truth asserted in the compensatory model that people who have an alcohol dependency problem are responding to stressors, such as complex personal influences, characterised by deprivation. These models, with their focus on responsibility, serve only as an introduction to some of the complexities of the condition, complexities that are further explored through a description of the characteristics of an alcohol dependency problem.

Characteristics of dependency

Endeavours to find a helpful definition and diagnosis of an alcohol dependency problem have looked for alternatives to model approaches in general, and to the

medical model approach of classification in particular (Epstein, 2001). One approach recognises the diversity of expressions of an alcohol dependency problem and seeks to quantify its elements by placing each patient on a continuum of severity of symptoms. This is an approach that has been applied to other aspects of mental disorders. In this way it is no longer the case that a person either has or does not have a discrete condition, but that he or she may exhibit a variety of aspects of a condition with varying degrees of severity. This approach adopts a multidimensional view of a person's mental condition.

In the field of alcohol dependency this multidimensional model has been adopted and is based on drinking behaviour and severity (Babor, 1994, p 1). For example, the World Health Organisation prefers to define what was previously described as alcohol addiction as an alcohol dependency syndrome (Barber, 2002). In this case the emphasis has shifted from questions about responsibility to questions surrounding characteristics of the condition. Köhnke (2008) defines an alcohol dependency problem as being,

> A cluster of physiological, behavioural and cognitive phenomena in which the use of alcohol takes on a much higher priority for a given individual than other behaviours that once had great value. (Köhnke, 2008, p 160)

Alcohol dependent syndrome

The term 'alcohol dependence syndrome' was coined by Edwards and Gross (1976) and is based on clinical impression. The syndrome refers to seven clinical phenomena. First, there is a narrowing of drinking repertoire where a drinker wants to achieve a certain blood alcohol level. This means that choice of drink, time of

drinking and pattern of drinking increasingly become narrow in their expression.
Second, there is a salience of drink seeking behaviour where priority is given to
maintaining or achieving a certain blood alcohol level over competing demands, for
example, for time, money or family commitments. Third, there is an increased
tolerance to alcohol. In the early stages of drinking the desired effects may have
been experienced with relatively small amounts of alcohol being taken: with time
the amount increases because the effect of the alcohol diminishes. Fourth, there are
repeated bouts of withdrawal symptoms. When alcohol levels in the blood drop, for
example, over night during sleep, the drinker experiences unpleasant symptoms that
can be relieved by taking more alcohol. Fifth, there is a seeking of relief from or
avoidance of withdrawal symptoms by further drinking. Sixth, the drinker has a
subjective awareness of a compulsion to drink: a self-knowledge that he or she has
strong desires to drink more alcohol. Finally, the drinker reinstates a drinking
pattern after abstinence and this often after only a short period of abstinence.

Discussion

Nevertheless, the contribution the alcohol dependence syndrome makes to a
discussion on the nature of an alcohol dependency problem is important for carers to
consider, because it allows for the essential characteristics of an alcohol dependency
problem to be expressed in a wide variety of combinations, each reflecting
observable patterns. Carers need to appreciate that the seven characteristics each
represent a facet of an alcohol dependency problem. These facets, when expressed
in their essential characteristics, incorporate the drinking lifestyle, with its
multifarious quality and broader life priorities. The facets include the physical
changes that take place due to prolonged alcohol ingestion, as well as the

physiological and psychological processes that conduce to an individual's dependency. They embrace a drinker's self-awareness, not only of the urge to drink, but of repeated failures to remain abstinent or abstemious. The possible variations to be derived from within some of these facets, and from combinations between them, declare a more detailed appreciation of the balance between the commonalities of an alcohol dependency problem and individual differences.

Not everyone has accepted the alcohol dependence syndrome model and its association with the diagnostic approach of the medical model, and it has not been without its critics, for example, Heather and Robertson (2001, pp 59 - 64) and Fingarette (1989). Edwards, Gross, Keller, Moser and Room (1977) made a further contribution to a discussion of characteristics of an alcohol dependency problem by making a distinction between the alcohol dependence syndrome, with its narrow definition, and alcohol related disabilities, which fits closer to contemporary thoughts of heavy drinking, alcohol related problems and alcohol abuse (Fingarette, 1989). This has been called the problems perspective, because it focuses on the continuum of drinking behaviour, and the social and psychological problems related to alcohol abuse.

So far we have briefly explored two attempts at conceptualizing an alcohol dependency problem by concentrating on responsibility and characteristics. Benefit may be derived from engaging in one more discussion, one that turns attention towards behaviour (Barber, 2002) and one that seeks an explanation of how alcohol dependency develops.

Clinical explanation

A carer will benefit from considering a clinical explanation of how an alcohol dependency problem develops, because this will enhance his or her understanding of the cognitive processes that operate in a drinker's mind. The most dominant theory in this context is undoubtedly that dependency is defined and explained by social learning theory. This theory suggests that people learn about drinking from others, for example, parents, peers and the media, and from personal experience. Personal experience informs the individual what to expect from drinking, and repeated use develops either pleasure or the removal of unpleasant thoughts or feelings. By this thinking Krivanek (1982) suggested the following definition,

> Addiction will be defined as a behaviour pattern characterised by an ongoing and overwhelming preoccupation with the use of a drug and the securing of its supply. (Krivanek, 1982)

The first behavioural theory was offered by a psychiatrist called Wikler (1965), who suggested that addiction was the product of operant conditioning, a theory based on the work of Skinner (1938). Drinking powerfully and immediately reinforces alcohol-seeking behaviour through reward contingencies (Sobell and Sobell, 1993). An alcohol dependency problem develops with the association of secondary reinforcements.

George (1989) outlined three key elements in rooting alcohol dependency in social learning theory. First, addictive behaviours are socially acquired as they are influenced by past learning experiences, situational antecedents (such as high-risk circumstances), biological make-up, cognitive processes (that lead to expectations

20

about likely consequences) and reinforcement contingencies. Second, degrees of dependency occur along a continuum where abstinence at one end is balanced by dependency at the other. Where a person falls on this continuum depends upon the unique interaction of the factors referred to in point one above. Finally, addictive behaviours are attempts at coping with life: they are attempts at mastering, tolerating or reducing stressful internal and external demands. In this way alcohol is used to restore equanimity.

Heather and Robertson (2001) explain in helpful detail how the classical conditioning model of behaviour operates in the context of an alcohol dependency problem. In the classical conditioning model behaviour is stimulated by certain external cues, or triggers, that the individual associates with the behaviour. Heather and Robertson use the example of a man who takes alcohol with his lunch on a regular basis. By the middle of the afternoon the drinker experiences a feeling of seediness as a result of imbibing alcohol during lunch. The drinker knows that by five pm an opportunity will be provided for him to go to a bar and have a pick-me-up. Here we see an unconditioned stimulus, a waning blood alcohol level, becoming associated with an unconditional response, a feeling of discomfort or seediness. With a repetition of this pattern a neutral stimulus enters the dynamics of behavioural choice. In this instance it is the time of day, five pm. Now the unconditional stimulus, waning blood alcohol level becomes associated with a neutral stimulus, finishing work at five pm. The result is that the neutral stimulus becomes a conditioned stimulus that at five pm each evening the drinker experiences a conditioned response of feeling discomfort and the desire for a drink intensifies. Finishing work at five therefore, becomes a trigger to ingest alcohol.

In the case of people who develop a dependency on alcohol there may be a considerable number of such external triggers. The use of alcohol becomes associated with a number of stimuli that are external circumstances in which the drinker frequently finds himself or herself; for example, playing golf, going to a rugby match, watching television, eating out with friends, cooking a meal at home or meeting friends socially.

A development of this process takes place when internal stimuli develop alongside the external circumstantial context in which alcohol is ingested. In this way certain internal emotions become stimuli that trigger the desire to ingest alcohol. Feelings of loneliness, emotional hurt, joy or boredom become the internal triggers that prompt thoughts of alcohol, what Heather and Robertson (2001) call a conditioned desire (Heather and Robertson, 2001 p 138). The more numerous and ubiquitous the external and internal cues the greater the potential for drinking behaviour to become problematic.

A further development of the process takes place when a drinker begins to experience uncomfortable feelings when his or her blood alcohol level drops below a certain level, an experience that has been described as going through withdrawal. The experience of withdrawal becomes so similar to the internal negative discomforts that acted as cues, that the drinker interprets them in the same way as before. Withdrawal causes anxiety and fear (Edwards, Marshall and Cook, 2003, p 53) and these create the same association in the drinker's mind as such emotions did when they were not caused by withdrawal.

In these ways alcohol provides immediate reinforcements that are both positive and negative. Positive reinforcement results when the pleasure that alcohol provides is experienced quite quickly after ingestion, and negative reinforcement occurs when the unpleasant aspects of life, such as negative emotions, are removed for a time. The frequently experienced negative consequences of alcohol abuse, including broken relationships, poor health or financial hardship, all occur much later in the drinking cycle, the immediate consequences are positive. Heather and Robertson put it like this, 'short term effects over-rule long term consequences' (Heather and Robertson, 2001, p 147).

At this point, in understanding an alcohol dependency problem as a learned behaviour, attention must focus on cognition, that is, the subconscious mental processes that take place in the mind of a person with this condition. These mental processes are described as subconscious because they rarely function as part of rational thought and are more akin to instincts or intuitions.

A drinker acquires expectations about alcohol by observing others, especially family members, community associates and the media. The most obvious example is that parents can model drinking behaviour for their children, and communicate what expectations can be anticipated from such behaviour. Modelling takes place by parents drinking at certain times, or in certain circumstances in life. Children learn early that if there is something to celebrate, alcohol is a reward, or if there are negative feelings of depression or sadness, alcohol will help.

As dependency on alcohol develops, the drinker's dependency does not come from

the pain of withdrawal or even the desire for a drink: the dependency comes from the strong association the drinker has developed between the cues (cues that are external, internal and related to drinking behaviour) and the behaviour of drinking alcohol. Dependency is expressed by the repetition of the drinking behaviour, even when the consequences of this behaviour are detrimental to the drinker.

Discussion

There is much to commend this clinical explanation of how an alcohol dependency problem develops. It harmonises with some observations referred to earlier in this chapter. For example, first, learning theory does not absolve a drinker from responsibility in both the development of and recovery from an alcohol dependency problem, as proposed by the moral model. Second, the understanding it presents of the influence of social factors, especially parental and home influences, reinforce the compensatory model, where people with an alcohol dependency problem are characterised as having experienced difficulties in early life and may, in one way or another, be described as being deprived. Third, salience in drink-seeking behaviour, as described in second point of the alcohol dependence syndrome, is reflected in the learned theory explanation, especially in relation to the personal expectations the drinker derives from alcohol use. Finally, the learned theory explains further the dynamics of avoiding withdrawal symptoms as referred to in point five of the alcohol dependence syndrome.

There is, however, a need to sound a cautionary note when presenting a learned theory of alcohol dependency. The caution is that, theoretically, if one learns to drink in a way that leads to an alcohol dependency problem, one can learn to drink

in a way that does not lead to dependency. Empirical evidence can be produced to support this theory. For example, Davis (1962) published a brief paper on the evidence that some people who had been alcoholic had recovered, and were able to drink 'normally' again. This contention remains highly controversial.

The caution that must accompany the theory has two elements. First, this theory does not take account of the genetical vulnerability that underlies the drinking experience of many people. This means that, for many people, genetically they are more susceptible to reverting to unhealthy alcohol use that preludes an alcohol dependency problem. Second, it does not allow for returning or persistent cues, either external, internal, or both, which reinstate cognitive processes that may eventually lead to an alcohol dependency problem again. As one person who formerly suffered from an alcohol dependency problem explained, 'if one sits in a barber's shop long enough, one is likely to get a haircut.'

Main findings

This chapter set out to explore the preliminary issue of an alcohol dependency problem with a view to helping carers consider their preconceptions about the condition. The chapter highlighted a number of issues for consideration.

First, carers need to consider the question of responsibility: is a drinker responsible for the development of an alcohol dependency problem and/or for taking steps to recover? The answer to this question dictates the approach a carer will take in offering pastoral support. The conclusion is that if a drinker is not responsible for

development and recovery, his or her motivation to change will be diminished to a greater or lesser extent.

Second, carers need to consider the language of morality as used by people with an alcohol dependency problem. For example, remorse, guilt and shame, referred to as the vocabulary of morality, are common words used in this context and have far reaching influences in the psyche of many drinkers.

Third, one of the most obvious challenges for carers is being able to support people who have an alcohol dependency problem through times of craving, when the urge to drink is strong. Linked to this concept is the sense in which the drinker is no longer in control and is being driven to behave against his or her better judgment.

Fourth, impulse and compulsion may influence behaviour, but they do not remove the necessity of choice entirely. Here carers need to explore the decision making process a person with an alcohol dependency problem follows. For example, how can the habit of making decisions based on feelings be changed so that decisions are based on future happiness, relational integrity and logical reasoning?

Fifth, carers need to assess the extent to which Cook (2008) is right when he states that an alcohol dependency problem has its roots in the individual's loss of contact with his or her God. The truth, or otherwise, of this statement may or may not be a factor a drinker has considered. Carers of a Christian and evangelical persuasion must exercise sensitivity, either to help an individual explore this truth as they journey in recovery, or to respect an individual's right to dismiss this concept.

Sixth, some people are more susceptible to developing alcohol dependency than others. This is true from a number of perspectives as a biopsycholsocial approach illustrates. Some people have a genetical predisposition to an alcohol dependency problem; some have a psychological predisposition expressed through personal characteristics and poor coping skills: and some have a family history of an alcohol dependency problem with peer influences and environmental pressures. Carers need to consider the possibility that some or all of these factors may play a part in the drinking behaviour and lifestyle of people they care for.

Seventh, carers need to consider drinking behaviour and lifestyle. Drinking behaviour focuses attention on behaviour that is directly related to drinking; for example, when drinking occurs, with whom it occurs and how often. Drinking lifestyle has a broader focus and includes, for example, beliefs about drinking, managing stress, coping with negative emotions and family relationships.

Eighth, carers need to appreciate the cognitive processes that influence drinking behaviour. In particular they need to explore the internal emotional triggers, as well as the external cues, that prompt thoughts of drinking which in turn lead to craving.

Conclusion

This chapter has not only highlighted important issues carers need to consider, but it has also raised topics that require further investigation in this dissertation. For example, issues such as drinking behaviour, drinking lifestyle and personal complexities are themes to which the dissertation will return later. The chapter also introduced spiritual language using terms such as higher power and the God of one's

own understanding. As the chapter has pointed out, the necessity for the dissertation

to focus on a range of issues requires a clear research methodology and a sample

population. The next chapter addresses both these themes; first, it introduces the

research methodology to be used in the investigative process; second, it describes

the sample population, thus maintaining the research interest in people.

<center>**Chapter Two**</center>

<center>**Methodology and sample**</center>

Chapter outline

Introduction

Theoretical context: methodological foundation

       Inter-disciplinary model

       Multidisciplinary model

       Intra-disciplinary model

Gathering information

       Questionnaire design

       Questionnaire content

       Questionnaire distribution

Statistical analysis

Sample population

       Sex

       Age

       Marital status

       Religious affiliation

       Employment

       Social background

       Personal difficulties

Main findings

Conclusion

Introduction

The fundamental question this dissertation addresses is 'What does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' In the previous chapter, preliminary preconceptions in relation to an alcohol dependency problem were explored. A list of issues to be considered arose from that discussion, along with themes for further investigation. However, with the

identification of themes for further investigation, two subsequent questions are now proposed, questions which constitute the two parts of this chapter. First, what methodological approach is appropriate in an investigation of this nature; second, with who are such investigations to be conducted? Part one of this chapter begins by introducing the research methodology that is used in the dissertation, and part two continues by describing the sample population in general terms.

In part one a discussion of the research methodology begins with a theoretical exploration of a number of models of approach, with a view to clarifying the methodological foundation upon which subsequent methods are built. This discussion is followed by an exploration of what information would be appropriate to gather, and how such information could be gathered efficiently. This introduces an explanation of questionnaire design and distribution, and proceeds by introducing the details contained in the questionnaires used in the research. A summary of the methods of statistical analysis used in the dissertation is included at the conclusion of this part of the chapter.

Part two defines and describes the sample population. The description includes a profile of the sample population drawn up by various considerations such as sex, age, marital status, religious denomination and practice, employment, social status and personal difficulties.

Theoretical context: methodological foundation

This dissertation uses empirical research methods associated with the social sciences. There is a need within practical theology for an empirical approach to

research, one that endeavours to understand the link between people in real social contexts, the specific problems such people may face and the faith perspective they may, or may not, have (Cartledge, 2003, p 11). In this dissertation the real people are those who come to Stauros for help; the real social contexts they represent include, from time to time, a family background of addiction; the specific problem they face is an alcohol dependency problem; and they may or may not express interest in religious belief and practice. Therefore, an empirical approach needs to be able to cross the boundaries of distinct disciplines such as religion, an alcohol dependency problem, sociological psychology and personality psychology.

Two questions arise from this approach. First, is it possible for such boundaries to be crossed; second, if boundaries are crossed, how do different disciplines relate to each other? In the first instance this dissertation accepts that it is possible to cross discipline boundaries by, first, adopting a recognised method of gathering quantitative information, for example, questionnaires; second, by inviting participants to respond to questions that constitute research tools considered valid in various disciplines. Recognised research tools employed in this dissertation include parental image perceptions in the discipline of psycho-sociology, Eysenck's Personality Questionnaire and the Francis Psychological Type Scales in the discipline of personality psychology. In the second instance, a number of models explore how distinct disciplines relate to each other.

Inter-disciplinary model

Berger suggests distinct disciplines relate in an inter-disciplinary way (Martin, 1997). For example, in reality theological or religious dimensions cannot be

researched empirically in the strict sense. In the context of this thesis, for example, empirical methods could be employed to explore an individual's alcohol dependency problem and his or her recovery from dependency, but not the influence of a higher power or the God of his or her understanding. Using a step-by-step procedure, theological issues can be explored in the light of how they correlate to other empirically verifiable facts: empirical methods are used in the areas of investigation in which they operate properly and, against these, theological or religious perspectives may be correlated. In this way the approach is inter-disciplinary.

Kay and Francis (1985) propose that it is important, in any inter-disciplinary research model, to be able to satisfy the practitioners of each discipline. Cartledge (2003) points out two limitations to this proposal. First, it places greater responsibility on the competence of the researcher than on the nature of the discipline; second, while boundaries help practitioners to define concepts and practice in established disciplines, they hinder innovative researchers who may wish to test such boundaries. An inter-disciplinary relationship, therefore, sees theology as being on an equal footing to other disciplines fostering the criticism that, by nature, it cannot be treated in this way, because it cannot be researched in a strictly empirically methodological way.

Multi-disciplinary model
Alternatively, researchers may employ a multi-disciplinary model. From this viewpoint empirical research is carried out on the relevant aspects by social scientists and the conclusions and observations are then reflected upon from a theological perspective. The theological perspective is totally dependent upon the

conclusions drawn by the social scientists and is, therefore, in some way subordinate to their contribution.

There are difficulties in understanding the relationship between distinct disciplines in either of these two models. One difficulty is that theology, religion or faith does not relate easily to more obviously social scientific disciplines, and another is that theology, religion or faith should not have to be the poor relation of such disciplines, because, for many people, religion and faith are an integral part of their life experience.

Intra-disciplinary model

Van der Ven (1993) proposes an intra-disciplinary model in understanding the relationship between differing disciplines even when one of the disciplines is theology. This model may be more easily understood as an integrationist model where concepts, methods and techniques from one discipline are integrated into the work of another. Van der Ven demonstrates that such a process is well established,

> Such intra-disciplinary processes occur in all scientific fields, in the natural sciences, in the linguistic, historical and social sciences, in the philosophical and theological sciences. By way of example one need only look at the relationship between biology and chemistry (biochemistry). (Van der Ven, 1993, p 101)

Cartledge explains that Van der Ven recognises that theologians will use the tools of the social sciences without claiming to do social science (Cartledge, 2003, p 16). From this point of view theological pre-eminence is maintained.

The research carried out in this dissertation assumes the validity of Van der Ven's position and holds that methodologies more commonly used in the social sciences are valid when exploring the relationship between personal profiles, personality psychology, alcohol dependence and faith. This integrationist approach allows for the work to be anchored firmly in the domain of practical theology while drawing from the other disciplines.

Gathering information

In addressing individual differences and an alcohol dependency problem, this dissertation is fundamentally about people. It is an investigation that seeks for patterns in the experience or perception of those who approach Stauros for help with their alcohol dependency problem. Patterns are sought through analysing information gathered from the sample population, but how might information be gathered in such an investigation as this?

One answer might have been to conduct a qualitative approach by selecting a small number of willing participants who fulfilled the criteria, and allowing them to talk about themselves, their life and their alcohol dependency problem. The conversations could have been recorded and the data analysed to search out possible patterns. This approach has a number of advantages. First, it certainly allows for the person centred emphasis to predominate the methodology. Individuals are provided with the opportunity to let themselves be known in the investigation. Second, this approach allows for individualism in communicating information that a participant wishes to deliver, without the restriction of set questions or fixed responses. Third, recordings of such information facilitate revisiting the data over

time, for example, to scrutinise details, vocabulary and non-verbal communication signals as desired.

There are two drawbacks, however, in such an approach. First, as the sample population is small, this approach does not easily allow for general conclusions to be made in relation to all individuals who may come to Stauros for help. One of the main purposes behind the research is to inform carers about the kind of people and issues they are most likely to encounter, and as a result, as wide a sample base as possible is important. Second, the individualism afforded by a qualitative approach allows for variance in the understanding of vocabulary and meaning of questions, variances that fixed questions and responses help to eliminate. For example, in conversation people may use words in different ways; they may take meanings from questions authors may not have intended or identified, and this weakens the integrity of the data. It was decided to gather the necessary information using questionnaires because they are both empirical and theoretical. The research questionnaire is empirical in that it aims at recording observations and measurements of reality, and it is theoretical in that it is hoped the information gathered will be used to develop approaches to pastoral care that are more fit-for-purpose.

Questionnaire design

Although the questionnaires target individuals, the results aim at establishing nomothetic rules, or patterns, from which generalisations can be drawn (Trochim, 2006). The purpose of the research questionnaire is, therefore, not to prove causal links between an alcohol dependency problem and other social or psychological factors. The information that was deemed appropriate for this research included

biographical and personal details, information about how alcohol influenced family

background, information related to drinking history, practice and motives,

information about the consequences of drinking and finally, information related to

belief in God and perceived pastoral needs.

The respondents were asked only for personal information, and for their opinions or

perspectives, and so questions were exclusively descriptive and relational.

Descriptive questions included, for example, the characteristics of their alcohol

dependency problem; relational questions included themes that would allow

comparisons to be made, for example, comparisons of themes such as sex, age and

relationships with mother and father. Some questions were dichotomous, requiring a

yes or no answer, while others were nominal, giving the respondent a number of

options from which to choose his or her response, for example, regarding

employment status and employment type. Likert scaling type questions were also

used in measuring one-dimensional concepts such as the reasons why the client

drank and how respondents would describe certain characteristics of his or her

drinking pattern and habit.

Questionnaire content

The sequence of the questionnaire followed the exploration of five areas of interest.

First, there were questions requesting information about the client and his or her

background. This information included biographical details, religious practices and

personality, which involved using the Revised Eysenck Personality Questionnaire

(Abbreviated) (Francis, Brown and Philipchalk, 1992) and the Francis Psychological

Type Scales (Francis, 2005). Second, information was requested regarding the

influence alcohol had had on the participant's family background. The questions included both positive and negative influences of alcohol, on the alcohol use of parents and other relatives, and how the participant would describe his or her relationship with his or her mother and father. Third, information was requested about the participant's own drinking habits. These questions included details about age of onset of drinking, frequency of drinking, why he or she began and continued drinking and how he or she would describe his or her drinking. Fourth, information was requested regarding the effects alcohol had had upon the respondent; effects that influenced personal health, work, family and social behaviour. Finally, information was requested regarding what the participant believed about God, how he or she would describe God and how he or she perceived personal wider pastoral needs. The questionnaire, therefore, captures information from all areas deemed relevant.

Questionnaire distribution

The distribution and completion of questionnaires was carried out by members of Stauros' pastoral care staff. Prior to using the questionnaires with participants the staff members were given an opportunity to go through a sample questionnaire to gain clarity on any issues deemed pertinent. Under the supervision of the primary researcher they were given the opportunity to practise completing a questionnaire with another member of staff who had had an alcohol dependency problem, so as to be as confident in the process as possible. Staff members were then requested to begin using the questionnaires with participants, supervising the completion of the questionnaires within the sample population, and subsequently to return completed questionnaires at their earliest convenience.

It was considered better for staff members to complete the questionnaire for participants so as to be inclusive of all people who requested pastoral support from Stauros, regardless of educational background and/or literary skills. Staff members were instructed to explain questions to clients only in the briefest terms, so as to encourage standardised approaches across the sample population and to minimise distortion and subversion. Levels of return of questionnaires were, therefore, very high because the sample population had a pastoral relationship with those conducting the research. The data was collected between March 2004 and May 2008 and the data consisted of 207 returned questionnaires.

Statistical analysis

The responses from the questionnaires were recorded, coded and loaded into the SPSS statistical package (Statistical Package for the Social Sciences), capable of receiving, analysing and presenting data of this nature and quantity. In this dissertation research data are analysed and presented in a number of different forms which facilitate making inferences and drawing conclusions.

First, data need to be recorded and presented as frequencies. Frequencies are the number of responses obtained by the questionnaires that relate to a single piece of information or variable. In this dissertation percentage scores are always rounded to the nearest whole number and totals may not always equal precisely 100% but range between 99% and 101%.

Second, data are presented in cross-tabulation tables. This allows for two categories of variables to be compared with one another, for example, one variable may be sex

and another may be a positive or negative response to a statement such as 'people at work joked about my drinking?' Each categorical variable may only have two responses, for example, male/female and yes/no (2X2). When responses in questionnaires had more than two possibilities, for example Likert scale responses, two responses were created by coding frequencies into yes and no responses. Therefore, agree strongly and agree columns were coded into a column designated yes, disagree strongly and disagree frequencies were coded into a column designated no, and frequencies marked 'not certain' were also recoded as 'no'. Cross-tabulations were carried out to search for relationships between two categorical variables.

SPSS tabulates the data and carries out statistical tests to see whether responses are statistically significant (Field, 2003). The basic Pearson chi-square test is calculated and presented as a numerical value to the second decimal place. This test detects whether there is a statistically significant association between two categorical variables and is identified by χ^2. This test only detects associations between categorical variables and does not suggest if one variable is dominant or influential on the other.

SPSS also calculates the strength of the association between categorical variables and this calculation is presented as the significance value, using the symbol $p<$. The significance value must be less than .05 for there to be a clear statistical association between two categorical variables. If this value is not low enough the table contains the symbol NS meaning there is no significance between the categorical variables. If the association is strong the significance value may be presented as a lower figure

than .05 and two further values may appear, .01 and .001, where the lower the value the stronger the association.

Third, data that involves creating constructs includes a measure of the reliability of the scale or correlation coefficient. A construct is a set of variables that relate to one another regarding one issue, for example, there are six questions (or variables) that relate to extraversion (a construct) in the Revised Eysenck Personality Questionnaire (Abbreviated) (Francis, Brown and Philipchalk, 1992). The reliability of the scale refers to the consistency of responses to the variables within each construct. Cronbach's alpha coefficient (α) is used to measure this consistency with a high alpha value meaning there is a strong consistency among the variables within the construct. A high alpha value, therefore, means the construct has been demonstrated to exist within the sample population.

Sample population

It was decided that the sample population would consist of those who had requested pastoral support from Stauros for an alcohol dependency problem. A precise definition of who qualified to be part of the sample was obtained by addressing the questionnaires to people associated with Stauros. Association was further defined by saying that a person had to have had a pastoral conversation at least once before the questionnaire was presented. This meant that no one was invited to participate in the research on his or her first meeting with a Stauros pastoral care worker. Furthermore, the designation of having an alcohol dependency problem was left to the discretion of the individual requesting pastoral support. The questionnaire was addressed to people who believed they have, or have had, an alcohol dependency

problem. Table 2.1 summarises the frequencies of responses to the question 'how

long have you been associated with Stauros?'

Table 2.1 Association with Stauros

	%
How long have you been associated with Stauros?	
Recently a new contact	16
Less than one year	23
1 – 2 years	11
2 – 4 years	17
4 – 6 years	9
6 – 8 years	5
8 – 10 years	4
10 – 15 years	6
15 – 20 years	10

This table clearly shows that over two-thirds of people in the sample population

(67%) were associated with Stauros for four years or less.

Sex

The population sample included both men and women who had identified they had a

problem with alcohol, and the proportion was 73% male and 27% female. The

balance of these percentages most closely reflects some alcohol statistics for

Scotland for 2005/2006 in relation to acute inpatient discharges with an alcohol

related diagnosis. The figures in these statistics excluded mental illness hospitals,

psychiatric hospitals, maternity hospitals or transfer cases, but showed that there

were 39, 061 such discharges, of which 27,812 (71%) were male and 11,249 (29%)

were female (Alcohol Statistics Scotland, 2007).

Again, a comparison with statistics from the National Health Service Hospitals in

Great Britain in 2006 / 2007 in relation to hospital admissions demonstrates a

similarity to the balance of these percentages. There were 57,142 admissions with a

primary diagnosis of illness or disease related specifically to alcohol, of which 69%

were male and 31% were female. These figures do not change when secondary and

primary diagnoses are taken together (Statistics on Alcohol: England 2008).

Investigations into sex differences in genetic influences on, and risk factors for,

alcohol dependence have been carried out. One such investigation concluded that

>Heritability of alcohol dependence is equally great in women and men, with
>
>approximately two-thirds of the variance in risk of alcoholism being
>
>attributable to genetic factors. (Heath, Bucholz, Madden, Dinwiddie,
>
>Slutske, Bierut, Statham, Duune, Whitfield and Martin, 1997, p 1392)

Nevertheless, there are physiological differences between the way men and women

respond to alcohol. For example, women develop problems with alcohol in a shorter

time than men: on average women develop problems after only three years of

alcohol abuse, whereas men develop problems after eight to twelve years of heavy

drinking. Women experience fewer symptoms such as delirium tremens than men

although they absorb alcohol faster and get drunk more quickly than men.

Möller-Leimkühler, Schwarz, Burtscheidt and Gaebel (2002) explain that whereas

there is little evidence of change in the drinking habits of women in the United

States of America, the same is not the case in Europe, where the drinking habits of

women are becoming more akin to those of men. Up to the Second World War

women's drinking behaviour was influenced strongly by social taboos. For

example, women generally did not go to public houses for the sole purpose of

drinking: drinking alcohol in public was unusual for women as they tended only to

drink alcohol with other women. But since the Second World War the social

conventions governing women's use of alcohol have changed. Smith (1989)

suggests that these changes have occurred because the social climate has altered the

way women define their position in society. Möller-Leimkühler, Schwarz,

Burtscheidt and Gaebel (2002) also refer to a narrowing in the sex difference in

alcohol consumption in the last two decades, and elaborate on Smith's point by

proposing that an understanding of gender-role orientation, which describes a

psychological disposition or self-concept that influences selection and meaning of

social roles, may help to explore the relationship between gender and alcohol

misuse.

Sex differences in relation to alcohol consumption can be significant in the context

of pastoral care. For example, Dawson (1994) demonstrated that, although there

was no sex differences in the hazard of stopping drinking among people who drank

less than on a daily basis, among daily drinkers the hazard of stopping drinking was

greater for women than for men. An exploration of sex differences in people with

an alcohol dependency problem admitted to a psychiatric hospital demonstrated that

women were more likely to be diagnosed with major depression and exhibit more

anxiety-related symptoms than men (Cornelius, Jarrett, Thase, Fabrega, Haas, Jones-

Barlock, Mezzich and Ulrich, 1995).

Age

Table 2.2 summarises the frequencies on age gathered by the questionnaires. The

population sample included people with an age range of below 20 years of age to

over 70 years of age. In the sample 1% was under 20 years of age and 1% was

Table 2.2 Age profile

	%
How old are you?	
Under 20	1
20 -29	9
30 – 39	24
40 – 49	36
50 – 59	23
60 – 69	6
70 or more	1

over 70 years of age. The remaining 98% were distributed in a normal distribution peaking in the 40 years of age bracket, with 9% being in their twenties, 24% being in their thirties, 36% being in their forties, 23% being in their fifties and 6% being in their sixties.

These figures represent a steady growth in the percentage of people identifying an alcohol dependency problem from before 20 years of age up to 49 years of age. This age range represents the transition from adolescence through young adulthood into mature adulthood, a transition that is often characterised by an increase in the prevalence of substance use and abuse (Johnston, O'Malley and Bachman, 1989). Elkins, King, McGue and Iacono (2006) summarise possible reasons for this characteristic increase in substance use and abuse, including environmental role transitions such as leaving home and/or going to college and genetically influenced high-risk factors such as personality traits that have a bearing on behavioural under-control and negative emotionality (Elkins, King, McGue and Iacono, 2006, p 26).

Marital status

Table 2.3 contains the frequencies of responses to the question 'what is your marital status?'

Table 2.3 Marital status

_____

	%
What is your marital status?	
Single	27
Married	34
Cohabiting	4
Widowed	1
Separated	11
Divorced	18
Remarried	5

In the population sample over one third (34%) of the respondents were married and 27% were single. Of the remaining respondents, 18% were divorced and 11% were separated, 5% were remarried and 4% were cohabiting; two respondents were widowed (1%).

Marital status is a significant factor to take into consideration because investigations have demonstrated a link between marital status and health behaviours, including alcohol consumption practices. Ellison, Barrett and Moulton (2008) summarise three possible ways of explaining the link between marital status and alcohol consumption. First, spouses may influence the drinking behaviour of their partner, and heavy drinkers may be more willing to accept advice about their drinking from a loving partner. Second, the existence of a marital relationship, and the value placed upon it, may motivate an individual to avoid heavy drinking or to abstain from alcohol entirely. Third, heavy drinking cannot be hidden as easily in a marriage relationship as it can in other relational circumstances (Ellison, Barrett and Moulton, 2008, p 662).

Religious affiliation

In order to gain some insight into the religious affiliation of the research sample, two questions enquired about religious denomination and church attendance. Tables 2.4 and 2.5 contain the frequency of responses to both questions respectively.

Table 2.4 Religious denomination

	%
Which Christian or religious denomination do you belong to?	
None	7
Roman Catholic	6
Protestant	46
Other	41

A small number of respondents (7%) declared they belonged to no Christian or religious denomination and 6% declared they belonged to the Roman Catholic denomination. The highest percentage 46% was recorded by those who identified themselves as Protestant and 41% of respondents chose other in the response options. Within this last category, when asked to specify their religious or church grouping, respondents replied by saying born again Christian, Assemblies of God, the Church of the Nazarene, Elim and Methodist, all of which fall into the general category of Protestant denominations.

Table 2.5 Church attendance

	%
How often do you attend a place of worship now (apart from weddings, funerals and baptisms)?	
Never	8
At least once per year	5
At least six times per year	6
At least once per month	9
Nearly every week	73

When asked how often they attended a place of worship at the time of responding to the questionnaire (apart from weddings, baptisms and funerals), 8% of the respondents declared that they never attended a place of worship. In total 19% of

respondents declared they sometimes attended worship with a frequency ranging from at least once per year to at least once per month, of this 5% declared they attended once per year, 6% declared they attended six times per year and 9% declared they attended worship once per month. By far the highest percentage of respondents (73%) declared that they attended worship every week.

Ellison, Barrett and Moulton (2008) suggest that these religious factors need to be brought into consideration when discussing the link between marital status and alcohol behaviour. In discussing…

> …the associations between marital status and alcohol behaviour, it is also possible that some – and perhaps all – of these patterns actually reflect the unobserved influence of religious factors. (Ellison, Barrett and Moulton, 2008, p 662)

Ellison, Barrett and Moulton (2008) go on to make reference to the influence of conservative Protestant churches on attitudes towards the use of alcohol (Clarke, Beeghley and Cochran, 1990). They propose that conservative Protestant churches 'uphold proscriptive norms opposing the use of alcohol'. In a similar vein it has been found that regular church goers are disinclined to drink heavily and are more likely to abstain altogether.

Discussion

At first sight the Stauros research sample seems to be at variance with these suggestions. For example, regarding the issue of denominational affiliation, Stauros research identified 87% of respondents who declared they belonged to Protestant

denominations. Similarly, regarding church attendance, the Stauros sample recorded 73% of respondents who attended church weekly, a figure that rises to 82% if those who attend church monthly are included and described as being 'regular' church attendees. One might have expected that from a population sample of people who declared they had a problem with alcohol, more specifically an alcohol dependency problem; figures relating to denominational affiliation and church attendance would be considerably lower than those recorded.

However, several points need to be born in mind when making comparisons in these areas. These research conclusions are drawn from very different audiences. The former research, enquiring about attitudes towards alcohol and about alcohol behaviour was aimed at an audience of church members and those who have had a life style that includes church attendance. Stauros research, enquiring about church affiliation and attendance, was aimed at an audience of people who have declared they have an alcohol dependency problem and who have sought a lifestyle change from an overtly Christian organisation which encourages church affiliation and attendance. Had this current research been carried out in a non-Christian agency the results may well have been very different.

Furthermore, one can be more precise in describing the lifestyle change that those who came to Stauros were seeking: it was a lifestyle change that, for many, involved returning to church, in contrast to starting a lifestyle that included church. For example, many in the Stauros sample declared they had attended church in childhood and adolescence. Table 2.6 contains the frequency of responses to the question that enquired about church attendance in childhood and teenage years.

Table 2.6 Church attendance in early years

	yes %	no %
Did you attend a place of worship at least six times per year at any of these ages, apart from weddings, funerals and baptisms?		
5 – 7 years old	72	28
8 – 10 years old	76	24
11 – 13 years old	65	35
14 to 16 years old	45	55
17 – 19 years old	34	66

Nearly three-quarters (72%) declared they had attended between the ages of five and seven, 76% declared they had attended between the ages of eight and ten, 65% declared they had attended between the ages of eleven and thirteen, 45% declared they had attended between the ages fourteen and sixteen and 34% declared they had attended between the ages of seventeen and nineteen.

It is not surprising that the numbers diminish with age as this is a common pattern in many, if not all church denominations, and neither should it be surprising that many in the Stauros sample should declare church affiliation and regular church attendance. For example, first, church affiliation and attendance are associated with faith and personal belief, which in turn are associated with sobriety. Second, the network of friends and fellow believers that is found in church is more likely to be considered a safe network by those wishing to avoid social contexts which do not uphold proscriptive norms opposing the use of alcohol.

Employment

Details of the employment status of the population sample were recorded in table 2.7.

Table 2.7 Employment status

	%
How would you describe your employment status?	
Full-time paid	33
Part-time paid	14
House wife/ husband/carer	6
Unwaged able to work	13
Unwaged unable to work	24
Student	1
Retired	9

Two employment states stood out from the rest, first, 33% of the sample recorded

that they were in full-time paid employment, and 24% recorded that they were

unwaged and unable to work. The next two highest numbers related to those who

were in part-time employment (14%) and those who were unwaged but able to work

(13%). Eighteen respondents described themselves as retired (9%), thirteen

respondents described themselves as housewives (6%) and one respondent described

him or herself as a student (1%).

The population sample was asked to describe their employment type.

Table 2.8 Employment type

	%
In your present or most recent employment type how would you describe yourself?	
Unskilled manual	8
Semi-skilled manual	24
Skilled manual	29
Non-manual	3
Semi-professional	20
Professional	16

The highest percentage of respondents described themselves a skilled manual (29%)

and a further 24% identified themselves as semi-skilled manual workers. There

were 41 respondents (20%) who categorised themselves as semi-professional

employees and a further 33 respondents (16%) who categorised themselves as

professional employees. Of the remaining respondents 8% described themselves as unskilled manual workers and 3% as non-manual workers.

In relation to a broad view of the labour market Terza (2002) summarises four ways alcohol abuse may potentially have an adverse effect, for example, employment, labour supply, job performance and earnings. In relation to one of these elements, employment, the results from the Stauros research harmonise with those presented by Terza (2002) in two ways. First, Terza observed that 'in many instances workers remain employed despite the fact that they are alcohol abusers' (Terza, 2002, p 403). This can be seen in that one third of Stauros respondents put themselves in this category. Second, Terza makes extensive reference to research carried out by Mullahy and Sindelar (1996) and he elaborated on their findings by demonstrating that, for both men and women, problem drinking is found to have a positive effect on the probability of unemployment and a statistically significant negative effect on the likelihood of being employed (Terza, 2002, p 394).

Social background

Having given consideration to their employment status and type, the respondents were invited to identify which category best described their social background. The frequency of responses is contained in table 2.9.

Table 2.9 Social background

	%
How would you describe your social background?	
Upper class	1
Upper middle class	4
Middle class	31
Lower middle class	14
Working class	50

Half of the respondents (50%) identified their social background as working class compared to almost one third (31%) who identified themselves as middle class. There were 28 respondents (14%) who categorised themselves as lower middle class and nine (4%) who categorised themselves as upper middle class; only one respondent (1%) identified him or herself as upper class.

Clarke, Beeghley and Cochrane (1990) researched the relationship between religiosity, social class and alcohol use from a reference group theory perspective. To begin with they noted the inter-relationships between religiosity, social class and alcohol use; for example, that there was a positive relationship between social class and religion, that there was a positive relationship between social class and alcohol use, but that there was a negative relationship between religiosity and alcohol use. The findings of their empirical research confirmed these inter-relationships.

Three points from their research are important here. First, focusing on the relationship between social class and alcohol use they discovered that, when class was measured by occupational prestige scores, there were no significant statistical differences, that those with higher prestige scores were as likely to use alcohol as those with lower scores. However, when class was measured by class identification the findings were curvilinear, that those who saw themselves as working class and middle class were twice as likely to drink alcohol as those who identified themselves as being lower class. Furthermore, those who saw themselves as upper class were no more or no less likely to use alcohol than those from lower class.

Second, when social class and religiosity were compared in terms of their influence

on alcohol use, it became clear that religiosity over-rides class. As Clarke, Beeghley and Cochrane put it,

> We conclude with confidence that, at least with regard to alcohol use, the impact of people's religious group is greater than that of their class collectively. (Clarke, Beeghley and Cochrane, 1990, p 214)

Finally, they challenge previous findings that declare a moderate positive relationship between social class and alcohol use by expressing their suspicion that this is incorrect and that the relationship is more complex (Clarke, Beeghley and Cochrane, 1990, p 214).

Discussion

The findings from the Stauros research mirror these conclusions with the majority of respondents (82%) identifying themselves with middle or working class status, only 5% identifying themselves as upper middle or upper class and 14% identifying themselves as lower middle class. These results are important because they illuminate the reference group with which respondents identify and this in turn reveals the values and beliefs they may have. It also reveals those peers with whom they have sustained interaction and how they may define help and leadership from those whom they consider to be significant others.

Personal difficulties

In order to gain some insight into the affective background of the population sample a question was included that targeted personal difficulties experienced in life. A range of personal difficulties were included in table 2.10.

Table 2.10 Personal difficulties

	yes %	no %
In your personal life have you ever had to deal with any of the following difficulties?		
An emotional trauma	84	16
A prison sentence	24	76
A life threatening illness	21	79
Mental health problem	46	54
The death of a close relative	77	23
The death of a close friend	54	46

A high percentage of the sample population (84%) recorded that they had had to deal with an emotional trauma of one kind or another and just less than one quarter (24%) recorded that they had and to deal with a prison sentence. Regarding personal health 21% intimated that they had had to deal with a life threatening illness and more than twice this number, 46%, identified that they had had mental health problems. Finally information was sought regarding the respondent's having to come to terms with someone's death and 77% recorded that they had had to come to terms with the death of a relative and 54% recorded that they had had to come to terms with the death of a close friend. Some of the respondents identified that they had had to deal with more than one of these issues and some that they had had to deal with more than two of these issues.

Anderson and Teicher (2009) introduce their contribution to this field of research by confirming that childhood adversity, of whatever form, is a major cause of poor mental and physical health and that one consequence of this fact is a markedly increased risk of substance use, abuse and dependence. They sum up their references to other studies by saying,

Exposure to early stress enhances psychopathology in general, and shifts

initiation of drug use to younger ages. (Anderson and Teicher, 2009, p517)

They go on to propose a number of observations. First, that substance abuse is a

developmental disorder, demonstrating that there are 'sensitive periods in which

discreet brain regions are maximally susceptible to the effects of stress' (Anderson

and Teicher, 2009, p517). Second, they propose that there can be a lag period

between the time of exposure to the stress and the emergence of adverse

consequences. The model they use to explain this lag time is a stress

incubation/corticolimbic development cascade demonstrating that exposure to stress

early in life predisposes an individual to use and abuse substances at a younger age

than typically observed in the normal population.

Danielson, Amstadter, Dangelmaier, Resnick, Saunders and Kilpatrick (2009) make

a further valuable contribution to the link between trauma and substance abuse.

They demonstrate that there are 'different patterns to trauma-related risk factors that

emerge for alcohol and drug abuse in men versus women' (Danielson, Amstadter,

Dangelmaier, Resnick, Saunders and Kilpatrick, 2009, p 398), patterns that are age

related. This can be illustrated in two ways. For example, in contrast to previous

findings, they discovered that trauma exposure increased the risk of substance abuse

disorders in young adult males as compared to male adolescents. They suggest,

Male gender may become more relevant with regard to risk for substance

abuse disorders in relation to traumatic event history in adulthood.

(Danielson, Amstadter, Dangelmaier, Resnick, Saunders and Kilpatrick,

2009, p398)

Furthermore, age and sexual abuse were significant factors for women in that those who into the lowest age bracket and who had experienced sexual abuse, were at heightened vulnerability for both alcohol and drug use.

Main findings

The responses to the questions enquiring after factual and biographical information allow for a carer to identify a rudimentary profile of a person coming to Stauros for help with an alcohol dependency problem. For example, the person is more likely to be male than female and, if male, to have been drinking for between eight and twelve years, and if female to have been drinking for three years or more. This person is most likely to be aged between 30 and 50 years old and to be, or have been, married or in a relationship. He or she most likely belongs to a church denomination, probably of Protestant persuasion, to attend regularly and to have been brought up in the church to the age of about 13 years old. The person is as likely to be out of work as working, and most likely to be semi-skilled, skilled or semi-professional by employment: he or she is most likely to be working class, middle class or lower middle class. Finally, the person is most likely to have had to face an emotional trauma in his or her life and/or the death of a relative or close friend. A profile like this represents an initial step towards gaining a deeper understanding of the people who come to Stauros with an alcohol dependency problem. It illustrates the importance of adopting an holistic view of individuals with an alcohol dependency problem, focusing on the person rather than their drinking problem. On first meeting a new contact for the first time, only two pieces of information, however, will be obvious to a carer, the person's sex and age. As a

result, in the chapters that follow, these two facts will be explored in more depth and in relation to other facets of his or her life and drinking experience.

Conclusion

This chapter set out to describe the methodological approach used in this dissertation and to introduce the sample population by presenting factual, biographical and background information. The methodological approach is important to clarify before enumerating the themes for further investigation, highlighted in the previous chapter, themes that will guide the contents of the next and following chapters.

Finally, having explored the methodological approach to be used in the rest of this dissertation, and having gained a rudimentary profile of the kind of person who comes to Stauros for help, it is possible to begin addressing the themes alluded to in chapter one, themes that warrant further investigation. To this end we will explore the question of the evangelical Christian ethos of Stauros.

Chapter Three

Religious belief and alcohol dependency

Chapter outline

Introduction

Theoretical context: religious belief

Biblical literature

Old Testament

New Testament

Biblical and therapeutic language

Responsibility

Symptoms

Explanation

Main findings

Conclusion

Introduction

Chapter one introduced the concepts of religious belief and religious experience to this dissertation on alcohol dependency. This language of belief is familiar to people who adopt the twelve step programme of recovery, presented by Alcoholics Anonymous, and was included in the discussion on the enlightenment model of alcohol dependency. Chapter one introduced religious belief in terms such as 'a power greater than ourselves' and 'God as we understand him' (Alcoholics Anonymous, 1979). In this dissertation religious belief is defined as having belief in the existence of God. The sample population was asked to assess belief in God and to intimate whether it believed God existed or not. Only one respondent intimated that he or she did not believe in the existence of God, with 204 positive declarations in the belief that God exists.

Religious experience was introduced through reference to Cook's (2008) report that an alcohol dependency problem has its roots in guilt: guilt that is derived from an individual's loss of contact with the God of his or her understanding. It is proposed that, by addressing guilt and highlighting the need for individuals to relate to the God of their understanding, Cook effectively introduced the concept of religious experience. This chapter focuses attention on religious belief, and the following chapter focuses on religious experience. These explorations of religious belief and experience, being set in the context of an evangelical Christian ethos, target biblical literature, in relation to belief, and evangelical conversion in relation to experience. The purpose behind the explorations relates to the fundamental question underpinning this dissertation, 'what do carers of those who are dependent upon alcohol need to consider in offering their support?'

For some readers the title of this chapter may seem like an oxymoron. People engaged in the task of researching the field of alcohol dependency often do so from a non-religious perspective. Cook (2006) explains that much of the discourse in this area takes place from a standpoint of 'pragmatic atheism' (Cook, 2006, p 8). Indeed, for some, it may be that the introduction of a religious dimension adds nothing of value to a clear understanding of recovery from an alcohol dependency problem, and positively detracts from furthering helpful discussions in the field. For example, Cook quotes Holloway (2000) who talks of the fundamentalist superstition (pp 96 and 105).

This chapter, in focusing on religious belief, addresses three issues in its exploration of recovery from an alcohol dependency problem. First, it includes a discussion of

potential links between an alcohol dependency problem and religious belief in general, before moving on to discuss Christian religious belief in particular. Second, it elaborates on the theme of Christian religious belief and alcohol abuse by reviewing biblical literature applicable to the discussion; biblical literature being considered the bedrock of evangelical Christian religious belief. Third, it compares and contrasts biblical and therapeutic language before exploring how evangelical Christian religious belief might compare with secular understandings of key concepts pertinent to recovery from dependency. Key concepts include, for example, responsibility for developing an alcohol dependency problem, characteristics of a dependency lifestyle and explanations of how such lifestyles develop. In conclusion the chapter addresses the specific issue of the contribution evangelical Christian religious belief makes to the process of recovery from alcohol dependence.

Theoretical context: religious belief

A discussion of the potential links between an alcohol dependency problem and religious belief may seem misplaced in the context of empirical research. The Alcohol Harm Reduction Strategy for England, published by the cabinet office (strategy unit) in March 2004, does not mention matters that relate to religious belief, focusing instead on,

- Harms to the health of individuals

- Crime, anti-social behaviour, domestic violence, drink driving and its impact on victims

- Loss of productivity and profitability

- Social harms including problems within families

Alcohol Harm Reduction Strategy for England (2004, p 7)

The document fails to elucidate on the moral and religious impact an alcohol dependency problem has on those who suffer with the condition, or on their family, friends and community. Cook identifies the way alcohol influences judgement, self control and integrity as examples of its moral impact (Cook, 2006, p 2). Clinebell (1998) expresses the same thought by stating that an alcohol dependency problem interferes destructively with spirituality (Clinebell, 1998, p 27). Through these references it is proposed that alcohol abuse has religious and moral implications. However, are there other reasons for including religious belief in a discussion on alcohol abuse?

First, many people relate to the world in a way that includes religious belief and appreciation, as McFadyen (2000, p 12) declares, 'consciously relating the world to God … holds explanatory and symbolic power in relation to reality'. Recognising religious belief, as part of the reality of life for some people, brings it into the arena of a discussion on alcohol abuse, at least for such people.

Second, the harm and human suffering caused by an alcohol dependency problem, especially emotional and psychological elements of that suffering, bring it into association with religious interests and concerns of life. Religious interests and sensitivities are often aroused by suffering, an arousal that is sometimes enunciated in a positive seeking after religious reality, and sometimes in anger towards God. This arousal of religious interest was documented by Jellinek (1946), who considered it to be one of the characteristic alcoholic behaviours; he found that 60 out of 98 respondents expressed 'a feeling of religious need' (Jellinek, 1946). It

must be remembered, however, that his research was limited to those who had connection with Alcoholics Anonymous already referred to above.

These two points illustrate how general religious belief may be placed in the same arena as alcohol abuse. In the first instance religious belief may characterise the world-view of someone who also abuses alcohol; in the second instance, religious belief is consequential to alcohol abuse. Neither of these points suggests there is a causal link between religious belief and alcohol abuse.

Third, May (1991) attempts to make a causal link between an alcohol dependency problem and religious belief when he suggests that there are 'psychological, neurological and spiritual dynamics in full-fledged addiction' (May, 1991, p 3). The causal link centres on his understanding of what he calls 'attachment.' He explains that an alcohol dependency problem occurs when human desire is attached to alcohol in a way that it becomes an obsession. Attachment is an expression with a long religious tradition, he states, because it describes the human instinct to worship. Its application to alcohol means that alcohol becomes an object of worship, an obsession, and in this way an alcohol dependency problem is understood in religious terminology such as idolatry: dependency, therefore, has religious undercurrents (May, 1991, p 4) in that it is an expression of misplaced worship. Clinebell expresses a similar thought when he depicts craving for alcohol as 'addictive – compulsive forces within their mind-body-spirit organism that are somewhat beyond their control' (Clinebell, 1998, p 28).

Fourth, Clinebell expresses another type of causal link between an alcohol

dependency problem and religious belief: an alcohol dependency problem results from attempting to satisfy spiritual needs through substance use. People have spiritual or existential appetites that they endeavour to satisfy with alcohol in a way that ultimately becomes destructive. A variant of this thought process suggests that some religious, existential and philosophical dynamics create vulnerability within the individual to the extent that he or she develops substance dependency problems.

Fifth, Mercadante (1996) approaches the discussion from a similar direction to May and Clinebell, but with more clarity, stepping closer to evangelical Christian religious belief. The clarity of her thought is represented by the move away from considerations of religious belief in general, towards belief language that is more evangelical in ethos. Key to her contribution is the sentiment expressed when she writes,

> The relationship between sin and addiction is complex. They are neither synonymous, sharply different nor totally unrelated.   (Mercadante, 1996, p 44)

In the context of addiction sin is an emotive word, but the context of Mercadante's writing is that of Christian theology, and her observation here describes the interface between addiction and the language of evangelical Christian religious belief. It is an interface between two different world-views, one that is representative of a therapeutic paradigm (Mercadante, 1996, p 39), and the other that is representative of a theological paradigm. These world-views express themselves using different vocabularies that embody variant ways of understanding the condition of dependency. In general, theological evangelical vocabulary, such as sin, has largely

been overruled by addiction terminology, such as addiction. Indeed, Mercadante suggests that, 'addiction recovery language has become a way society describes, diagnoses and ameliorates the human predicament' (Mercadante, 1996, p 5). In this way addiction and theology are not synonymous.

Nevertheless, neither are they sharply different. Human dysfunction, as illustrated by an alcohol dependency problem, is addressed using different metaphors which are not dissimilar. Human dysfunction can be described using the addiction metaphor or the fall metaphor, from evangelical Christian belief. Dependency speaks of the need for recovery, while evangelical belief speaks of the need for salvation; the former speaks of human frailty, while the latter speaks of original sin; both speak of powerlessness to change and the need for grace to be received. Recovery language, therefore, reciprocates the language of evangelical Christian religious belief.

Finally, recovery from substance dependency and evangelical belief are not unrelated in that both tackle human frailty. Theologically, human beings are in a predicament caused by the fall, and they experience vulnerability, anxiety and anguish. Human instinct is to respond to this predicament in various ways, one of which is to distract themselves from the dull pain of discontentment. One of the distractions is the use of chemical substances, and this is where addiction connects with the theological structure.

Biblical literature

The acceptance, or rejection, of such ideas largely depends upon one's world-view.

It may be unhelpful to try to homogenise terminology, perspectives and understanding arising from the differing fields of addiction and theology. Rather, more benefit may be derived from allowing them to be explored side-by-side, as Mercadante endeavours to do. Biblical literature, being considered the bedrock of evangelical Christian religious belief, has an important role to play in facilitating comparisons between the fields of addiction and theology. To this end, an appraisal of the contribution of biblical literature to central issues within dependency, issues such as responsibility, characteristics and clinical explanations, may prove valuable.

These central issues emerged in chapter one: responsibility emerged from the discussion on models of addiction; characteristics emerged from the description of the alcohol dependence syndrome; and clinical explanations emerged from theories of how dependency develops. Before discussing these three concepts in the light of biblical literature, let us first review relevant references in both the Old and New Testaments. To this end references to 'drunk, drunkard and drunkenness' have been singled out.

Old Testament

Pentateuch

Although Pentateuchal references to people being drunk are few, some warrant attention. In Genesis 9:20-21 there is an account of how Noah planted a vineyard, drank of its wine, became drunk and lay uncovered in his tent. Genesis 19:30-38 describe how Lot's daughters plied their father with wine so as to lie with him and become pregnant. Deuteronomy 21:20 includes instructions about how parents are to deal with a rebellious son; they must take him to the elders declaring, 'He is a

profligate and drunkard.'

Each of these references, although mentioning drunkenness, does not address the topic primarily. Kidner (1974) explains that Noah's drunkenness is without moral comment, and that, in the account of Lot's seduction by his daughters, 'drunkenness is incidental' (Kidner, 1974, p 103). The purposes of the two narratives were, first, to explain Ham's disinheritance, and second, to explain the origin of the Moabites and Ammonites. Similarly, the directives contained in Deuteronomy 21 are not focused on drunkenness, but are about parental authority, as Craigie (1976) explains, 'the words profligate and drunkard do not specify crimes but are examples of the kind of life that has resulted from disobedience to parents,' (Craigie, 1976, p 284).

Historical books

There are a few references to drunkenness in the historical books of the Old Testament. For example, Eli thought that Hannah was drunk as she was praying in her heart, with her lips moving, but with no voice being heard (1Samueal 1:12-14). Later, in 1Samuel 25:36, Abigail delays talking to her husband because, 'he was in high spirits and very drunk.' In 1Kings 16:9 there is a record of Elah's assassination, while he was getting drunk in the home of Arza; and in 1Kings 20:16 Ahab's young officers lead Israel's army into battle against Ben-Hadad and his allies while they, 'were in their tents getting drunk'.

Prophetic books

There are more references to drunkenness in the prophetic books of the Old Testament. References to drunkenness are either statements of judgement, for

example, 'Drink, get drunk and vomit, and fall to rise no more because of the sword I will send among you' (Jeremiah 25:27); or references that use drunkenness as illustration or imagery, for example, 'Babylon was a gold cup in the Lord's hand: she made the whole earth drunk. The nations drank her wine therefore they have now gone mad' (Jeremiah 51:7).

Wisdom literature

The most extensive reference to drunkenness in the Wisdom literature of the Old Testament is Proverbs 23:29-35. This text vividly depicts the life-style and drinking experience of an inebriate, and warrants closer scrutiny. The text begins with questions that pinpoint the consequences of 'lingering over wine.' Woe, sorrow, strife, complaints, needless bruises and bloodshot eyes quickly establish the range of consequences emanating from such a lifestyle. Clarke (1967) suggests *oi,* translated woe, and *aboi,* translated sorrow, are the vociferations of an inebriated person, suffering the nauseating effects of too much liquor. The six-fold consequences result from lingering and sampling. Proverbs 23:31-34 contain, first, a command not to gaze at the wine when it is red, sparkling and smooth – sentiments that trace the allure of alcohol for some drinkers; and second, warnings as to the possible effects of a drinking life-style. The warnings are introduced in Proverbs 23:32 using imagery that allegorises wine as a snake and a viper, and talks of bites and poisons. The warnings further represent a range of possible effects a drinker may experience, including visual hallucinations, mental confusion and dizziness. The final verse carries a number of inferences associated with inebriation, for example, violence as in 'they hit me…they beat me'; the anaesthetic qualities of wine, as in 'I am not hurt…I do not feel it'; sleep as in 'when will I wake up'; and desperation and

compulsion as in 'so I can find another drink'.

Discussion

Mounce (2000) summarises the Old Testament's presentation of alcohol by suggesting that drinking is sometimes good and sometimes evil, and that drunkenness is always evil. Cook (2006) thinks this summary over simplistic, choosing instead to distinguish between drunkenness and the consequences of drunkenness, pointing out that it is the latter that is condemned in Old Testament literature, not the former. He proposes, instead, that drunkenness, as a form of excess, is unwise rather than evil. This may be true in some instances on Old Testament literature, as for example in the Pentateuchal references, but it belies the inferences in such texts, addressing the letter rather than the spirit of the texts. Nevertheless, the stories do refer to drunkenness and contain implications relevant to this investigation.

First, the narratives in Genesis imply that drunkenness can lead to lack of decency, honour and degradation (Kidner, 1974). Second, the Deuteronomy narrative implies that drunkenness may threaten family order and can lead to, 'the dissolution of a proper style of life' (Craigie, 1976). These points highlight detrimental consequences that may result from alcohol abuse, and show how the disinhibiting effects of alcohol can be used to facilitate behaviour considered inappropriate under normal circumstances. Guilt and shame are emotions that underpin consequences such as these, and are issues relevant to discussions on how to pastorally care for people who experience them.

Other than Eli's misplaced rebuke of Hannah, references in the historical books make no moral comment on drunkenness, although they imply injudicious behaviour. In contrast, references in the prophetic literature are unlike those that contain no moral comment. Without exception, whether statements of judgement, illustrations or imagery, the prophetic references convey either moral disapproval or divine disapprobation.

The Wisdom literature demonstrates an appreciation of physical, emotional, volitional and social consequences of habitual alcohol consumption, elements of the condition to which this dissertation will return in later chapters. Furthermore, it contains warnings against such behaviour.

New Testament

Gospels

Two gospel references to drunkenness merit scrutiny. First, Luke 12:45 is a reference to getting drunk in the context of a parable about watchfulness. Jesus warns about managers who do not remain faithful to their master, and their waywardness is illustrated by them beating servants over whom they have charge, and by them eating, drinking and getting drunk. The same parable appears in Matthew 24:36-51 where the same point is made as Jesus says, 'he then begins to beat his fellow-servants and to eat and drink with drunkards' (24:49). Second, Luke 21.34 contains Jesus' teaching about 'dissipation, drunkenness and the anxieties of life', which, he warns, will weigh down the heart and close on an individual unexpectedly like a trap.

The first of these references is in the context of teaching about being ready for the second coming of Christ. The reference to eating, drinking and getting drunk , or eating and drinking with drunkards, is illustrative of the behaviour of one who abuses his privileges and takes advantage of the delay in the master's return (Wilcock, 1979). Jesus' teaching in Luke 21:34 is also a warning to be watchful, prayerful and ready to stand before the Son of Man. The inference in these references is that drunkenness can develop as a lifestyle, when proper spiritual vigilance and devotion are in short supply, the former a possible consequence of the latter.

Epistles

Cook (2006) identifies four lists of vices that occur in the epistles attributed to Pauline authorship. First, a list appears in Romans 13:11-14, a passage that, as Stott suggests, contains, 'an eschatological foundation for Christian conduct' (Stott, 1994, p 351). This foundation involves, first, an appreciation of the significance of the time in which Christians live; second, it involves an understanding of what is appropriate conduct for such a time, namely to, "…behave decently…not in orgies or drunkenness, not in sexual immorality and debauchery, not in dissension and jealousy." Stott suggests that lack of self control is what opposes decent Christian behaviour and that such a lack is exposed in alcohol, sex and social relationships.

Second, in 1 Corinthians 5:10 – 11 the author makes a distinction between how Christian believers should relate to those who are from within and without the church. Verse 11 stipulates that anyone who calls himself or herself a believer but who, 'is sexually immoral or greedy, an idolater or a slanderer, a drunkard or a

swindler,' must not be associated with. A drunkard needs to be disciplined as much as those who persist in sexual immorality (Prior, 1985, p 82).

Third, in 1Corinthians 6:9-11 the author includes another list, this time of people characterised by behaviour that excludes them from inheriting the kingdom of God. The list includes all those behaviours mentioned in 1Corinthians 5 but adds four more, adulterers, male prostitutes, homosexual offenders and thieves. According to the text, a drunkard, as with all other behaviours previously mentioned, will not inherit the Kingdom.

Finally, the context of Galatians 5:16-21 is that the author is writing about life in the Spirit, and contrasting the reality of such a life with what life is like according to the sinful nature (v 16). In clarifying life according to the sinful nature, the author lists them as 'sexual immorality, impurity and debauchery; idolatry and witchcraft; hatred, discord, jealousy, fits of rage, selfish ambition, dissensions, factions and envy; drunkenness, orgies and the like' (Galatians 5:19-21). Cole explains that the references here to drunkenness and orgies probably refer to the 'drunken orgies at festivals of the pagan gods' (Cole, 1984, p 163). Fung (1998) follows the punctuation of the New International Version, and identifies four categories of sins from this list, sexual sins, religious deviations, disorders in personal relationships and sins of intemperance, the latter being the category that contains drunkenness and orgies or drinking bouts and carousing or revelling (Fung, 1998, p 254). Again there is a clear association between a lifestyle that is not honouring to God and enmeshment in pagan culture.

The author of 1Peter includes a vice list similar to those contained in the epistles attributed to Paul, and includes 'debauchery, lust, drunkenness, orgies, carousing and detestable idolatry' (v 3), two of which, Davids (1990) declares, are concerned with indulgence to alcohol, namely drunkenness and carousing (Davids, 1990, p 151). The cultural context for such behaviour, Davids explains, is indicated by the last item on the list, detestable idolatry.

Discussion

In summarising the New Testament presentation of drunkenness several layers of comprehension can be explored. First, drunkenness is presented as a lifestyle that is culturally influenced, for example, as Davids (1990) points out when he refers to the former pagan lifestyle of the recipients of 1Peter, and as he highlights in the text 'do not be conformed' in its relevance to the culture around them (Davids, 1990, p 67).

Second, drunkenness is presented as one of many expressions of an inner human frailty which is described in Romans as a sinful nature, Greek *sarx*, and in Galatians as flesh. The sinful nature has passions and desires and the flesh has 'an autonomy that properly belongs to it and which stands for mankind in sin apart from the grace of God' (Fung, 1998).

Third, along with other vices, drunkenness is presented as being the target for passions and desires that seek gratification. Desires, Greek *epithymiai*, refer to an inner directive force, one that Cole (1984) refers to as 'longings': passions, Greek *pathēmata,* refer to the outward expressions of the inward desires. Davids describes desires as the 'unsanctified longings of fallen humanity' and as 'evil impulses'

72

(Davids, 1990, p 68). He draws a parallel between these evil impulses and what Freud calls the id. The id represents 'an aspect of the personality that acts in terms of instinctual drives. The id is a metaphor for a pool of energy that is directed toward the satisfaction of …desires"' (Estelle, 1990, p 564). In Jewish doctrine, unbridled evil impulses reside within the human body and fight to take over the self, and their power is so strong that people are powerless to follow ethical aspirations even if they have such (Davids, 1990, p 96).

Finally, freedom from the vice of drunkenness is presented in the New Testament as a dualistic experience, one where both the drinker and God play a part. The drinker's part in this experience is set forth in terms such as, 'washed, crucified and abstain.' Prior (1985) explains that washed literally means 'you washed yourselves,' (1 Corinthians 6:11) a meaning that is noted by the middle tense of the verb. Barrett (1979) develops the explanation by saying that it is the middle voice, which normally denotes an action performed with reference to the agent. The meaning Prior (1985) suggests is that the drinker 'makes a clean break from his or her old way of life.'

Crucifixion is the word used in the context of effectively dealing with the passions and desires of the sinful nature. Fung explains that when the author of Galatians declares, 'those who belong to Christ Jesus have crucified (Greek, *estaurōsan*) the sinful nature with its passions and desires' (Galatians 5:24), he writes in the aorist tense indicating that crucifixion is in the past and that believers have participated in the crucifixion of Christ – a reference to both conversion and its symbolism in baptism.

Using the frequent ethical demand, the author of 1Peter commands his readers to 'abstain from sinful desires which war against the soul' (1Peter 2:11). Each of these three terms, washed, crucified and abstain, implies a part played by the perpetrator of drunkenness.

God's part is specified in the terms sanctified and justified (1Corintians 6:11). Barrett explains that sanctified does not mean the process of ethical development expected after a conversion experience, or it would have come after justification in the triad of words, washed, sanctified and justified. Rather sanctification refers to when 'you were claimed by God as his own, a member of his holy people' (Barrett, 1979, p 142). Justification refers to a converts new standing in relationship to God, again an action only God can accomplish on peoples' behalf.

Biblical and therapeutic language

Biblical literature comes at the issue of an alcohol dependency problem using language different from that of a therapeutic approach. Understanding biblical references to alcohol related issues, in the light of modern clinical terms, needs to be given careful consideration. First, it must be remembered that biblical terms originated in a non-scientific age and this raises the issue of the vocabulary used in interpreting the biblical documents. For example, Titus 2:3 is translated as, 'addicted to much wine.' The word addicted has a clinical connotation that may not have existed at the time of writing, so this verse is variously translated in other versions using a different vocabulary, not given to much wine (King James), slaves to drink (Revised Standard Version), slaves to strong drink (New English Bible) and over-fond of wine (Phillips). Biblical translation, therefore, involves both

translation and a measure of interpretation that utilises a vocabulary that is contemporary, in order to convey the significance or meaning of a text. In the example of Titus 2:3 using the modern word addicted seems a reasonable interpretation of the concept of slavery used in both the RSV and the NEB.

Second, it must be remembered that the purpose of biblical writers stands in contrast to that of modern non-theological writers in this field. The dichotomy between the two stand-points must be borne in mind when making comparisons. The modern perspective is to investigate a condition that affects people detrimentally, with a view to understanding its nature and developing a means of recovery. The New Testament perspective is to refer to the condition, not in terms of understanding its nature, but in recognising its potential for harm to those wishing to live a faith based Christian life.

Bearing these caveats in mind, the present task is to explore the biblical terms that relate to alcohol and its abuse. In particular, this exploration targets three key concepts raised earlier in the dissertation, responsibility, characteristics and explanation.

Responsibility

The moral and enlightenment models of an alcohol dependency problem both suggest the individual drinker has a high level of responsibility for the development of his or her dependence problem. First, there is a free choice influenced by a desire for pleasure; second, there is a spiritual emptiness within the drinker which is the result of his or her being out of touch with a higher-power. An evangelical Christian

belief approach could echo the concept of desire, and reflect the oft observed characteristics of compulsion and craving, in its portrayal of desires and passions being both the inner drives and outward expressions of dysfunctional behaviour. More specifically, evangelical Christian belief could incorporate the concept of how a spiritual vacuum creates a need for satisfaction, a need that alcohol initially promises, but ever fails to meet. The vulnerability and susceptibility that individuals have towards an alcohol dependency problem, along with moral failure and spiritual emptiness, are indicative of the consequences of the intrinsic malfunction that pervades all aspects of life. In this way too the biopsychosocial background simply reflects different aspects of this malfunction.

The medical and compensatory models both propose that individuals have a low level of responsibility in developing their dependence on alcohol, because, either they have a medical condition, and/or their drinking is a learned response to personal and social stresses. Christian belief could concede that an alcohol dependency problem, as a condition, is influenced by physical and/or psychological pre-requisites, yet hold that, as a lifestyle, it reflects the volitional nature of habitual behaviour. In this way evangelical Christian belief can agree that individuals have a condition, but a condition that is volitional and one anchored in inner desire and behavioural passions.

By this process of thought, the powerlessness which features in the medical model is a reality, but not in the way suggested by that model, one that refers to a person's inability to stop drinking. In evangelical Christian belief, powerlessness refers to the

inability to change instinctive desires and passions that spoil life's potential, and is a much broader concept than the narrow focus of stopping drinking.

The moral and compensatory models of an alcohol dependency problem both suggest the individual drinker has a high level of responsibility for changing his or her dependency behaviour. The responsibility for change lies in choosing not to drink and in taking steps to overcome the negative behaviour patterns that time has allowed develop. Evangelical Christian belief could concur with these ideas, while expressing them in biblical language. For example, choosing to stop drinking is mirrored in willing the sinful nature crucified and making a clean break with past destructive behaviours; again, overcoming negative behaviours is implied in sanctification and justification.

The medical and enlightenment models place a low level of responsibility on individuals for changing their behaviour because both propose the need for a higher power. Evangelical Christian theology does specify the need for intervention from God to accomplish tasks that people are unable to accomplish for themselves; but more specifically it suggests people and God each play a part in achieving an agreed goal. To this end evangelical Christian theology would have a broader sweep on issues, and see alcohol dependence as only one issue that may need to be targeted for change.

Symptoms

The seven elements of the alcohol dependence syndrome are an attempt at describing the variety of features that constitute alcoholism. To a greater or lesser

extent each element touches on the subjective experience of the drinker. For example, first, the narrowing of the drinking repertoire signifies an increasing similarity in drinking behaviour from day to day, especially in terms of quantity, type and pattern of drinking. Second, the salience of alcohol seeking behaviour refers to how drinking becomes increasingly more important in the drinker's life, overshadowing other responsibilities such as marriage and morality. Third, the relation between the amount imbibed and the effect experienced demands that a drinker needs to increase alcohol intake over time because his or her body becomes tolerant to the substance. When significantly large amounts are taken for long periods the body's capability of processing alcohol efficiently begins to shut down and the result is a reverse tolerance where small amounts have a large effect on the drinker. Fourth, the drinker can experience withdrawal symptoms when the blood alcohol level drops, symptoms which are primarily physiological but which are accompanied by psychological anxiety and, at times, disturbance. Fifth, drinking is resumed in order to remove unpleasant withdrawal symptoms. Sixth, the drinker's subjective experience is typically that of a strong inner drive (Cook, 2008, p 91, ed. Geary and Bryan). Seventh, the reinstatement of a dependent pattern of drinking after abstinence is a rapid process, even though the abstinence may have been for several years.

Proverbs 23:29 -35, includes a description of the symptoms and subjective experience of an inebriated drinker. Some of the symptoms presented in the alcohol dependence syndrome may have tenuous links with the Proverbs 23 text; for example, the reference to a drinkers drinking repertoire may be reflected in the suggestion that the drinker lingers over wine and samples bowls of mixed wine.

This biblical description focuses on the overall life experience of an inebriate, and alongside the physical consequences of drunkenness, on the emotions that he or she may experience, emotions that are inferred by words such as woe, sorrow, strife and complaints, and emotions such as depression, anger and annoyance. The passage also infers the concept of a progressive pattern to a drinking life style, one where the beginning of a drinking career may be very different from the end. To begin with one can gaze on the beauty of wine and appreciate its smoothness, but in the end still be bitten and poisoned, as if by a snake. The warning about alcohol abuse includes an explanation of the psychological effects of abuse, seeing strange sights and imagining confusing things.

Evangelical Christian belief, therefore, not only recognises the specific problem of alcohol abuse but demonstrates an understanding of its nature, albeit in a different way from that of the alcohol dependence syndrome. The question remains, however, does evangelical Christian belief offer an explanation for what Cook (2008) has summarised in the sixth point of the alcohol dependence syndrome, the strong inner drive?

Explanation
The learned behaviour model has been referred to above as a contemporary explanation of how an alcohol dependency problem develops. Drinkers learn to drink; it is a behaviour that is socially acquired, that is influenced by many other factors and that is nurtured by stress. Drinking behaviour is encouraged by triggers that become associated with the perceived benefits of drinking, and triggers can be

external events and/or internal emotions. Withdrawal becomes associated with negative emotions, such as fear and anxiety, which in turn create the stress that nurtured dependence in the beginning. There is a major role played by cognition and thinking processes in the development of this learned behaviour.

An evangelical Christian belief places drunkenness firmly in the context of pagan idolatry, suggesting that it is behaviour associated with a particular social and cultural influence. Part of the significance of sanctification is that a convert is placed in a new social and cultural context, namely God's kingdom and family. Cognition too is recognised as playing an important part in the transformation of an individual, for example,

> Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. (Romans 12:2)

Main findings

Discussion of an alcohol dependency problem and evangelical Christian belief belong to two different academic disciplines. It is not suggested in this dissertation that either biblical literature, or evangelical Christian belief, radically challenges current understanding of the nature of an alcohol dependency problem: adherence to an evangelical Christian belief does not negate the value of secular views. However, it is suggested that evangelical Christian belief may prove helpful and liberating for some people, endeavouring to recover from an alcohol dependency problem. In keeping with evangelical Christian belief, the enlightenment model, outlined earlier, is one way of offering hope to those defeated by addiction. The question underpinning this research is, 'what do carers need to consider in offering support to

80

people with an alcohol dependency problem?' This question must now be revisited, in the light of the discussion in this chapter about evangelical Christian belief.

At the outset of offering support to someone with an alcohol dependency problem, carers must not assume religious belief on the part of a client. Initially, the existence, or absence, of religious belief, and the relevance such belief has to discussions on his or her alcohol dependency problem, are matters for a client to raise. Although overtly evangelical in ethos, Stauros respects the right of an individual to hold his or her belief, or non-belief, as private and personal. That said, many people who request support from Stauros, choose to approach the agency because of its adherence to evangelical Christian beliefs. Clarifying the client's willingness, or otherwise, to include matters of religious belief in conversations, helps the carer understand which route future conversations may appropriately follow.

If a client declares personal Christian belief, and considers his or her beliefs to be pertinent to conversations relating to an alcohol dependency problem, the carer must then consider, what contribution might such belief make to recovery? This question prompts several responses.

First, evangelical Christian belief, based as it is in biblical language and literature, may affirm for a client their need to change. Having what in their view is an objective perspective, derived from Biblical sources, of how a drinking lifestyle is represented in biblical literature, may help catalyse motives for change. The need to change, therefore, emanates from a belief in a God of justice and righteousness.

Second, and running concurrently with the first point, evangelical Christian belief may prove a source of hope for people with an alcohol dependency problem. The hope lies in the belief that, God, while denouncing a drinker's lifestyle, welcomes the drinker, and offers power, beyond the individual's own capability, to break free from the control alcohol has exerted in the past. When asked to reflect upon the statements 'God loves me' and 'God gives me hope,' 99% and 100% of respondents in the sample population, respectively, answered in the affirmative. Similarly, when asked to reflect upon the statements 'God can help me' and 'God can guide me,' 100% of respondents answered in the affirmative to both statements. Hope, therefore, emanates from a belief in a God of love and hope, and power emanates from such belief in a God who helps and guides.

Third, evangelical Christian belief provides a theological framework within which individuals may grapple with the painful emotive issues that accompany an alcohol dependency problem. This theological framework provides a world-view of humanity in general, and an understanding of the human condition in particular, and it demonstrates empathy for those who are emotionally broken and enslaved. When asked to reflect upon the statements 'God understands me' and 'God can heal emotional hurt,' 99% of respondents answered in the affirmative to both statements. Recovery, therefore, emanates from belief in a God who, not only understands, but who desires to heal and restore.

Finally, evangelical Christian belief provides a vocabulary that facilitates discussion of inner struggle, so familiar to those grappling with an alcohol dependency problem: a vocabulary that expresses the potency of destructive desires, appetites

and passions. In Ephesians 4:22 and Colossians 3:9, vocabulary such as 'old nature' provides a distinguishable identity around which discussion of desires, appetites and passions may take place. Yet evangelical Christian vocabulary may also present the possibility of dignity, honour and renewal, as is illustrated in the epistles with references to concepts and terms such as 'put on the new self, created after the likeness of God in true righteousness and holiness' (Ephesians 4:24), and 'put on the new self, which is being renewed in knowledge after the image of its creator' (Colossians 3:10). When asked to reflect upon the statements 'God is relevant to life' and 'God can forgive me,' 99% and 100% of respondents, respectively, answered in the affirmative. Renewal, therefore, emanates from belief in a God who is relevant and forgiving, and, therefore, one who wishes to regenerate inner self-worth.

Conclusion

This chapter has focused on the concept of religious belief, and its potential role in helping people recover from an alcohol dependency problem. Belief was defined as an acceptance of the existence of a power greater than oneself, or in the God of one's own understanding. Evangelical Christian belief was then introduced and discussed. This topic was facilitated by a review of biblical literature and language, and introduced an analysis of such language in comparison to therapeutic language. In summing up issues which carers need to consider when helping people who have an evangelical Christian belief in God, the chapter illustrated the relevancy of belief to concepts such as change, hope, recovery and renewal. The relevancy of belief introduces a subsequent question, how does such belief prove helpful? This introduces religious experience as a theme, to the discussion of recovery.

Chapter Four

Religious conversion and alcohol dependency

Chapter outline

Introduction

Theoretical context: religious conversion

Religious conversion and alcohol dependency

      Psychology of religious conversion

      Alcoholics Anonymous

      Stauros Foundation

Main findings

Conclusion

Introduction

The previous chapter recommended an exploration of religious experience, in discussing the contribution religious belief makes to recovery from an alcohol dependency problem. Religious experience was introduced in chapter one through reference to Cook's (2008) report that an alcohol dependency problem has its roots in guilt: guilt that is derived from an individual's loss of contact with the God of his or her understanding. It is proposed that, by addressing guilt and highlighting the need for individuals to relate to the God of their understanding, Cook effectively introduced the concept of religious experience.

Religious experience was something many in the sample population were already familiar with. For example, when asked, 'Have you ever had something you would describe as a religious experience?' 10% of respondents declared they had not had a religious experience and 9% declared that they possibly had had such an experience, but they were not certain. However, 13% declared they probably had had a religious

experience and 68%, over two-thirds, said that they definitely had had. Exploring the nature or meaning of such religious experiences may illicit many varied responses. However, this chapter, being set in the context of a discussion on recovery from an alcohol dependency problem, targets conversion as a religious experience, while recognising that this is only one aspect of religious experience.

The purpose behind this chapter is to provide a link between the theory of religious conversion and the practical necessities involved in recovery from an alcohol dependency problem. This purpose is fulfilled in three phases. First, the chapter includes an exploration of the theoretical background to religious conversion. Second, it includes a discussion of how religious conversion is linked to recovery from an alcohol dependency problem, initially, by reflecting on the psychology of conversion, and latterly, by discussing the approach of Alcoholics Anonymous. Third, the chapter fulfils its purpose by describing the Stauros approach to pastoral care for those with an alcohol dependency problem. In conclusion the chapter relates the summation of these phases to the fundamental question underpinning this dissertation, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?'

Theoretical context: religious conversion

There is no doubt that some people, working in this field, will consider a discussion on religious conversion inappropriate for a number of reasons. For example, people with an alcohol dependency problem are vulnerable, and religious conversion, offering friendship and support, could be considered to be taking advantage of individual vulnerability. Vulnerability lies in low self-esteem, at times depression,

and a limited network of social support (Beit-Hallahmi and Argyle, 1997). Others may propose that a religious conversion has overtones of mind control, coercion and manipulation; while others will dismiss the concept of religious relevance in its entirety, on the grounds that substance dependency is not a religious phenomenon at all, and should not be treated as such.

Understanding of religious conversion has evolved in the last thirty years. For example, Greil (1977) understood mankind as a seeking animal, a being that sought meaning in a world often bereft of purpose. The need for conversion lay in seeking a world-view that would restore meaning for those whose identity had been spoiled. A spoiled identity was the result of poor relationships with significant others, or of having a world-view that proved inadequate to deal with everyday problems. Hierich (1977) added that the basis of conversion was the destruction of one's root reality, and this destruction took place when life's problems could not be solved with a conventional perspective, because of individual stress and tension. It is not difficult to reflect such thoughts into the context of an alcohol dependency problem. People with an alcohol dependency problem could be described as people who face problems in life that overwhelm them, and people who need to seek a new world view, one that will enable them to overcome circumstances and negative inner identity and reality inadequacies. The emphasis here is one of inner psychological import.

Richardson and Stewart (1978) included the problem solving motif in their dynamic model of conversion, a model that included three broad categories or phases, namely, prior socialisation, contemporary experiences and circumstances and the

opportunity structure available for problem definition and resolution. This dynamic model, reflected what Richardson (1978) called 'multi-event conversions,' by which he meant that people often moved from involvement in one movement to involvement in another. His empirical base was those people who were caught up in the Jesus movement of the 1970s. He observed that, those who joined the Jesus movement had come via a route that included the hippy drug scene and the peace movement. Perhaps one can reflect this dynamic in the lives of people with an alcohol dependency problem, those who seek conversion from a drinking culture to an abstinent culture. The emphasis here is one of socialisation and culture.

Straus (1979) outlined what he considered to be the typical pattern of conversion, as he addressed the question of how seekers went about discovering an adequate world view for handling life's problems. The pattern, he suggests, begins in social networks, echoing Richardson and Stewart (1978), where a seeker looks for prospective means of help. It continues with the learning of the language of the group, progresses with acts of bridge burning and is completed when the convert becomes an active agent representing the new group. Bromley and Shupe (1979) present the 'role theory model' which states that converts' needs are both met and shaped by the group to which they attach. They identified five components of the conversion process as including predisposing factors, attraction, incipient involvement, active involvement and commitment. Transposing these concepts into an alcohol dependency context is not difficult. A seeker, or drinker, needs help; he or she looks for prospective sources of help and discovers a group of people with a similar life experience; an educational element is added that helps the seeker grasp the truths that relate to his or her experience; a volitional element results in the past

87

being left behind; and an integration process secures the individual in the new group which shapes beliefs and models recovery. Both Stauros and Alcoholics Anonymous have facilitated just such an experience for seekers or converts through meetings. The emphasis here is on the influence of the group.

Snow and Machalek (1983) wrote of the change that conversion effects in an individual's life experience. They proposed that change takes place in a convert's universe of discourse, by which they meant 'the broad imperative framework in terms of which people live and organise experience' (Snow and Machalek, 1983, p 265). The process of change contains four distinct elements. First, the convert's biography is reconstructed, using a combination of jettisoning some aspects of the past, whilst redefining others. This means that a 'convert's former understanding of self, past events and others are now regarded as a misunderstanding' (Snow and Machalek, 1983, p 267). Second, a convert understands that his or her feelings, behaviour and past events, are reinterpreted from the stand point of a new pervasive scheme. Third, iconic metaphors such as being 'born again' help develop the uniqueness of the new group. Finally, a new convert's embracing of his or her new role is reflected in language and behaviour. Long and Hadden (1983) describe a similar process to this as socialisation. Socialisation is the process of creating and incorporating new members of a group, from a pool of non members, carried out by members and their allies. The emphasis here is on the psychological processes that take place within the group dynamic.

Rambo (1990) explains that, in biblical Hebrew and Greek, the words translated *conversion* mean to turn, turn again or return. He explains that these words describe

changes in people's thoughts, feelings and actions, as they turn away from false gods and towards a covenant relationship with God; and that, in the New Testament, the words are used exclusively in relation to God's message in Christ. Rambo identifies four types of conversion including tradition transition, institutional transition and intensification, all of which refer to a change in religious association or commitment. The fourth type is designated as affiliation. Affiliative conversion refers to a change from non-involvement to involvement with a religious group, religious behaviour and/or religious ideology (Rambo, 1990, p 228).

Two details emerge from this overview on religious conversion. First, conversion is facilitated or encouraged in some way by other people, a group or network; second, conversion incorporates change in one's inner world of thoughts, feelings and behavioural choices, change that involves restructuring the past, reinterpreting the present and understanding change using metaphors as well as learning a new vocabulary that describes change.

Religious conversion and alcohol dependency

It is well documented that religious conversion has clearly played a part in the recovery of people with an alcohol dependency problem. For example, James (1982) records in detail the conversion experience of S. H. Hadley, a self confessed, 'homeless, friendless, dying drunk' (James, 1982, p 201). Furthermore, conversion formed the backcloth to the life experiences of Wilson and Smith, the founders of Alcoholics Anonymous. The relationship between conversion and recovery from an alcohol dependency problem, as experienced by Wilson and Smith, can be demonstrated in two ways.

First, Wilson experienced conversion. Wilson's experience took place when he was in Town's Hospital, New York. Having been introduced to the concept of religious conversion being a cure for an alcohol dependency problem by a friend called Thacher, Wilson described his experience in the following way,

> When he (Thacher) was gone, I fell back into a black depression. This crushed the last of my obstinacy. I resolved to try my friend's formula, for I saw that the dying could be open minded. Immediately on this decision, I was hit by a psychic event of great magnitude. I suppose theologians would call it a conversion experience. First came a feeling of ecstasy then a deep peace of mind, then an indescribable sense of freedom and release. My problem had been taken from me. The sense of a power greater than myself at work was overwhelming, and I was instantly consumed with a desire to bring a like release to other alcoholics. It had all seemed so simple – and yet so deeply mysterious. (Wilson, 1950)

Second, both Wilson and Smith found support in an evangelistic small group religious movement, known as the Oxford Group Movement, extant in the early decades of the twentieth century. This movement had been started by a Lutheran minister called Buchman, and was strongest in Episcopal churches (Clinebell, 1998). The Oxford Group Movement, Clinebell (1998) explains, first flourished on college campuses, including Oxford, in England. It endeavoured to recreate first century Christianity and to have its followers' change, so as to adopt high moral and ethical absolutes, and to become evangelists, seeking others to change in a similar way, and 'It stressed the importance of groups in this change process' (Clinebell, 1998, p 473). Smith had been attending an Oxford Group meeting in Akron, Ohio, before he

found sobriety, while Wilson accompanied his friend Thacher to an Oxford Group meeting in New York, run by Shoemaker, who became Wilson's mentor. Smith had been searching for an answer to his dependency problem and, after he had met and talked extensively with Wilson, he later declared,

> Here was a man who had been cured by the very means I had been trying to employ…the spiritual approach. (Clinebell, 1998)

Once again, the experiences of the founders of Alcoholics Anonymous reflect the same two details as outlined above. They found that other people, a group or network, facilitated conversion; and they found that change incorporated inner revelation in relationship to their thoughts, feelings and choices, about the past, the present and the future.

Psychology of religious conversion

Wilson's description of his conversion experience could be explained in psychological rather than religious terms. James (1982) first recorded the observation that conversion was associated with a profound personal crisis, and later Batson, Schoenrade and Ventis, (1993) proposed that conversion was a cognitive response to crisis. In either effect, conversion was a creative way of solving problems by finding a new way of looking at life and of interpreting events. In this instance conversion is stimulated by the crisis, by loss of meaning in life and by discontentment.

Smith's experience of the Oxford Group Movement prior to meeting Wilson could also have a psychological explanation using social psychological theory. Argyle

(2000) explains that conversion can result from an individual joining a new group. Converts have a sense of social isolation, but, when they join a new religious group, they begin to be influenced by the people in it, and they become attached to the members of the group. Conversion, in these terms, is not sudden but rather gradual, and it is worth noting that Smith had been attending the Oxford Group Movement for two years before meeting Wilson.

Ullman (1982) observed that converts to new religious groups tended to have a weaker relationship with their fathers than would normally be expected, suggesting that this fact may underpin their feeling of social isolation Relationships with parents, especially fathers, play an important part in a psychodynamic understanding of conversion. Fathers should become an internalised love object within the psyche of a son or daughter. When the father is absent or when there is conflict and a disintegration of the relationship with the father, unconscious conflict results. Conversion comes when this unconscious conflict is resolved through a process that involves reorganising impulses and attachment. As Beit-Hallahmi and Argyle (1997) explain, this process leads to revitalisation, through a new internalised love object. This new intense emotional attachment is accompanied by a rise in self-esteem and general well-being.

With the introduction of psychological explanations of conversion, it has become clear that there may be two types to conversion, one religious and one secular. James (1985) quotes an example of secular conversion from an essay called 'Decision of character,' written by Foster: the example is of a young man who is converted to avarice (James, 1985, p 178). Malony (1998) suggests that these two

types of conversion can be distinguished from each other, not by the psychological

processes involved, but rather by the content. The content of religious conversion

differs from other types by implying a relationship with a divinity. The proposal

here is that this understanding explains the emergence of organisations such as

Stauros and Alcoholics Anonymous whose movements illustrate, not only to the

psychological processes of conversion, but also to religious conversion that includes

a relationship with the divine (James, 1985). In the case of Stauros, the divine being

is identified in the traditional understanding of the God of the bible and of Christ,

while in Alcoholics Anonymous the divine being is a power greater than oneself, or

the God of one's own understanding.

Rambo (1990) explains that conversion is a process with seven discernable stages.

These stages were developed from Tippett (1977), Lofland and Stark (1965) and

Snow and Machalek (1983 and 1984). Indeed, Gooren (2007) explains, 'Rambo's

approach to conversion covers the full spectrum of religious activity and offers a

very useful synthesis of many previous models' (Gooren, 2007, p 345). The

discernable stages are, first, there is the context in which conversion takes place.

The context includes cultural, social and religious considerations as well as

individuals, family and community. Second, there is crisis: although crisis is

necessary for conversion to be real, in itself it is not sufficient to cause conversion.

Crisis is more than dissatisfaction and restlessness; it refers to the painful awareness

of the banality of life, its destructive nature and its meaninglessness. Third, there is

a quest stage where people seek new ways of thinking, feeling and behaving; the

quest assumes an active participation in seeking a new way of life. Fourth there is

an encounter stage in which people discover a person or group whose message

strikes a responsive chord. As a relationship with the group is established and as a friendship network develops new meaning in life is discovered. Fifth, interaction takes place so that a person's needs are addressed, especially needs for intellectual meaning, emotional belonging, new way of living and leaders to model how the new life should be lived. Sixth, commitment grows as satisfaction with the new life matures and this accompanies a clear break with the past. Often this break is symbolised with a ritual such as baptism or a public testimony. Finally, there are consequences which refer to the consolidation of a person's new beliefs and way of life and there is a continual process of growth and renewal.

Alcoholics Anonymous

The key elements that emerge from these stages of conversion are, first, *acceptance*. Acceptance refers to the acquiescence of the truth of one's cultural context and personal condition. It not only alludes to the social and religious context in which conversion takes place, but to the personal convictions that precede actions designed to change lifestyle. In Alcoholics Anonymous acceptance involves the admission of being powerless over alcohol, that life has become unmanageable and that a higher power can restore sanity, sentiments expressed in steps one and two of the twelve step programme (Alcoholics Anonymous, 1979).

The second key element is a *decision* to change. A decision to change is inextricably linked to conversion crisis that results from powerlessness and unmanageability and to a conscious choice to surrender will and life to 'a power greater than ourselves' (step three of the twelve step programme).

94

The third key element is the *process* by which conversion, and change, is accomplished. The process element concerns the quest for new ways of thinking, feeling and behaving, and it is expressed in steps four to seven in the twelve step programme. In an Alcoholics Anonymous setting this process involves making a moral inventory, confessing wrongs, wishing character defects to be removed and then asking for such defects to be removed.

The fourth key element from the process of conversion is *relationships*. At first there seems to be a dichotomy between the relationships as they are described in Rambo's (1990) stages, and as they appear in steps eight and nine of the twelve step programme. In the conversion process, relationships are important in terms of a convert encountering and interacting with people in a new group, and the process of change is facilitated by such integration into a new network of people. In the Alcoholics Anonymous steps, relationships are more about identifying people whom the drinker has harmed in the past and making amends where possible. Yet references in the twelve traditions, which deal with how an Alcoholics Anonymous group operates, hint at encounter and interaction as expressed in Rambo's stages. For example, there are references to the common welfare of the group and its unity (tradition one), to a common group purpose and a group conscience (tradition two) and to a shared aim expressed in the requirement of desiring to stop drinking (tradition three). In practice, the encounter stage of conversion in an Alcoholics Anonymous setting is found in the affiliation a new member feels with those who are already members, and the sense of belonging to a group of like-minded people who accept others unreservedly. In the same way interaction develops in Alcoholics Anonymous as new members find their intellectual needs satisfied as they grasp the

95

theoretical perspective of alcohol dependence expressed by members, their emotional needs met in the fellowship that exists and having leaders whom they can look to as models of how to live.

The fifth element of conversion is *growth*, where commitment develops into maturity and where breaks with a past life are marked by ritual of one kind or another. In an Alcoholics Anonymous setting this is reflected in the process of a continual practice of personal inventories and active steps to know and do God's will (steps ten and eleven). Perhaps a ritual within the fellowship would be the invitation to speak at top table and be part of the formal reaching out to others.

Finally, the last element of conversion is *purpose* which is expressed in the Alcoholics Anonymous' fellowship as carrying the message to others who still suffer from alcohol dependence (step twelve and tradition five).

This exploration of a comparison between the stages of religious conversion as expressed in Rambo (1993) and the Twelve Steps and Twelve Traditions of Alcoholics Anonymous, endeavours to demonstrate that there is a link between the theory of religious conversion and recovery from an alcohol dependency problem.

Furthermore, as Malony (1988) explains, this is more than adherence to a psychological process, but is described in terms that are clearly religious. For example, God is mentioned in four of Alcoholics Anonymous' the twelve steps. Step three reads, 'make a decision to turn our will and our lives over to the care of God as we understand Him.' The caveat 'as we understand Him' endeavours not to

place too restricting a limitation on one's understanding of God. Nevertheless, the

explanation of step three includes exhortations to let God into one's life (Alcoholics

Anonymous, 1979, p 35) and to turn one's will and one's life over to the care of God

(Alcoholics Anonymous, 1979, p 36). These sentiments express the attribution God

has for caring for people. Step five reads, 'admitted to God, to ourselves, and to

another human being, the exact nature of our wrongs.' The elaboration that follows

includes the declaration,

> Most of us would declare that without a fearless admission of our defects to
>
> another human being we could not stay sober. It seems plain that the grace
>
> of God will not enter in to expel our destructive obsessions until we are
>
> willing to try this. (Alcoholics Anonymous, 1979, p 58)

Here God's grace is attributed with the ability to expel destructive obsessions.

Step six reads, 'we are entirely ready to have God remove all these defects of

character.' Alcohol is identified as the source of a self-destructive drive that goes

against the deepest of human instincts, self preservation. As people are

> …humbled by the terrific beating administered by alcohol, the grace of God
>
> can enter them and expel their obsession. Here their powerful instinct to live
>
> can co-operate fully with their Creator's desire to give them new life.
>
> (Alcoholics Anonymous, 1979, p 65)

In this extract God is attributed with the ability to give new life.

Finally, step eleven reads, 'Sought through prayer and meditation to improve our

conscious contact with God as we understand Him, praying only for knowledge of

His will for us and the power to carry that out.' This step clearly identifies

conscious contact with God as something to be positively desired, and tackles, head on, the problem it might create for agnostics. The explanation talks of people who have identified the Alcoholics Anonymous Group as their higher Power and of those who might admit to 'the God of the atom,' but who would not submit to prayer and meditation, holding to their beliefs that 'there wasn't any evidence for God.' Nevertheless, the section continues

> We all need the light of God's reality. (Alcoholics Anonymous, 1979, p 100)

> We may be granted a glimpse of that ultimate reality which is God's kingdom. (Alcoholics Anonymous, 1979, p 100)

The prayer of Saint Francis, although not attributed to him by name, is included in the step as an example of a prayer to pray. In this step the reality of God is presented and exhortations to seek Him in prayer and meditation are strong.

In an increasingly secular context, the religious focus of the conversion process, as outlined above, has been challenged in many Alcoholics Anonymous settings while still retaining the psychological elements of the process. This reflects the evolution of an understanding of conversion, an evolution that is summed up in the writing of Gooren (2007) who suggests that,

> If conversion is to remain a useful concept for scholars, it has to be carefully distinguished from its original religious – Christian – context and meanings. In other words, conversion needs to be thoroughly reconceptualised to move it beyond the Pauline idea of a unique and once-in-a-lifetime experience. (Gooren, 2007, pp 349-350)

Stauros Foundation

Gooren's (2007) suggestion that conversion needs to be thoroughly reconceptualised to move it beyond the Pauline idea of a once-in-a-lifetime experience, is a challenging concept to an organisation like Stauros. Before discussing this challenge, it is important to understand more about the Stauros approach to ministry, and how it fits into this discussion on conversion and an alcohol dependency problem.

Stauros is the New Testament Greek word for the cross of Christ. The agency is so named because it is an evangelical organisation that centralises faith in Christ in recovery from alcohol dependency. Whilst recognising the validity of other routes to recovery, Stauros proposes that faith in God through commitment to Christ, constituting a conversion experience, mark the beginning of a journey to recovery.

Williams founded the Stauros Foundation in 1980, when he was carer of an independent evangelical church in Glasgow. Williams grew up in a family where his father's drinking was a constant source of tension and anxiety, and Williams himself had his first drink when he was 14 years old. By the time he was 28 years old, Williams was suffering from an alcohol dependency problem. At that time he went to his family doctor privately for advice and help, and, in May 1971, went through a Christian conversion experience; an experience prompted by an acceptance of the belief that Christ is alive.

The aims of Stauros are both evangelical and pastoral. The agency promotes the gospel of Jesus Christ among people suffering and/or recovering from addiction, and

offers fellowship to the families of such individuals. These aims are achieved in two ways, through one-to-one pastoral care and group meetings.

Pastoral care

It is important to re-state that Stauros respects the right of individuals to choose not to adhere to belief in God, and, in such cases, carers may either refer a client to another agency that may prove more appropriate, or tailor conversations in an appropriate way for that individual. Nevertheless, there are also individuals who do have a sincerely held belief in God, and who wish to pursue recovery in a faith context. For such people, the Stauros pastoral care approach, revolving as it does around a conversion experience, may prove to be helpful. Pastoral care is delivered using counselling skills. When appropriate, pastoral conversations highlight the emphasis laid upon belief in God, as outlined in the previous chapter, and on the power derived from such belief.

However, the Stauros pastoral care approach also incorporates six practical elements, which have been found to be valuable to carers as they help people recover from an alcohol dependency problem. First, these elements begin with the importance of befriending the client. In this element the key concept is establishing a rapport with the client, by actively listening, in order to establish a working relationship that develops mutual respect and trust.

Second, pastoral care progresses by assessing the client in two ways. Initially, the assessment process involves using an alcohol screening test, the purpose of which is to help a client clarify whether or not he or she has an alcohol problem. In a

subsequent conversation, assessment involves building an holistic view of the individual client, a view that includes physical, emotional, rational, volitional, and finally, moral/spiritual elements. In this subsequent conversation, assessment means gathering information about the client, and his or her drinking, in order to have as accurate an understanding of his or her well-being as possible. Assessments carried out in these ways, are important because they help both the client and the carer be clear about the exact nature of the drinking lifestyle under review: they also provide a point of reference for progress by helping inform the direction of future pastoral conversations.

Third, pastoral care involves helping the client develop the motivation necessary to change. Developing motivation initially involves accurately recognising the degree of motivation that already exists. To this end Proschaska and DiClemente's (1986) model of change is helpful. This model sets out a cycle of change that begins with a pre-contemplation phase, where a client feels no need to make change at all. This is followed by a contemplation phase, where the client is ambivalent about change and is still discovering reasons why he or she should change. The preparation phase marks the beginning of a client looking for ways change might happen; and this is followed by the action stage, where plans for change are put into practice. In the maintenance phase, change is sustained and the potential for relapse is actively addressed. Finally, relapse is considered as part of the cycle, where change is tested, before the individual rejoins the cycle at either the contemplation or preparation stages once again.

Fourth, pastoral care of people with an alcohol dependency problem involves

helping them actually stop drinking. In this phase practical planning is required, where the client thinks through the implications of stopping in some detail. Setting realistic goals plays an important part in this phase.

Fifth, the need for pastoral care does not cease when a client stops drinking. For many people, there are underlying rational, emotional and behavioural patterns that need to be challenged, if an alcohol dependency problem is to be resolutely overcome. Uncovering the links between circumstances, feelings, thoughts and behaviour, is a precursory step to reconfiguring decision making processes, but one that facilitates long term recovery.

Sixth, pastoral care plays a role in building a lifestyle that maintains change. In this phase of recovery, relationship issues are but one foci of attention, especially marital and/or personal relationships: other considerations include managing time, earning trust and finding a new lifestyle track, or purpose, to follow.

Not everyone who comes to Stauros for help is expected to declare personal faith, or claim a conversion experience, although, without exception, the ethos of Stauros is made clear at the outset. People of any faith, and none, are welcome to be referred, and help, based on the six phases outlined above, is tailored to the needs of the individual, so as not to impose religious ideals on unwilling participants. Again carers respect the rights of individuals to make their own religious choices.

Group meetings

Stauros group meetings often emerge from the operation of an effective community

based pastoral ministry. As a member of staff builds up the number of his or her clients, it may be possible for them to meet together for mutual support. A Stauros meeting has three clear aims. First, it provides opportunities for a Bible based talk, which covers a theme relevant to people with dependency problems. Second, it provides an opportunity to encourage individuals who have gone through a conversion experience, and who have an interest in developing their faith. It is not the intention of Stauros to proselytise to any particular doctrinal school of thought, mode of worship or denominational affiliation. Rather, the meeting is designed to establish believers in the basics of the Christian faith, and to help them learn to cope with life in a Christian way. Third, a Stauros meeting provides an opportunity for people to feel that others care for them, understand the issues they face and accept them for who and what they are.

With these aims in view, a Stauros meeting always has a time of open prayer which is honest, realistic and specific; it always includes a reading from the bible followed by the application of biblical truths through teaching or preaching. Finally, it always includes a time of open and honest sharing around the truths presented at the meeting. Not everyone who approaches Stauros for help will attend such meetings: many individuals rely solely on the one-to-one pastoral conversations with a carer for their support in recovery.

Residential care

When it is deemed necessary, a client may receive a more concentrated period of support by attending a short term residential care facility run by Stauros, a facility that allows clients to stay for up to eight weeks. The aim of this facility is to provide

clients with spiritual, emotional and physical care, within an evangelistic Christian framework, that is free from the normal distractions of everyday life. Residents are provided with biblically based teaching to help them address issues with which they may feel they need support. A key worker is assigned to each resident to provide one-to-one pastoral care, using counselling skills. This centre acts as a care facility where clients are treated as individuals and where they can begin to rediscover their dignity and self-worth.

Main findings

In the light of Gooren's challenging proposal, one key question arises from this exploration of Stauros' approach to pastoral care: does an evangelical Christian approach, with its emphasis on conversion, have anything positive to offer people recovering from an alcohol dependency problem? For some, who approach the topic from a non-religious perspective, the answer to this question will be no, because religion is considered to play no part in recovery from an alcohol dependency problem. However, from other perspectives the answer could be yes, for a number of reasons.

First, an evangelical Christian approach may well appeal to some people; for example, those who have a personal and active faith, those who have been brought up in a family that emphasised the importance of Christian faith, and who wish to return to it, or those seeking for a new meaning in life, one that incorporates religious thinking.

Second, an evangelical Christian approach, like the one Stauros adopts, is holistic;

for example, it incorporates practical guidance on health issues through assessment, on motivation to stop drinking and how to stop drinking, and it addresses emotional, rational, volitional and spiritual/moral issues in the process of recovery.

Third, an emphasis on conversion provides an understanding of self that may facilitate personal change; for example, James (1982), introduces a discussion on individuals who become aware of two selves, of a duality within; one that is actual, the other ideal; one that is natural, the other that is spiritual. James (1982) quotes Saint Augustine as an example of such division within the self,

> The new will which I began to have was not yet strong enough to overcome
>
> that other will, strengthened by long indulgence. (James, 1982, p 172)

Here, two wills are identified. To illustrate this point, James (1982) refers to Romans, where the author describes the effects of a divided self,

> For I do not understand my own actions. For I do not do what I want, but I
>
> do the very thing I hate. (Romans 7:15)

This statement suggests that when one self is present, the other is absent. If, however, one self remains permanently in focus, and if that self is a religious one, then it is described as a Christian conversion.

Fourth, the language of conversion provides a way of viewing the self, the inner being of the individual, in a way that clarifies the necessity, and the means, for change. Psychologists may interject by saying that this understanding of change through conversion is a psychological process couched in religious language: what if, on the other hand, this understanding of change through conversion is a religious

process couched in psychological language? For many people, religious conversion makes sense of psychology, rather than psychology making sense of conversion.

Finally, an evangelistic Christian approach harmonises with the two fundamental details alluded above. The details are that conversion is facilitated by people, a group and/or network, and incorporates inner change involving restructuring the past, reinterpreting present thoughts, feelings and behavioural choices, and learning a new vocabulary that includes metaphors of change. All these are reflected in the sentiments of the twelve step programme of Alcoholics Anonymous. Clinebell (1998) considers Alcoholics Anonymous to be 'our greatest resource,' bringing hope and help in what he calls, 'the dismal history of the problem of alcoholism' (Clinebell, 1998, page 195). An evangelical approach sits comfortably with steps two, three, five, six and eleven, of the twelve step programme: that is, believing in a higher power, handing one's will and life over to God, admitting to God the exact nature of one's wrongs, allowing God to remove defects of character and, through prayer, improving one's contact with God. The caveat Stauros makes in these steps is to be more traditional, some might say narrow, in identifying the higher power, or God, with a traditional Christian understanding of God in Christ. Therefore, sentiments such as belief in Christ, surrender, confession, progress in character development and maintained contact with God, are all sentiments familiar in evangelical thinking. The integrity of experience lies in the fact that, for many people, divine help opens the door of hope.

Conclusion

This chapter began by exploring the theory of religious conversion, and this was

followed by a demonstration of how religious conversion and recovery from an alcohol dependency problem have been linked historically. A review of the evolution of an understanding of conversion, and of the psychology of religion, introduced a discussion of how the twelve steps and traditions of Alcoholics Anonymous reflect many of the psychological dynamics that are outlined in the process of conversion. The chapter concluded with a description of the pastoral approach adopted by Stauros.

The fundamental question this dissertation addresses is 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' In the context of this chapter, this question relates to religious conversion, and the potential contribution it makes to people recovering from an alcohol dependency problem. It is important to note four things to consider from this chapter.

First, much has been spoken about crisis in this chapter, and the contribution it makes to the process of conversion. Carers need to be aware of the way individual drinkers react to crisis. It is true that crisis plays an important part in bringing individuals to a point where they know they must change. However, carers must distinguish between a desire for help in a crisis, and a desire to change long term. Requests for help are not synonymous with requests to change. It is important to carers, therefore, to consider the question of motivation to change on the part of the drinker requesting support.

Second, a deep desire to change may be helpfully discussed using biblical language, because it distinguishes between two natures. Dualistic language depicting the

battle between the actual and the ideal nature, the natural and the spiritual, the old

and the new or the bad and the good, helps carers to foster self-awareness in clients

and deepen their self understanding. In a biblical context, all that is negative about

the actual, the natural, the old and the bad, is balanced by positive images of hope;

images that present opportunities for renewal, restoration and freedom from an

alcohol dependency problem. For example, much is written in New Testament

Pastoral Epistles that relates to getting rid of the old self and putting on the new.

Third, some people may only be able to welcome the hope that God alone can offer.

For example, practical help and support can be accepted from others, but the inner

struggle of the mind, the emotions and the will, can leave an individual feeling

totally powerless, rendering as futile all efforts to change. Personal devastation and

isolation, repeated failure and hopelessness, all combined with fear and depression,

create the mindset that nothing short of a miracle will suffice to raise up an

individual from the despondency of an alcohol dependency problem.

Fourth, an emphasis upon conversion and the inner struggle with an alcohol

dependency problem is not intended to detract from the benefits of belonging to a

group of like-minded people. There is healing in human relationships when people

with an alcohol dependency problem feel they are accepted and cared for, and have a

group to belong to and identify with. An evangelical Christian ethos does not

dismiss the importance of the psychological benefits of having a fellowship to which

to belong.

This chapter, has followed up the theme of the previous chapter on religious belief by exploring religious conversion: it also brings to an end the first phase of this dissertation exploring the preconceptions that pastoral cares need to be aware of before offering support to people with an alcohol dependency problem. The chapter has also introduced new themes that must now engage the detail of this dissertation: new themes that represent the content of the second phase in this dissertation. Much has been said about an alcohol dependency problem and attention now turns to exploring this phenomenon in relation to the sample population. This next phase will begin by exploring drinking behaviour.

<div align="center">**Chapter Five**</div>

<div align="center">**Drinking behaviour and alcohol dependency**</div>

Chapter outline

Introduction

Theoretical context

     Predetermining factors

Drinking history

     Profile pattern: sex

     Profile pattern: age

Drinking practice

     Profile pattern: sex

     Profile pattern: age

Main findings

Conclusion

Introduction

This chapter marks the beginning of phase two in the development of this dissertation. In this phase the focus of attention is the drinking lifestyle of the sample population. In the preceding chapters many references have been made to an alcohol dependency problem. Chapter one addressed preconceptions carers may have in relation to an alcohol dependency problem, and chapter two focused on describing the sample population of people who have declared they have an alcohol dependency problem. Chapters three and four explored the role of religion in recovering from an alcohol dependency problem, specifically, religious belief and religious conversion. In all these, an alcohol dependency problem has been the common thread. This chapter introduces a more detailed discussion of an alcohol dependency problem by focusing attention on drinking behaviour.

The search for patterns in relation to drinking behaviour is not a new one, and they can be conducted in a variety of ways. Patterns in drinking behaviour could be explored in terms of the substance. In this way the types of drinks people consume, or the amount of alcohol they consume, could be investigated. Such an investigation could focus, either on one drinking session, or over one week or in the past year. National Statistics collected in 1997 and 2002 collated information such as drink types and amounts and sought to extrapolate patterns reflecting changes in drinking behaviour in relation to these specific elements. Yet Single and Leino (1998, p.7) suggest different patterns, other than types of drink and levels of consumption, determine problematic consequences in drinking behaviour.

Drinking patterns could be interpreted in terms of how people drink, that is, the characteristics of each drinking occasion. Single and Leino (1998) point out that how people drink can be understood in reference to particular drinking characteristics, such as temporal rhythm, settings of drinking and activities associated with drinking, and that when there are combinations of such drinking characteristics this constitutes an alcohol drinking culture. Many investigations have been conducted into how people drink by observing, describing and discussing the cultural context in which drinking behaviour takes place (for example, Bunzel, 1940; Berreman, 1956; Heath, 1962; and Mandelbaum, 1965). However, from a pastoral perspective, exploring patterns in drinking behaviour becomes most helpful when it focuses on other aspects of drinking behaviour than the ones mentioned here.

This chapter explores the theme by concentrating on two characteristics of drinking behaviour. The first characteristic is how drinking behaviour began; this issue deals

with drinking history. The second characteristic considers how drinking behaviour is expressed; it deals with drinking practice.

The chapter begins by setting characteristics in a theoretical context, exploring broader considerations in relation to drinking behaviour. It proceeds by justifying focusing on drinking history and practice, before presenting the findings of the research relating to these issues. In describing the research findings, two further explorations are included: explorations that are based on the most obvious of observations a carer might make, when meeting a client for the first time, sex and age. Sex and age profiles have been selected because they represent two of the most fundamental elements of individual differences, and statistically significant patterns in relation to them, would prove helpful for carers. The chapter includes a summation of findings before drawing conclusions in relation to the key question at the heart of this investigation, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?'

Theoretical context

Dependency describes the condition sometimes referred to as alcohol addiction. In 1964 the World Health Organisation adopted the term dependence in favour of addiction. Over a decade later, Edwards and Gross (1976) used the word dependence in their clinical description of alcohol addiction as an alcohol dependence syndrome. Dependence incorporates two characteristics; first, a psychogenic characteristic, referring to the psychological cause of behaviour; and second, a physiological characteristic. The sample population in this research consisted of people who had come to a conclusion their drinking was problematical

and that they were dependent upon alcohol in one way or another. Their dependence upon alcohol is determined by their perception of the relationship they have with it, which maybe either psychological or both psychological and physiological. Their perception underlies their drinking behaviour.

Dependency also implies that drinking behaviour has developed, or progressed, over time. Progressivity is an important, if controversial, consideration when exploring an alcohol dependency problem. Jellinek, writing in 1946, 1952, 1960(a) and 1960(b), applies the concept of progressivity to the symptoms of an alcohol dependency problem by proposing that, once an alcohol problem had developed, as Sobell and Sobell explain, it 'will inevitably worsen and follow a predictable course of symptoms if drinking continues' (Sobell and Sobell, 1993, p11). Sobell and Sobell (1993) point out however, that this idea of progressivity was based on data gathered retrospectively, from a sample population of people who attended Alcoholics Anonymous, and who had a severe alcohol dependency problem. Jellinek's sample population confirmed that they experienced less severe symptoms of dependency early in their drinking career, compared to those when their drinking problem was intense. On the other hand, prospective studies, ones that track people with an alcohol dependency problem over time, demonstrate a different pattern: a pattern where the intensity of symptoms of an alcohol dependency problem ebb and flow. In this pattern extreme drinking seasons are interspersed with less intense seasons, even abstinence. Therefore, it can be concluded that drinking behaviour may be expressed in more than one way, and carers need to be aware of such variations.

An examination into the development of an alcohol dependency problem raises other key questions, such as, are sex and age differences reflected in drinking behaviour? Furthermore, do sex and age differences provide clues as to how recovery might be pursued? Livingstone and Room (2009) explored the relationship between age, sex and alcohol related problem behaviours. They proposed that the amount of alcohol consumed, and the pattern in which it was consumed, vary according to sex and age. As a result, this research, on behalf of Stauros, examines profiles of people based on sex and age. Drinking patterns could be interpreted in terms of the personal characteristics of the drinker, exploring individual characteristics such as sex and age. Again the National Statistics include differentiating information such as this in its exploration of drink types and total amounts consumed. The pattern is based, therefore, on biographical or factual details related to the person who has an alcohol dependency problem.

Predetermining factors

Why do individuals express their drinking behaviour in different ways? Perhaps different expressions reflect predetermining influences. Acuda and Alexander (1998) address the influences that may contribute to predetermining an alcohol dependency problem from two perspectives. First, they focus attention on the biomedical differences individuals may have. From this perspective credence is given to the genetic contribution to the aetiology of an alcohol dependency problem, a contribution that includes not only the body's capability to process alcohol out of the digestive system, but also the pleasure rewarding systems within brain function (Acuda and Alexander, 1998, p 45).

Predetermining factors may also include personality traits. Acuda and Alexander (1998) discuss traits that may interact with drinking behaviour. For example, personality traits that may correlate with alcohol problems include chronic anxiety, inferiority complex, self indulgence, antisocial disorders, aggression, impulsivity and novelty seeking traits. More recent investigations by Cyders, Flory, Rainer and Smith (2009) have contributed to this line of thought. They propose that, personality dispositions not only predict drinking behaviour, but that specific personality traits predict specific types of drinking behaviour (Cyders, Flory, Rainer and Smith, 2009). Their proposal focuses specifically on sensation seeking traits, suggesting that these predict the frequency of drinking behaviour. The research carried out by Cyders, Flory, Rainer and Smith (2009) demonstrates that personality influences behaviour when in a new context of behavioural freedom. Sensation seeking traits are ones that seek special experiences, and are bolstered by four separate dispositions, including, lack of planning (acting without thinking), lack of perseverance (inability to stay focused on a task), negative urgency (acting rashly when distressed) and positive urgency (acting rashly when excited or high). Sensation seeking traits predict frequency of drinking behaviour, because they seek stimulation; whereas positive urgency predicts quantity in drinking behaviour, and the problems associated with drinking large amounts.

Acuda and Alexander (1998) go on to highlight two important points. First, they point out some psychopathologies frequently predate an alcohol dependency problem within individuals. These psychopathologies include depressive disorders, disruptive behaviour disorders and anxiety disorders: they also include conditions such as manic disorders, schizophrenia, hyperactivity and attention deficit disorders.

Elementary observations of patterns, related to such psychopathologies, highlight that adults under 30 years of age abuse alcohol more than those over 30 years of age; that higher numbers of older people drink because of negative life events; that more males abuse alcohol than females; and that anxiety disorders effect more females than males (Acuda and Alexander, 1998).

Second, Acuda and Alexander focus attention on psychosocial differences between individuals, a focus that features individual lifestyle considerations such as poor impulse control, inability to form close relationships, difficulties in concentration, lack of self-reliance and confidence and a tendency to withdraw under stress (Acuda and Alexander, 1998, p 54). Acuda and Alexander (1998) make important observations about people who present with individual characteristics such as these. Such individuals find it difficult to make the transition from adolescence into adulthood, so the problems that emerged in adolescence continue into adulthood. Acuda and Alexander (1998) comment that helping individuals make this transition involves what amounts to a re-parenting process, where an individual has an ongoing relationship with at least one person providing a secure basis to develop trust, autonomy and initiative and where this person provides high yet realistic expectations for the individual drinker.

The current chapter explores drinking behaviour in detail by researching drinking history and drinking practice for a number of reasons. First, drinking history and practice are ordinary topics of conversation, between carers and clients with an alcohol dependency problem: clients who wish to talk, may talk with ease about when drinking began and what habitual form it takes. Such conversations serve as a

basis for an effective pastoral relationship, and as an introduction to discovering the pertinent issues that hold the key to recovery.

Second, conversations about drinking history and practice allow carers to recognise various expressions of drinking behaviour. For example, these topics allow observations to be made of clients, in relation to psychogenic dependence compared to psychogenic and physiological dependence. Such distinctions not only influence drinking behaviour, they also dictate the route to recovery: a client who is not physically dependent upon alcohol will have a different experience of dependency and recovery, from others who have a physiological dependency.

Third, drinking history and practice provide clues that relate to personality traits. Personality traits, and their influence on drinking behaviour, are fundamental to a carer's understanding of an individual; an understanding that has an effect on how recovery might best be pursued. Pastoral conversations, aimed at helping drinking behaviour to stop, will prove most effective when a carer appreciates the relationship between alcohol and the personality type of the client seeking recovery.

Fourth, conversations about drinking history and practice facilitate carers becoming aware of psychopathologies that pre-date alcohol problems. Establishing a time-line which co-ordinates when various problems emerged, in relation to each other, facilitates clarity, both on the part of the client and a carer. Awareness of conditions such as depression and schizophrenia, conditions that predate an alcohol dependency problem, is essential for appropriate help and care to be offered.

Finally, an understanding of drinking history and practice highlights psychosocial concerns on the part of a client. Psychosocial concerns that relate to a client's personal development, from pre-adolescent to post-adolescent behaviour, may prove to be contributing issues to conversations about recovery.

Drinking history

Drinking history investigates when drinking began, how often drinking took place at the onset of the drinking career, and how often drinking occurred when the individual first thought that their drinking behaviour might be problematical. The time span between the onset of a drinking career and the realisation there is a drinking problem is important because it reflects a number of other significant factors. For example, frequency of drinking behaviour echoes the amount of alcohol being consumed on a regular basis, it indicates elements of lifestyle that may have to be altered and it illuminates the impact that an individual's drinking behaviour may be having on family and profession. How a drinking problem came to light may help carers know the terms of reference that will have the most resonance with a problem drinker. Table 5.1 contains a summary of the frequencies relating to drinking history.

The question enquiring into the age at which individuals had their first drink revealed that the majority (82%) of the sample population began their drinking before 17 years of age. Over a quarter of the sample (26%) had their first drink before their teenage years, arguably when they could be still regarded as children. If we accept that 15 years old is midway through teenage years, over half the

respondents had had their first drink by mid adolescence. In general, the sample

population indicated that its drinking career began early in life.

Table 5.1: Drinking History: overview

	%
At what age did you have your first drink?	
Before the age of 12	26
12 to 14 years old	30
15 to 17 years old	26
Over 17 years old	18
When you first started drinking, how often did you drink?	
Special occasions	30
Once or twice per month	24
Once or twice per week	42
Every day	4
How often were you drinking when you first	
thought you might have a problem?	
Special occasions	1
Once or twice per month	7
Once or twice per week	37
Every day	55
How long was it before you thought you might?	
have a problem with alcohol?	
The first time I drank	2
After some weeks	2
After some months	11
After some years	85
Who suggested to you that you might have a problem?	
with alcohol?	
A relative	36
A friend	12
A drinking companion	2
Your own realisation	42
Other	8
How long is it since you had your last drink?	
Less than one week	1
More than one week	21
More than one month	34
More than six months	11
More than one year	8
More than three years	25

Grant and Dawson (1997) suggest that early onset can predict alcohol abuse and dependency, because their research demonstrated that alcohol abuse showed a steady decline in proportion to postponement of age at first use. There was a less uniform trend demonstrated between an alcohol dependency problem and age at onset of drinking. This study identified pre-adolescence and early adolescence (16 years old and younger) as a particularly vulnerable time to initiate drinking, and is strongly associated with higher risk of alcohol use disorders.

The implications of the findings of this current research are significant because early onset is associated with other factors such as car crashes, sexual intercourse, sexually transmitted diseases, pregnancy, violence, depression and suicide (Grant and Dawson, 1997). With early onset behaviour patterns, psychological associations and attitudes have been influenced by alcohol and its effects from early life. Furthermore, emotional and psychological development, which takes place during adolescence, may have been overshadowed by alcohol abuse, certainly by episodic drinking experiences. Corte and Zucker (2008) suggest that self concept and self definition are associated with alcohol problems at early onset, and with familial alcoholism. The association is one comprised of, 'few positive and many negative domains of self definition' (Corte and Zucker, 2008, p 1283). They develop the idea of domains of self definition by calling them 'self schemas' and negative self schemas in early adolescence directly predicts early drinking onset. Finally, the healthy development of life skills and coping methods may have been hindered by alcohol use and abuse.

This research included two questions which enquired about the frequency of drinking: one that targeted drinking frequency at the outset of a drinking career and the other that targeted frequency when drinking behaviour was problematical. A comparison of the results of these two questions shows interesting trends. For example, at the outset of their drinking career almost one third (30%) reported they drank only on special occasions and almost one quarter (24%) said they drank once or twice per month. By the time drinking behaviour was recognised as a problem, these figures had dropped to 1% and 7% respectively. However, those who indicated that they drank every day rose from 4%, at the onset of drinking, to 55% when drinking behaviour was problematical. These figures represent a significant advance in drinking frequency and interpreting these results leads to two observations.

First, there is a strong link between increased frequency of drinking and the realisation of a drinking behaviour problem. Drinking history shows, therefore, that drinking frequency increases and that this increase correlates to the realisation of a drink problem; and an increased frequency in drinking behaviour may form the basis upon which to base a judgement about being at risk of a drinking problem. However, Martinic (1998) points out that frequency of drinking and amounts consumed are inadequate in delineating a clear understanding of drinking patterns. Reference is made to Pearle (1926) in comparing drinking behaviour that was moderate in amount, and steady in frequency, with that which was heavy in amount and occasional in frequency. Nevertheless, in this current research, if the sample population has concluded that its alcohol consumption is problematical, and is able to make a clear distinction between frequency at onset of drinking and frequency at

the time of realisation, it is reasonable to conclude that a correlation between the two exists. Furthermore, Breslow and Graubard (2008) linked alcohol quantity, frequency and mortality, and concluded that alcohol quantity and frequency were significantly, and independently, associated with mortality caused by alcohol consumption. In female respondents they found that cancer was especially associated with frequency.

Second, it would be wrong to categorically state that there is always an irrefutable link between drinking frequency and problem drinking, because for 1% and 7% respectively, their drinking problem existed while they drank only occasionally or only once or twice per month. These figures show up anomalies and carers do well to keep these in mind.

Another trend is the tendency towards weekly drinking within drinking history. At the outset of their drinking careers, 42% of respondents drank once or twice per week in a non-problematical way. Describing these drinking occasions as being non-problematical is a generalisation, because some drinkers realised their drinking was problematical from the outset. For example, when asked about how long it took to realise there might be a problem with alcohol, 2% of respondents replied they realised they had a drinking problem the first time they drank, a further 2% realised it after only some weeks and 11% realised it after some months. That said the trend towards daily drinking is very striking. This is seen in comparing the figure of 4% of daily drinkers at the outset of their drinking career, with 55% daily drinkers after they realised alcohol was a problem. By combining frequency categories into two frequency bands, monthly or less and weekly or more, highlights of these trends

become even clearer. Monthly or less drinking frequency drops almost seven-fold from 54% to 8% from outset to problem drinking; and weekly or more drinking frequency doubles from 46% to 92% from outset to problem drinking. These figures represent very significant trends in drinking frequency, trends that the majority of respondents took years to become aware of, 85% stipulating that some years passed between drinking onset and problem drinking.

Respondents were asked about who suggested each might have a drinking problem. Three figures stand out in their responses. First, the lowest figure (2%) identified a drinking companion as the one who suggested there might be a problem. It is significant this figure is so low because of the parity between drinking amounts among drinking companions. Second, the highest figure (42%) is significant because it represents the self-awareness of the sample population, they realised their drinking was problematical before anyone made the suggestion. Third, 36% of respondents identified a relative as the one who suggested there might be a problem. This means over one third of drinkers had families who had realised their problem before a drinker had drawn the conclusion, and if family and friends are combined the resulting figure represents almost half the sample (48%). From these figures it can be observed that a drinking problem is likely to come to light from family, friends or from self realisation.

The final question investigating drinking history enquired about the last drink the respondent had had. Almost one quarter (22%) could place their last drink in terms of weeks, almost a half (45%) placed it in terms of months and exactly one third placed it terms of years. Bearing in mind that the sample population consisted of

those who were associated with Stauros, it seems significant that that association

was still important even after months, and indeed years, of sobriety. This echoes the

community element of belonging, explored in a previous chapter on the link between

religious conversion and recovery from alcohol problems.

Profile pattern: sex

A sample profile relating to sex was explored in relation to drinking history. Table

5.2 shows the results of a cross-tabulation, aimed at testing for associations between

sex and drinking history characteristics.

Table 5.2: Drinking history: sex

	male %	female %	χ^2	$p<$
At what age did you have your first drink?				
Over the age of 14	40	55	4.05	.05
When you first started drinking, how often did you drink?				
Monthly or less	52	59	0.72	NS
How often were you drinking when you first thought you might have a problem?				
Weekly or more	94	88	2.45	NS
How long was it before you thought you might have a problem with alcohol?				
More than one year	84	86	0.08	NS
Who suggested to you that you might have a problem with alcohol?				
Someone other than self	60	52	1.21	NS
How long is it since you had your last drink?				
More than one year	29	45	4.84	.05

The sex profile reveals that some of the drinking history characteristics did not

demonstrate significant association in terms of elements of drinking history. For

example, frequency of drinking at drinking onset, the length of time it took for a

124

drinking problem to be identified and the person who suggested there might be a problem, all have numerical similarities that do not distinguish significant differences on the basis of sex. The frequency of drinking when a problem was first realised is important although not statistically significant.

Two elements of drinking history in relation to sex did demonstrate a statistically significant association, the age of onset of drinking and the time since the last drink. Significantly more females than males began drinking at over 14 years of age, which means that more males than females began drinking before 14 years of age, and perhaps this is indicative of the male characteristic of risk taking. However, Grucza, Norberg, Bucholz and Bierut (2008) report significant increases in life time prevalence of drinking and an alcohol dependency problem among women aged between 26 years old and 55 years old. They correlated age at onset with other factors such as attitudes towards drinking, peer associations and family liability to drinking. Even though early onset is a consistent indicator of liability of an alcohol dependency problem, they raised the question 'do the trends in age at onset of drinking account for the changes in alcohol dependence?' Grucza and his colleagues concluded, yes, the increase in risk of an alcohol dependency problem can be statistically attributed to earlier onset ages among white women in the United States of America (Grucza, Norberg, Bucholz and Bierut, 2008, p 1499).

Significantly more females than males had gone for more than one year since their last drink, the corollary being that more males than females drank within the last year.

Profile pattern: age

The second sample profile related to age. Table 5.3 shows the results of a cross

tabulation aimed at testing for an association between those under or over 40 years

of age and characteristics of drinking history.

Table 5.3: Drinking History: age

	under 40 years %	over 40 years %	χ^2	$p<$
At what age did you have your first drink?				
Over the age of 14	40	48	1.31	NS
When you first started drinking, how often did you drink?				
Weekly or more	54	43	2.05	NS
How often were you drinking when you first thought you might have a problem?				
Monthly or less	10	7	0.36	NS
How long was it before you thought you might have a problem with alcohol?				
More than one year	84	86	0.11	NS
Who suggested to you that you might have a problem with alcohol?				
Someone other than self	62	59	0.19	NS
How long is it since you had your last drink?				
More than one year	21	38	5.52	.05

It would appear that age does not have as significant an impact on drinking history

as only one response was identified as being statistically significant. Fewer people

over 40 years of age drank in the last year compared with those under 40 years of

age. The corollary is that fewer people under 40 years of age had more than a year's

sobriety, compared to those over 40 years of age. Does this mean that the older

problem drinkers become, the greater the chance of them having longer periods of

sobriety? If this were the case then terminology such as drinking life cycle, and the implications that such terminology might uncover, may prove helpful to carers.

The concept of a drinking life cycle, in psychological terms, may mirror the physical expression of a drinking life cycle as illustrated by the amounts of alcohol consumed. For example, levels of alcohol consumption can increase dramatically over time; but as the life cycle motif implies, the body's capacity to process unhealthy levels of alcohol diminishes with time, so that the drinker returns to small levels of consumption in inebriation.

Drinking practice

Drinking practice refers to how individuals engage in drinking and this involves scrutinising specific characteristics of how alcohol is consumed. This section includes a description of those specific characteristics; for example, craving alcohol, drinking alone, drinking secretly and binge drinking.

Seven statements, relating to drinking practice, were presented in response to the question 'how would you describe elements of your drinking problem?' Table 5.4 contains the frequency of the responses.

Drinking practice in this research is a phrase used to describe some elements of what drinking behaviour is like in reality. An alcohol dependency problem finds expression in various forms, the most obvious of which is in drinking behaviour. But the reality of what an alcohol dependency problem is like incorporates more than the behaviour of drinking too much alcohol. Within an individual problem drinker's experience, it involves obsession, physical health, and personal

Table 5.4: Drinking practice: overview

	yes %	? %	no %
How would you describe elements of your drinking problem?			
I craved alcohol	80	4	16
I drank to avoid withdrawal symptoms	60	7	33
I preferred to drink alone	30	9	61
I had to conceal how much I drank	74	4	22
I felt remorse after drinking	78	5	16
I was a binge drinker	59	8	34
My drinking was out of control	92	4	3

preferences, behavioural routines associated with drinking, feelings, habits and attitudes. The statements selected, therefore, were aimed at investigating various elements of an individual's drinking behaviour.

One statement was aimed at quantifying any sense of obsession a respondent might have by presenting the statement 'I craved alcohol.' This statement elicited a high positive response with 80% of respondents identifying with it as true. An interpretation of this finding highlights two important points. First, the drinking practice of the majority of problem drinkers involves a sense of compulsion and carers do well to understand this phenomenon, and how an addict may overcome its power. It is a reality that needs to be recognised, addressed and managed, before it can be overcome. Second, 16% of respondents did not identify with a sense of obsession through craving, and this again highlights individual differences, or anomalies, and that not every person with an alcohol dependency problem will identify with the experience of craving.

Another statement focused on physical health and general well being, by introducing avoidance of withdrawal symptoms as an aspect of drinking practice. The

128

symptoms of withdrawal from alcohol may include a range of physical experiences such as headaches, sweats, tremors, fever, fatigue, insomnia and occasionally convulsions. The symptoms may also include mental experiences such as confusion, hallucinations and depression; and emotional states that include agitation, anxiety and stress (Parker and Parker, 2004). Symptoms such as these are indicative of both a physical and psychological dependence on alcohol, and avoidance may be gained through further drinking. Almost two thirds of respondents (60%) identified with this sentiment, whilst over one third (35%) did not. Bearing in mind that all respondents had identified that they had a problem with alcohol, the significance of the balance of these figures is that not all alcohol problems need involve the intensity of dependence withdrawal symptoms represent. This is not to diminish the need of those who cannot identify with drinking to avoid withdrawal symptoms, but it does increase the necessity for flexibility and understanding on the part of those offering help to problem drinkers.

The statement 'I preferred to drink alone' enquired about an aspect of drinking practice that was a matter of personal preference. One interesting response feature was that this question had the highest number of respondents declaring they were uncertain about this statement (9%). Assuming that the statement itself was not confusing, 9% of respondents decided they could neither agree nor disagree with the sentiment. One interpretation of this response is that 9% of respondents *sometimes* preferred to drink alone and *sometimes* did not. When this response is considered alongside the balance of numbers who responded yes (30%) and no (61%), the conclusion drawn is that there is an evenness of preferences to drinking alone or in company with a bias towards drinking in company. Once again, although there are

trends represented by these figures, individual preferences are reflected. Indeed the figures in response to this question are not dissimilar to those of the previous question on withdrawal, except in reverse.

When asked to consider the statement 'I had to conceal how much I drank,' just under three quarters of respondents (74%) could identify with this drinking practice. In the context of recovery this figure is illuminative in two ways. First, it may imply a value judgement on the part of the drinker, that his or her drinking is unacceptable. A value judgement implies assessing the amount consumed, either by comparison or instinct. Comparisons may be made with former drinking levels, or with the drinking levels of others, especially family and friends; after such comparisons have been made the drinker may well realise that his or her drinking has reached a pitch at which others would be surprised. Alternatively, an individual drinker may know instinctively that his or her drinking is abnormal, and so choose not to make it known. A drinker may declare 'Yes, I drink too much and so I don't want people to know.' Second, it may imply awareness of a value judgement on the part of others associated with the drinker, that his or her drinking is unacceptable. In this instance concealment avoids confrontation and a drinker may declare, 'No I don't drink too much, but others think I do.' The former point represents a reluctance to address the problem, whereas the second point represents a denial that there is a problem.

A further statement focused on negative emotions caused by drinking practice. In response to the statement 'I felt remorse after drinking,' over three quarters (78%) positively agreed. Remorse means deep regret or guilt over an action committed (Oxford Concise Dictionary) and introduces the language of morality. The

significance of this result is that it sheds light on the fact that there are negative emotions experienced by the majority of the sample population, and highlights the impotence of such emotions to effect lasting behavioural change. For family and friends, a drinker's expression of remorse without the corresponding change in behaviour, makes their sentiments incredulous, and threatens the security of fulfilling relationships.

The statement, 'I was a binge drinker' describes an episodic drinking practice with bouts of inebriation followed by periods of abstinence. Binge drinkers, therefore, follow a different drinking pattern from those who drink every day. Again it is interesting to note the number of respondents (8%) who were uncertain as to how to answer this question. This may be because problem drinkers can go through different drinking patterns, as their dependence evolves or develops more intensely. So a daily drinker may at one time have been a binge drinker, except that the length of the binges increased, while the duration of the times of sobriety diminished. Just under three fifths (59%) agreed that they were binge drinkers, and just over one third (34%) denied that they were. The consequences of binge drinking are summarised by Gmel, Gaume, Faouzi, Kulling and Daeppen (2008) and include blackouts, unintended pregnancies, violent acts, academic failure, suicide and unintentional injury. They also demonstrate that, in Switzerland, binge drinking is more of the norm than the exception as 76% of alcohol consumers binge drink monthly.

Goudriaan, Grekin and Sher (2007) make a case for linking binge drinking with poor decision making skills. They observed that people with alcohol use disorders displayed disadvantageous decision making skills, and have fewer self-regulatory

131

functions necessary for goal-related behaviour. They explain that neurobehavioural

addiction theories have pointed out a relationship between substance dependence

and neural dysfunction in the ventromedial prefrontal cortex, striatum and basal

ganglia, all of which play an important role in evaluating the consequences of

actions. Prefrontal lobe development continues through adolescence, and binge

drinking during these years makes decision making skills vulnerable. Bingeing at an

early age is more strongly related to poor decision making skills and, therefore, is

related to age at onset as well as sex and impulsivity.

Fischer and Smith (2008) explored impulsivity as a trait underlying problem

drinking, binge eating and gambling. An impulsivity construct most relevant to

problem drinking consisted of four elements; first, a sense of urgency, which they

defined as the urge to act rashly under stress. Second, it consisted of sensation

seeking tendencies, which they understood as seeking novel or exciting experiences;

third, lack of planning demonstrating a tendency to act without thought; and finally,

lack of persistence, which, they suggested, was the inability to stay focused when

distracted. Of these four, urgency seems to contribute to a binge drinking practice.

The final statement, 'my drinking was out of control,' targeted an attitudinal

perception that related to an individual's drinking practice. This statement elicited

the highest response from the sample population, with 92% identifying with this

sentiment. Their attitudinal perception was that they no longer had control over

their drinking. This response could be interpreted in one of two ways. It could be

seen as a symptom of a condition, or as a perception of a condition. As a symptom

of a condition, lack of control is a reality, literally meaning there is nothing the

individual can do to help him or herself; this mirrors an understanding of an alcohol dependency problem being a disease. Alternatively, as a perception of a condition the lack of control is not absolute, and an individual can do things to help him or herself; this mirrors an understanding of an alcohol dependency problem as a learned behaviour, and is reflected in cognitive behavioural approaches.

Profile pattern: sex

Table 5.5 contains a cross-tabulation aimed at testing for an association between sex and the seven elements of drinking practice described above.

The results show that some elements of drinking practice demonstrate no significant difference in relation to sex. For example, craving alcohol, preferring to drink alone, feeling remorse after drinking and feeling that drinking was out of control, all had statistical findings that were very comparable indeed, within a few percentage points of one another.

However, three of the seven elements of drinking practice displayed statistically significant sex specific associations. First, significantly more males than females drank to avoid withdrawal symptoms, 71% compared with 49%, respectively. Perhaps this is a reflection of the findings of research carried out by Livingstone and Room (2009), that men drink more than women and consequently experience more alcohol related problems. In the light of this research, the results may be interpreted in various ways. For example, if withdrawal symptoms are evidence of physical dependence, the observation may suggest that females are less likely to suffer from physical dependence and, therefore, less likely to need to drink to avoid the

Table 5.5: Drinking practice: sex

	male %	female %	χ^2	$p<$
How would you describe elements of your drinking problem?				
I craved alcohol	86	84	0.09	NS
I drank to avoid withdrawal symptoms	71	49	6.04	.05
I preferred to drink alone	67	68	0.00	NS
I had to conceal how much I drank	75	89	3.24	.05
I felt remorse after drinking	81	84	0.10	NS
I was a binge drinker	66	49	3.33	.05
My drinking was out of control	97	95	0.25	NS

symptoms it creates. This interpretation may hint that females with an alcohol

dependency problem display a bias in favour of the psychological, as opposed to the

physical element of addiction, the opposite being true for males with an alcohol

dependency problem. Alternatively, the observation may indicate that females have

a greater ability to tolerate withdrawal symptoms, to the extent that they are less

influenced by them to drink. In this view withdrawal symptoms are comparable for

both male and female drinkers, but that female and male psyches are significantly

different in their response to such symptoms.

Second, significantly more females than males declared that they had to conceal how

much they drank, 89% compared with 75% respectively. This observation raises

questions. Does the observation reflect differences in male and female psyches,

where female drinkers are more secretive about their drinking and less willing to

report or admit accurate amounts of alcohol consumption? Alternatively, does the

observation reflect cultural perceptions, where people frown more on females with

an alcohol dependency problem than on males with the same problem? Or, do

females feel they have to conceal how much they drink for fear of the subsequent

implications for family life, especially in relation to children and their care? These questions are important for two reasons. First, they are important for carers to be aware of because the answers represent the individualism of dependency. Secondly, they have repercussions for those providing opportunities for recovery to females, in that residential care is rarely able to offer a facility that includes children, thus keeping families together while a mother is recovering.

Third, significantly more males than females declared that they were binge drinkers, 66% compare 49%, respectively. If this observation is a true reflection of differences in the patterns of sex specific drinking practice, then female drinking tends to be either so sporadic that respondents did not recognise it as binging, or they have a greater tendency to drink every day.

Profile pattern: age

A cross-tabulation aimed at testing for an association between age differences (here defined as those under the age of 40 years of age and those over 40 years of age) and drinking practice was carried out and table 5.6 shows the bands and the resulting figures from this process.

The age profile appears not as statistically significant as the sex profile, since only one drinking practice emerged as significant. Significantly more people aged over 40 years of age agreed that they felt remorse after drinking compared to those less than 40 years of age, 86% compare 72% respectively. This observation seems to indicate that feelings of remorse may intensify with age, perhaps as a result of a

changing view of life, or as a result of a greater awareness of what has been lost

through an alcohol dependency problem.

Table 5.6: Drinking practice: age

	under 40 years %	over 40 years %	χ^2	$p<$
How would you describe elements of your drinking problem?				
I craved alcohol	91	83	1.39	NS
I drank to avoid withdrawal symptoms	61	67	0.63	NS
I preferred to drink alone	70	64	0.16	NS
I had to conceal how much I drank	70	82	2.85	NS
I felt remorse after drinking	72	86	4.00	.05
I was a binge drinker	67	59	0.95	NS
My drinking was out of control	95	96	0.07	NS

Main findings

Drinking history

There were four main findings from this research regarding drinking history. First,

over one quarter of the sample population began drinking before their teenage years,

and over three quarters had begun before they were 17 years of age. This particular

element of drinking history is important for a variety of reasons. For example, early

onset of drinking seems to indicate a reaction to prior life experiences and further

investigation into what these experiences might be, including a review of family

background and of the individual's relationships with parents, is carried out in a later

chapter. Furthermore, early onset has implications for the psychological and

emotional development of the individual, implications that are expressed in

behavioural patterns and personality traits. Further investigation into behavioural

patterns and personality traits is pursued in a later chapter. Second, 92% were

drinking more than once or twice per week, when they considered they may have a problem with alcohol, and, at this stage, over half were drinking every day. Third, over three quarters had been exhibiting unhealthy drinking behaviour for some years before they realised they may have a problem. Fourth, over three quarters concluded they may have a problem as a result of their own realisation or by comments from a relative.

Drinking practice

The main findings regarding drinking practice were that, first, 80% of respondents declared they craved alcohol. Second, over three quarters admitted that they concealed how much they were drinking. Third, over three quarters felt remorse as a result of their drinking. Binge drinking is important because of its associations with other aspects of behaviour and lifestyle choices; it seems to be one of a number of elements that express an attitudinal identity that, for some, has become a cultural norm. Fourth, just over half believed themselves to be binge drinkers. Fifth, 92% said they felt their drinking was out of control.

When age profiles were explored, significantly more drinkers over 40 years of age declared they felt remorse, as a result of their drinking. Sex profiles demonstrated that females were more likely to start drinking later than males, but were more likely to conceal how much they drank. Males were more likely to drink to avoid withdrawal symptoms than females, and were also more likely to be binge drinkers.

Conclusion

This chapter addressed an alcohol dependency problem in terms of drinking

behaviour and, having put this theme in context, proceeded to justify targeting two aspects of behaviour for particular attention, drinking history and practice. The chapter included a description of drinking history and practice, as they related to the sample population's responses to specific questions.

The key question at the heart of this investigation is, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' From this chapter a number of relevant points emerge. First, carers may begin establishing a working relationship with clients, by allowing them to talk about their drinking history and practice. In this way, an introduction is made that may highlight other issues that impact drinking behaviour. Second, conversations around drinking history and practice help a carer appreciate the perception a client has of his or her drinking behaviour, and to grasp the way an individual's drinking behaviour is expressed. For example, Lavikainen, Lintonen and Kosunen (2009), demonstrated a link between drinking style and sexual risk taking behaviour, e.g. early age intercourse, unprotected intercourse, exposed to sexually transmitted diseases, HIV, pregnancy and multiple partners. They found that drunkenness-related drinking substantially increased the likelihood of engaging in risk-taking sexual behaviour. Recurrent drunkenness was associated with unprotected sex, most especially multiple partners. Third, carers may be alerted to the influence of personality traits. When individuals discuss drinking history and practice, personality traits play an important role, not only in understanding thoughts and attitudes behind behaviour, but also in steering the direction of recovery. Fourth, carers need to consider the possibility of there being psychopathologies which predate alcohol dependence. It is paramount that carers consider that a client may

have more than one behavioural, or psychological, problem besides an alcohol dependency problem. Fifth, with so many of the sample population beginning their drinking career before 17 years of age, carers need to reflect on the psychosocial impact that has had.

This chapter has raised several factors that influence drinking behaviour and contribute to an alcohol dependency problem. For example, three important considerations include the influence of personality traits, the existence of psychopathologies and the psychosocial problems, in each case these topics are revisited in later chapters. But one final element in relation to drinking behaviour has so far not been addressed, motives for drinking, and this is the topic for the following chapter.

Drinking motives and alcohol dependency

Chapter outline

Introduction

Theoretical context

Reasons for drinking

Outcome expectancies

Motivational model

Motives for drinking

Conformity motives

Social motives

Enhancement motives

Coping motives

Profile pattern: sex

Profile pattern: age

Main findings

Conclusion

Introduction

This chapter continues on the topic of drinking behaviour, but with specific

reference to drinking motives. Drinking history and practice are important concerns

for carers, because they represent a conversational starting point, aimed at initiating

a journey towards recovery. These elements of drinking behaviour, however, are

observational, biographical and external: they are elements of drinking behaviour

that family and friends can see, but offer no insight into why drinking takes place.

Drinking motives, on the other hand, are hidden, personal and internal: they are

elements of drinking behaviour that family and friends may not see.

Drinking motives are important because they direct pastoral conversations towards

issues which will constitute the details of a journey towards recovery, details that represent challenges to be met, and hurdles to be overcome. The purpose of this chapter, therefore, is to further develop understanding of people with an alcohol dependency problem, and to reflect on issues, raised by exploring drinking motives, which may prove significant for carers to highlight and address.

The chapter approaches the topic in two stages. First, there is a discussion of the theory of drinking motives with reference to reasons for drinking. This discussion includes an exploration of outcome expectancies, where drinking motives are influenced by what drinkers can anticipate and expect from their drinking behaviour. The purpose of this discussion is to select a particular approach in exploring drinking motives, an approach that has both academic integrity and pastoral insight, and one that can be used with the research sample population. The theoretical context begins with a discussion of the reasons people have for drinking, it proceeds by considering the expectancies people have from drinking, and includes a description of a motivational model for alcohol use. A review of the relationship between motives for drinking and profile patterns, in relation to sex and age, forms a link with the second part of the chapter, which consists of the report on the research, its findings and conclusions.

Second, there is an explanation of questions that address motivation and that are included in the questionnaire. A report on the findings of the research is followed by a discussion of the significance of selected elements of the findings, in relation to helping people recover from an alcohol dependency problem. The conclusion follows a summation of the main findings of the research, and it includes

observations in relation to the key question behind the dissertation, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?'

Theoretical context

Motivation for drinking is a topical issue in light of the media attention on current drinking trends in the United Kingdom, and the dramatic increase in alcohol consumption reported throughout the 1990s. It has been suggested that these dramatic increases have now diminished and that the tide began to turn even before recent campaigns by the government, the health boards and the drinks industry. Indicators suggest that young adult consumption of alcohol is levelling off (Measham, 2008).

Equally intriguing questions are, where do motives for drinking originate and when do they begin. Mennella and Forestell (2008) suggest that from a very early age young children have a well developed cognitive schema about alcohol, one that develops even before drinking begins. This cognitive schema is demonstrated by the facts children know about alcohol and its use; for example, they know that adults drink more alcohol than children, and they know that men drink more than women. Children's understanding about alcohol is developed from the information at their disposal, information gleaned from media advertisements, the internet and sporting event associations (Mennella and Forestell, 2008). Mennella and Forestell (2008) demonstrated that children, whose parents used alcohol to escape a negative frame of mind and to reduce feelings of dysphoria, were more likely to report a dislike for the smell of beer. They concluded that when children experienced smells during

negative emotional situations, they were less likely to like that smell (Mennella and Forestell, 2008, p 250). The transition from an early cognitive schema and associations with alcohol, to having specific reasons for drinking alcohol is a complex one, but it is a transition that significant numbers of young people make.

Reasons for drinking

One approach to considering the reasons young people have for drinking is to adopt a thematic approach and to explore reasons in association with a specific psychological condition. Ham, Bonin and Hope (2007) adopted this approach when they investigated the potential link between social anxiety and reasons for drinking alcohol. Social anxiety was defined as a persistent fear of negative evaluation in social situations, and is the fourth most common psychiatric disorder in the United States of America. It was noted that people suffering from social anxiety disorder were twice as likely to have an alcohol use disorder. It would be natural to assume that people viewed alcohol as a readily accessible method of coping with anxiety related to social interactions. But research carried out by Ham, Bonin and Hope, (2007) did not immediately affirm this conclusion.

Initial investigations explored the relationship between social anxiety disorders and expected outcomes from drinking, for example, that expected outcomes initiated drinking behaviour because this led to sociability and reduced tension. Ham, Bonin and Hope (2007) later reviewed this approach by comparing and contrasting expected outcomes with drinking motives. They reasoned that expected outcomes of drinking behaviour may or may not be desirable, whereas drinking motives (the basic psychological reasons for drinking) always focused on desirable effects. So,

perhaps the research did not affirm the link between social anxiety disorder and alcohol use, because of the significance of the terminology used.

It was found that when people with social anxiety disorder considered four distinct drinking motives (enhancement, coping, social and conformity motives) social anxiety sensitivity was more strongly associated with coping and conformity motives. Ham, Bonin and Hope (2007) found that social anxiety could not be directly linked to alcohol related problems, nor directly to drinking outcomes, yet their findings did indicate some form of relationship, in that people with high or moderate social anxiety were more likely to hold specific drinking motives, especially coping motives. Furthermore, multiple regression analysis revealed coping motives were associated with alcohol related problems. Multiple regression analysis is used when data scores representing different elements are intercorrellated, as Theakston, Stewart, Dawson, Knowlden-Loewen and Lehman (2004, p 976) explain,

> Multiple regression analysis are conducted to predict each motive from the
> alternative… motives…in order to derive relatively 'pure' measures of
> drinking motives. (Theakston, Stewart, Dawson, Knowlden-Loewen and
> Lehman, 2004, p 976)

Another example of a thematic approach to considering the reasons young people have for drinking, explored such reasons in association with the specific issue of sexual orientation. Ziyadeh, Prokop, Fisher, Rosario, Field, Camargo and Austin (2007) observed that there were higher rates of drinking among sexual minority groups of young people, relative to their heterosexual peers. They hypothesised that

144

gay-related stress, experiencing society's stigmatisation of being gay, or pubertal development, influenced motives for drinking. They wondered if gay-related-stress impacted girls more than boys, because girls enter puberty earlier than boys and at a stage when their cognitive development has not reached the abstract and formal operational thinking of adulthood. Their findings were consistent with national studies that observed that young girls, who declared bisexual and homosexual attractions, reported more risky alcohol related behaviour, and young adult women who declared bisexual attractions were at greater risk of binge drinking.

Another route to investigating reasons people have for drinking alcohol is to adopt a more open approach, by questioning a sample of drinkers. This was the approach adopted by Kuntsche and Gmel (2006). They proposed that reasons for drinking emerged from subjectively derived decisional frameworks, and that reasons were based on prior experience, the current situation in which drinkers found themselves, and the expectancy they held concerning the effects of alcohol. The reasons for drinking they found included enjoyment, partying, improving social gatherings, in general social and enhancement reasons. Reasons such as coping with stress, or taking away negative emotional states, were not common among the adolescent population that made up their sample. The five categories of drinking reasons used were to party, enjoyment, ease tension, cope and to be sociable. The research demonstrated that the most common reason for drinking among adolescents was curiosity, to try alcohol, and that boys drank because of the effects of alcohol they anticipated. Kuntsche and Gmel (2006) noted, however, that reasons for drinking, and drinking habits, changed from 1994 to 2002, in that adolescents in 2002 had more reasons to drink, they drank more frequently and they got drunk more often. It

was also noted that whereas drinking to cope with problems or negative emotional states had not been prevalent, during these years the reason 'I feel better when I drink' showed a marked increase.

Outcome expectancies

De Visser and Smith (2007) identified a link between outcome expectancies and motives for drinking: outcome expectancies influenced the decision to drink or to abstain. Indeed outcome expectancies and motives together constitute drinking behaviour. They pointed out, however, that expectancies were rarely black or white, and this is why, they suggested, many young men remain ambivalent towards alcohol, that is, having mixed motives for and against drinking.

Ambivalence is to be expected for a number of reasons. First, alcohol can have both positive and negative outcomes in one drinking session. For example, a drinker may be disinhibited in the early stages of a drinking episode, but later become antisocial and aggressive. Second, ambivalence is to be expected because a drinker may have both reasons for drinking and abstaining. Few men weigh up reasons for and against drinking, in a rational way. In one sense it is not so much ambivalence, as it is potential ambivalence, because ambivalence is not recognised for what it is. Furthermore, rational evaluation may not be compatible with irrational behaviours, such as having fun or becoming disinhibited and losing a measure of control. Finally, drinking may be ambivalent because it can quickly become habitual, as opposed to being based on rational cognitive processes, and drinkers often pursue or maintain drinking behaviour automatically (De Visser and Smith, 2007).

The positive expectations drinkers held included relaxation, less worries, more confidence and feeling less nervous. In turn the reported motives for drinking, that correlated with these positive expectations were to get drunk, for enjoyment, social facilitation and escaping problems. The negative expectations drinkers held included the depressant effects of alcohol, impaired cognitive function, feeling dizzy and dissatisfaction with self. The reported motives for not drinking that related to these negative expectations included intoxication, fear of alcoholism and becoming more vulnerable. Most expectations and motives were transferable from positive to negative or negative to positive; only three motives for not drinking were not also motives for drinking and these were violence, alcoholism and cost. The link between expectations and motives can be further explored by considering a motivational model of drinking behaviour.

Motivational model

Cox and Klinger (1988) presented a motivational model of alcohol use. They proposed that, although drinking is influenced by multiple factors, the final decision to drink is motivational: a person drinks because he or she is motivated to drink. A person is motivated by incentives, and incentives in turn are based on the affective change drinking initiates. Affective change is the goal at which such incentives aim, and the desire, or perceived need, for affective change is related to the individual's values and personal aspirations. This raises two important elements; first, the link between motivation and affective change; and second, the influence of personality traits, personal values and aspirations.

First, the link between motivation to drink and affective change was explored by

Cooper, Frone, Russell and Mudar (1995). They accepted the assumption that people drink to regulate positive and negative emotions, but endeavoured to answer two questions in this field; first, why do people drink for these reasons; and second, what are the consequences of doing so? Their investigation, into the motives for using alcohol to regulate emotions, prompted the identification of two broad types of motives, coping and enhancement. It was suggested that coping motives were part of a reactive process, where alcohol was used strategically to cope with negative emotions: and that enhancement motives were part of an appetitive process, where alcohol was used strategically to increase positive emotions.

The nature of the two processes, reactive and appetitive, demonstrated that these antecedents were distinct dimensions, and not just representative of emotions at opposite ends of the same continuum. Furthermore, their research confirmed that the consequences of drinking for coping motives were that the drinker was more likely to abuse alcohol, and go on to develop dependency, because this type of person was less likely to exercise volitional control over drinking. The consequences of drinking for enhancement motives were less negative, because this type of person is more likely to have greater personal control over his or her drinking.

Second, Theakston, Stewart, Dawson, Knowlden-Loewen and Lehman (2004) explored four drinking motive categories, enhancement, coping, social and conformity motives in relation to personality traits. They found that personality traits predicted internal drinking motives, namely coping and enhancement motives, but did not predict external motives, namely conformity and social motives. More

precisely, high extraversion and low conscientiousness predicted enhancement motives, whereas high neuroticism and low emotional stability predicted coping motives, this latter relationship being of the highest magnitude. Theakston, Stewart, Dawson, Knowlden-Loewen and Lehman (2004) concluded by stating that drinking motives mediate the pathway between personality traits and alcohol use and abuse. In later chapters this psychological perspective is explored through the relationship between personality traits and alcohol abuse.

According to the motivational model, incentives become goals when a person commits to, or pursues them, and goals can be simultaneously positive and negative; positive in that they promise something desirable and negative in that they repel something undesirable. Incentives are characterised by a specific motivational state which is a current concern to drink for affective change, and so, having an incentive involves having expectations about what will happen if incentives are pursued as goals.

Expectations about alcohol are formed before drinking occurs, and they not only dramatically influence motivation, but also the effects alcohol may have when it is consumed. The multiple factors that influence drinking behaviour exercise their influence through such expectations, specifically expectations concerning affective change. Therefore, a decision to drink is the result of a combination of both emotional and rational processes: emotional in the sense that the decision is based on the affective change that is expected, and rational in the sense that drinking takes place by choice. The decision is made non-consciously and automatically, but it still contains choice determined by the drinker's total motivational nexus (Cox and

Klinger, 1988, p 172). The strength of this motivational model is that it provides an explanation of alcohol use without negating all the other elements of an alcohol dependency problem, such as brain changes and inheritable characteristics that impact physiological reactions to alcohol. Furthermore, it maintains focus on the element of choice that each drinker has in his or her drinking behaviour.

This discussion into the theoretical context of drinking motives has raised a number of important issues. The discussion has highlighted the centrality of affective change at the heart of drinking motives; it has demonstrated the links between issues such as outcome expectancies, drinking incentives and drinking goals; and it has shown how drinking motives lead to alcohol craving. In this discussion particular reference has been made to the motivational model of drinking motives, a model that has demonstrated its versatility in relating to these differing elements. The question that is now addressed is, 'how does the sample population in this research respond to questions that explore a motivational model?'

Motives for drinking

A series of 18 statements was put to the sample population under the general question, why did you drink alcohol? Following the question, the 18 statements indicated a number of reasons for drinking, and a Likert scale, ranging from agree strongly to disagree strongly, was used as a response mechanism. The statements reflected the four categories of the motivational model referred to above, namely, conformity motives, social motives, enhancement motives and coping motives.

Conformity motives were explored through statements such as 'all my friends drank

socially,' 'I felt pressurised into drinking' and 'drinking was expected of me.'

Social motives included statements such as 'drinking helped me overcome shyness',

'drinking helped me relate to others socially' and 'I drank because I felt rejected.'

Enhancement motives included statements such as 'drinking made me feel good'

and 'drinking made me feel better about myself.' In keeping with the findings of

Theakston, Stewart, Dawson, Knowlden-Loewen and Lehman (2004), who found

intellect/imagination emerging as a predictor of enhancement motives and who

explained these as openness to novel ideas and perspectives, this motive category

also included a statement about curiosity, 'I was curious as to what drinking was

like.' Other enhancement motives were characterised by negative statements such

as 'I drank because my mind was troubled', 'I drank because my feelings were

troubled' and 'I drank because my life was meaningless.' Coping motives included

statements that further demonstrated the link between motivation to drink and

negative emotions. A number of scenarios were represented in this category of

statements, for example, sleeplessness, stress, an unhappy past, memories of what

people did, memories of traumatic events and feelings of insecurity.

To facilitate an examination of the motives people had for drinking, three responses

to each motive statement were created by combining the positive and negative

responses respectively. The agree strongly and agree responses were combined to

form a yes category; the disagree strongly and disagree responses were combined to

form a no category; and, together with the not certain response (represented as ?),

these three facilitated an examination of motives for drinking. Tables were created

using these responses and these were categorised into four groups of motives

corresponding to the motivational model described above.

Conformity motives

Table 6.1 contains the frequency of responses to statements that relate to drinking in order to conform to others.

Table 6.1 Conformity motives

	yes %	? %	no %
Why did you drink alcohol?			
All my friends drink socially	74	7	19
I felt pressurised into drinking	26	5	69
Drinking was expected of me	41	4	55

Clearly almost three-quarters of the sample (74%) identified positively with the statement that they drank because their friends drank socially; equally clear is the high percentage (69%) of people who denied that they drank because they felt pressurised into drinking. Drinking motivated by the drinking habits of friends, and not by feeling pressurised into it, indicates a lifestyle of choice for the majority of people. However, this is not to diminish the importance of peer pressure because almost one quarter (24%) of the sample identified with this response. Nevertheless, choice as opposed to peer pressure prioritises the social activity of drinking as a shared pursuit among friends in a ratio of three to one, respectively. In this sense drinking is an activity.

Social motives

A group of three statements formed a category that related to the capacity alcohol has to facilitate social interaction. This group constituted the social motives behind drinking. Three elements of social interaction were targeted by these statements, a feeling of inadequacy caused by shyness, a desire to experience the enjoyment of social interaction and overcoming previous experiences where the respondent felt

excluded from meaningful relationships, social or otherwise. Table 6.2 records the frequency of responses to these statements.

Table 6.2 Social motives

	yes %	? %	no %
Why did you drink alcohol?			
Drinking helped me overcome shyness	79	3	17
Drinking helped me relate to others socially	87	1	11
I drank because I felt rejected	51	10	39

Very high percentages were recorded by respondents who identified with drinking motives that tackled shyness and nurtured positive social interaction, 79% and 87% respectively. Just over half the respondents (51%) identified with drinking to overcome past rejection. Over one third of respondents (39%) categorically denied that rejection motivated their drinking behaviour. Social motives, therefore, refer to drinking as being not just an activity but more of an experience, one whereby the majority feel they are enabled to enjoy social interaction more meaningfully as a result of drinking.

Enhancement motives

A consideration of the experiential aspect of social drinking introduces the more specific category of enhancement motives. Enhancement motives refer to drinking to enhance mood and pleasure, and because it takes away negative feelings. Table 6.3 records the frequency of responses to these statements.

Table 6.3, containing the frequency of responses on enhancement motives, demonstrates that 95% of respondents agreed that they drank because it made them feel good, and 80% confirmed that they drank because it made them feel better about

153

themselves. Clearly these results suggest that positive emotions play an important

Table 6.3 Enhancement motives

	yes %	? %	no %
Why did you drink alcohol?			
Drinking made me feel good	95	1	4
I was curious about what drinking was like	73	8	18
Drinking helped me feel better about myself	80	5	15
I drank because my mind was troubled	76	3	21
I drank because my feelings were troubled	82	2	16
I drank because my life was meaningless	56	7	37

role in motivating the majority of this sample population to drink. Furthermore,

alcohol's ability to anaesthetise troubled thoughts and feelings is reflected in the

results, 76% and 82% of respondents agreeing with these motives respectively.

Drinking because one felt one's life was meaningless was a motive for over half

(56%) the sample, a lower, yet not unimportant, number by comparison.

Enhancement motives explore the inner world of the respondent's thoughts and

feelings. Those that relate to improving positive emotions have appetitive qualities

that may contribute to dependency, and those that relate to changing negative

emotions have reactive qualities that introduce the category of coping motives.

Coping Motives

The frequency of responses reflecting coping motives are recorded in Table 6.4.

Using alcohol to overcome a practical problem, like sleeplessness, proved to be the

least popular response from the sample population, with over two-thirds (70%)

denying this was their experience. In contrast, stress was identified by over two-

thirds as a motive behind their drinking behaviour, although one quarter did not

resonate with stress as a motive. The intention behind the statements was to indicate

Table 6.4 Coping motives

	yes %	? %	no %
Why did you drink alcohol?			
I drank because I had difficulty sleeping	24	6	70
I drank to cope with stress	71	4	25
I drank to forget the past	68	8	24
I drank to cope with what people did to me	50	7	44
I drank to cope with what happened to me	54	6	39
I drank to cope with my insecurities	82	3	15

motives at the outset of a drinking career, which means a feeling of stress may or may not be current. No conclusion can be drawn here regarding the cause or causes of stress at the beginning of the drinking career, yet further investigation into this question may prove worthwhile.

Responses to the statement about drinking to forget the past were comparable to those about stress, with just over two-thirds agreeing with the statement, and approximately one quarter disagreeing. This implies that, for 68% of the sample population, something in their past could be identified as having been disturbing enough to require the use of alcohol to blot it out. Once again, no conclusion can be drawn here about what that might have been, and any link that may exist between the issues of stress and the past would require further investigation. What is implied is that the practice of self medication using alcohol, as a means to cope with stress or the past, may lead to the development of alcohol problems. Furthermore, this implication has repercussions for those offering pastoral help in recovery in that coping with stress and memories of the past could be specific issues to be addressed. It is interesting that positive responses to the next two questions dropped significantly. Drinking to cope with people's actions or what happened, did not illicit the same levels of response as stress and the past. One might have anticipated

that coping with the past would have been reflected in the identification of people, or events, that contributed to such memories, but only half the sample population identified what people did (50%), and just over half identified what happened (54%), as motives for drinking. This must not be allowed to detract from the importance of these numbers. For example, 50% and 54% of respondents could clearly identify an action carried out against them, or an event in which they were involved, as being directly associated with their motives in drinking. These are very specific considerations in relation to drinking motives.

Finally, drinking to cope with insecurities proved to be the statement with the highest response rate (82%). Drinking to cope with insecurities implies that alcohol diminishes, or removes, such feelings, replacing them with the opposite sensations of having confidence and being self assured. This particular response demonstrates the close affiliation that exists between the reactive and appetitive motives discussed above. Furthermore, it opens the possibility of there being a link between feelings of insecurity, stress and the past, without these necessarily being anchored in specific events of the actions of other people. Perhaps the link is with upbringing, early childhood experiences, family environment and parental relationships. These issues form the basis of the exploration of the psycho-sociological perspective in later chapters. Having completed an overview of the research findings, a subsequent step is to investigate sample profiles in relation to sex and age.

Profile patterns: sex

A cross-tabulation was carried out, aimed at testing for an association between sex

and drinking motives. The results, in relation to conformity motives, are

summarised in table 6.5. There were no statistically significant differences between

male and female respondents in relation to conformity motives to drinking.

Table 6.5 Conformity motives: sex

	male %	female %	χ^2	$p<$
Why did you drink alcohol?				
All my friends drink socially	78	64	3.69	NS
I felt pressurised into drinking	23	32	1.72	NS
Drinking was expected of me	42	38	0.30	NS

However, with regard to social motives, significantly more females than males

identified feeling rejected as a strong motive behind drinking behaviour (table 6.6).

As Table 6.6 demonstrates three-quarters of the female respondents (75%),

compared to less than half the male respondents (42%), recorded feeling rejected as

a motive for drinking, and the association between these figures was particularly

strong (.001).

Table 6.6 Social motives: sex

	male %	female %	χ^2	$p<$
Why did you drink alcohol?				
Drinking helped me overcome shyness	80	79	0.02	NS
Drinking helped me relate to others socially	88	86	0.21	NS
I drank because I felt rejected	42	75	17.39	.001

Furthermore, in relation to enhancement motives, significantly more females than

males identified drinking because their feelings were troubled as Table 6.7 indicates.

A majority of female drinkers (91%) identified troubled feelings as a motive for their drinking at the outset of their drinking career. It must be noted that this is not to suggest that troubled feelings was not a important motive for males (78%), rather only to point out that it tended to be more true for females.

Table 6.7 Enhancement motives: sex

	male %	female %	χ^2	$p<$
Why did you drink alcohol?				
Drinking made me feel good	97	91	2.8	NS
I was curious about what drinking was like	75	71	0.25	NS
Drinking helped me feel better about myself	80	82	0.18	NS
I drank because my mind was troubled	77	75	0.08	NS
I drank because my feelings were troubled	78	91	4.55	.05
I drank because my life was meaningless	54	63	1.12	NS

Finally, in relation to coping motives, a significantly higher percentage of females (66%) than males (44%) reported drinking because of what people did to them, as Table 6.8 demonstrates. In terms of sex differences, these figures suggest that female motives for drinking reflect significantly higher instances of drinking because of rejection, troubled feelings and to cope with things that people did to them. There are clear implications for recovery approaches from these figures, although generalisations should not be allowed to overshadow individual differences.

Table 6.8 Coping motives: sex

	male %	female %	χ^2	$p<$
Why did you drink alcohol?				
I drank because I had difficulty sleeping	23	29	0.82	NS
I drank to cope with stress	72	70	0.13	NS
I drank to forget the past	66	71	0.51	NS
I drank to cope with what people did to me	44	66	8.17	.05
I drank to cope with what happened to me	52	61	1.16	NS
I drank to cope with my insecurities	80	89	2.68	NS

Profile patterns: age

The second sample profile related to age, and this was defined as those under 40 years of age and those over 40 years of age. Cross-tabulations were calculated in order to test for an association between age differences and drinking motives.

Table 6.9 shows the resulting figures for conformity motives.

Table 6.9 Conformity motives: age

	under 40 years %	over 40 years %	χ^2	$p<$
Why did you drink alcohol?				
All my friends drink socially	74	74	0.01	NS
I felt pressurised into drinking	34	21	4.19	.05
Drinking was expected of me	46	38	1.16	NS

It is clear that significantly more people under 40 years of age felt pressurised into drinking. Bearing in mind that only 26% of the total sample population agreed that they drank because they felt pressurised to do so, a significant number of this percentage must have been under 40 years of age.

As Table 6.10 below demonstrates there are no age related significant differences in social drinking motives, although this is not the case with enhancement motives (see table 6.11). Significantly more people under 40 years of age reported drinking because their mind was troubled and because they felt their life was meaningless, compared to those who were over 40 years of age, as table 6.11 demonstrates.

Table 6.10 Social motives: age

	under 40 years %	over 40 years %	χ^2	$p<$
Why did you drink alcohol?				
Drinking helped me overcome shyness	76	81	0.79	NS
Drinking helped me relate to others socially	86	88	0.29	NS
I drank because I felt rejected	56	49	0.86	NS

As with other results, it must be made clear that these figures do not mean that
respondents over 40 years of age did not drink because their feelings were troubled,
or that their life was meaningless, rather they mean that there were more under 40
years compared to over 40 years of age who identified with these motives. Indeed,
over three-quarters of those under 40 years of age and over half of those over 40
years of age, respectively, agreed they drank because of troubled feelings and
because their life felt meaningless.

Table 6.11 Enhancement motives: age

	under 40 years %	over 40 years %	χ^2	$p<$
Why did you drink alcohol?				
Drinking made me feel good	96	96	0.07	NS
I was curious about what drinking was like	80	71	2.03	NS
Drinking helped me feel better about myself	81	80	0.10	NS
I drank because my mind was troubled	83	73	2.50	NS
I drank because my feelings were troubled	90	77	4.93	.05
I drank because my life was meaningless	67	51	4.86	.05

Finally, with regard to coping motives, a significantly higher number of those under
40 years of age drank to forget the past, over three-quarters compared with less than
two-thirds of those over 40 years of age (see table 6.12).

Table 6.12 Coping motives: age

	under 40 years %	over 40 years %	χ^2	$p<$
Why did you drink alcohol?				
I drank because I had difficulty sleeping	30	21	1.97	NS
I drank to cope with stress	73	71	0.10	NS
I drank to forget the past	76	64	3.16	.05
I drank to cope with what people did to me	57	46	2.31	NS
I drank to cope with what happened to me	63	50	2.92	NS
I drank to cope with my insecurities	81	83	0.04	NS

Main findings

The main findings that emerged were that almost three-quarters of the sample

identified that they drank because all their friends drank, demonstrating a motive to

conform. Their social motives demonstrated a clear preference for drinking because

it helped them relate to others socially (87%), and because it helped them overcome

shyness (79%). When asked about motives that were categorised as enhancing, high

percentages (76% or more) of the sample declared, in descending rank order, they

drank because it made them feel good (95%), because their feelings were troubled

(82%), because it made them feel better about themselves (80%) and because their

mind was troubled (76%). In relation to coping motives, three motives emerged as

representing the highest responses: 82% declared they drank to cope with feelings of

insecurity, 71% declared they drank to cope with stress and 68% said they drank to

forget the past.

The sample profile reflecting sex differences highlighted that female respondents

were much more likely to drink because they felt rejected, because their feelings

were troubled and to cope with what people had done to them. The sample profile

reflecting age differences highlighted that significantly more people under 40 years

of age felt pressurised into drinking, drank because their feelings were troubled, because they felt life was meaningless and to forget the past.

Conclusion

Having placed drinking motives in a theoretical context, this chapter applied a motivational model of drinking behaviour to the sample population. This involved investigating the sample in relation to four drinking motives, including conformity, social, enhancement and coping motives.

From the observations and discussion in this chapter, four issues emerge that are of interest to those working in the pastoral field of recovery, issues that represent what they should consider if asked to offer pastoral support. First, there is an element of drinking motivation that is rooted in social dynamics. Social dynamics refers to the way drinkers in this sample related to other people socially, and the way they felt about how they relate. Drinking operates at three levels in this social way. At a shallow level it provides the context in which social interaction can take place, while at a deeper level it has a positive influence on the perceived quality of such interaction. At the deepest level, however, it helps cover feelings of inadequacy in social interaction, what Ham, Bonin and Hope (2007) describe as negative self-evaluation, for example, feelings that are strongly expressed as insecurities and shyness.

Second, motives for drinking revealed some insight into the self-concept of many of the sample. Self-concept is closely allied to a feeling of rejection, reflected

particularly by female respondents. Swinson and Eaves (1978, p 75) suggested that an alcohol dependency problem is caused by the interplay of three antecedents, including alcohol's pharmacological action, the social context of the drinker (including his or her community and family), and the psychological make-up of the individual drinker. The individual psychological make-up is what is here described as the self-concept. This psychological make-up is formed by the combination of two mechanisms, the neurobiological mechanism within the brain (Cloninger, 1987) and the learning mechanism understood in terms of classical conditioning (Drobes, Saladin and Tiffany, 2001). In this research, further investigation is carried out into the learning mechanism by exploring the relationship between the drinker and his or parents' as this relationship is the earliest learning context of all.

Third, drinking motives in this research have demonstrated the importance of experiencing emotional change, either as a reactive or an appetitive element of drinking. Again those working in pastoral care could find this information enlightening in regard to what sort of approach to adopt and what kind of issues need to be addressed in pastoral care.

Fourth, the sum of all these elements is the subjectively derived decisional framework within individual drinkers. This refers to how and why individuals make the decisions they do regarding alcohol. This subjective decisional framework is explored in a later chapter in which personality traits are investigated.

Finally, this chapter, along with its predecessor, has addressed the theme of drinking behaviour by exploring drinking history, practice and motives. As demonstrated,

there are profile patterns reflected by sex and age in relation to each of these considerations, but such patterns are not only reflected in drinking behaviour, they are also reflected in the consequences drinking behaviour can have, and the next chapter introduces this theme.

<center>**Chapter Seven**</center>

<center>**Primary consequences of alcohol dependency**</center>

Chapter outline

Introduction

Theoretical context

> *Current drinking*
>
> *Withdrawal*

Primary consequences: current drinking

> *Physical health*
>
> *Mental health*
>
> *Emotional health*

Primary consequences: withdrawal

> *Physical health*
>
> *Mental health*
>
> *Emotional health*
>
> *Profile pattern: sex*
>
> *Profile pattern: age*

Perceived needs

> *Profile pattern: sex*
>
> *Profile pattern: age*

Main findings

Conclusion

Introduction

In the previous two chapters the focus of attention has been on drinking behaviour,

first in relation to drinking history and practice, and latterly in relation to drinking

motives. Drinking history, practice and motives were explored from a pastoral

perspective, in the light of the key research question underlying this dissertation,

'what does a carer need to consider when he or she is asked to help a person who has

an alcohol dependency problem?'

<center>165</center>

The next two chapters develop the investigation into drinking behaviour by turning attention to the consequences of drinking; first, to the primary consequences for a drinker, and second, to the secondary consequences for a drinker and his or her family. It is important to consider consequences in this way because this broadens the spectrum of issues with which people with an alcohol dependency problem must contend.

The chapter begins by enquiring into the primary consequences an alcohol dependency problem has for an individual drinker, in particular the impact it has upon physical health, mental well-being and emotional state. There are two edges to the impact that an alcohol dependency problem can have; one relates to the impact while drinking is current, and the other to the impact when drinking ceases and withdrawal begins. After a review of the theoretical background relating to physical, mental and emotional well-being, the sample population is described using these terms, both for when drinking is current and when withdrawal begins. Each drinker's physical, mental and emotional well-being is explored further by investigating possible patterns that may exist in relation to sex and age. The chapter also includes a reflection of the perceived needs of the sample population, by exploring how individuals perceived their consequential pastoral needs. Before drawing conclusions, the chapter includes a summary of the main findings and a description of the perceived pastoral needs as they emerge.

Theoretical context

Current drinking

There are primary health consequences for people who have an alcohol dependency problem and who, therefore, are harmful drinkers. Harmful drinkers are those who drink more than the recommended limits, and who cause harm to their physical health and/or mental and emotional well-being, directly as a result of the amount of alcohol they consume (International Classification of Diseases, 2006).

Medical science outlines the consequences of harmful drinking. The effects of harmful drinking on the liver are well documented and include fatty liver, cirrhosis and liver cancer. Hatton, Burton, Nash, Munn, Burgoyne and Sheron (2009) demonstrate that daily drinking patterns are more closely associated with mortality, through an alcohol dependency problem, than binge drinking. They point out that in 2001 the United Kingdom Chief Medical Officer postulated that the increase in the number of deaths from liver disease was linked to increases in binge drinking patterns. The result was a shift from weekly unit recommendations to daily unit recommendations, so as to avoid the saving up of units for weekend binges. However, 25% of the United Kingdom population exceed their daily unit recommendations. Two suggestions may help in combating the levels of liver disease; first, reducing overall amounts of alcohol intake and second, liver holidays, when recuperation is encouraged by temporary abstinence.

Edwards, Marshall and Cook (2003) make it clear that drinking pattern is important. Heavy drinking with frequent intoxication may lead to alcohol-related medical disorders, such as chronic gastritis, whereas weekend or binge drinking puts drinkers

at high risk of physical injuries such as brain trauma. Harmful drinking's effects on the gastrointestinal tract include oral cavity cancer, oesophageal neoplasm and varices and pancreatitis (Edwards, Marshall and Cook, 2003). Conditions in the cardiovascular system related to harmful drinking include arterial fibrillation, hypertension, strokes, cardiomyopathy with heart failure, and in the neurological system it is expressed in a range of conditions from acute intoxication, with loss of consciousness, to peripheral neuropathy.

For a drinker, the presenting symptoms of drinking practice may not initially suggest harmful drinking. The presenting symptoms that appear first may seem incidental, or inconvenient, and may include being intoxicated at inopportune times, such as the night before important events. They may include time off work, due to hangovers, alcohol related accidents, strained family relationships, financial difficulties, drink driving offences and remorse over the frequency of intoxication or the amount consumed (Alcohol Concern, 2010).

The presenting symptoms that clearly demonstrate abusive drinking are usually health concerns directly related to alcohol consumption. Early health concerns arising from harmful drinking may be proneness to infections, or blackouts that cause injuries, ranging from black eyes to head injuries serious enough to cause subdural haemorrhaging. Serious physical health concerns may be raised by symptoms such as acute pain in the right upper quadrant, jaundice, fever, derangement, vomiting blood, passing blood in stools and epigastric pain with vomiting. Symptoms such as these indicate alcoholic hepatitis, portal hypertension and bleeding from oesophageal varcies and chronic pancreatitis (Edwards, Marshall

and Cook, 2003).

Early mental health concerns may be raised by symptoms such as nightmares, and more serious concerns may be raised by symptoms such as alcoholic amnesia and auditory and/or visual hallucinations. More specifically, confusion, visual impairment and ataxia, with memory deficits and confabulations are indications of Wernicke – Korsakoff syndrome.

The emotional well-being of harmful drinkers may cause initial concern, in their expression of regret about events in the recent or more distant past, emotional outbursts, especially under the influence of alcohol and feeling down or a 'bit under the weather.' In later stages, more serious emotional concerns include anxiety, irrational fear and depression. These factors often reflect how a drinker feels about him or herself, usually described as negative self-worth or self-esteem.

Withdrawal

There are health considerations in relation to withdrawal for those with an alcohol dependency problem. An alcohol dependency problem incorporates both psychogenic and physiological characteristics. Although a harmful drinker may abuse alcohol, this need not mean he or she is alcohol dependent; however, one who has an alcohol dependency problem is by definition one that abuses alcohol and is therefore a harmful drinker. Health concerns for those with an alcohol dependency problem include, but go beyond, the concerns that relate to harmful drinking, because they incorporate issues that relate specifically to withdrawal from alcohol use.

Health concerns related to withdrawal include, first, symptoms that cause discomfort such as fatigue, fever, headache and sweating. Second, they may include symptoms related to the digestive system such as loss of appetite, nausea or vomiting. Third, there may be symptoms related to the heart, such as rapid or irregular heart beat. Fourth, withdrawal symptoms related to brain function include convulsions or seizures. There are mental health concerns, related to withdrawal from alcohol use, which range from hallucinations to delirium and confusion. Emotional health concerns related to alcohol withdrawal include stress, agitation, anxiety and depression. Banger, Philipp, Herth, Hebenstreit and Aldenhoff (1992) affirmed that alcohol withdrawal consisted of automatic, neurological and mental symptoms, and they developed a rating scale for quantifying mild and moderate alcohol withdrawal symptoms. The quantifiable element of this rating scale necessitated the removal of some items in spite of their well accepted clinical relevance, e.g. hypertension and tachycardia. Nevertheless, the remaining eight items included disorientation, hallucinations, inattentiveness, disturbance of contact, agitation, tremor, hyperhidrosis and anxiety, and these symptoms constitute the Mainz Alcohol Withdrawal Scales (MAWS).

Primary consequences: current drinking

The sample population was surveyed, using one question designed to capture information about the impact drinking had had on physical, mental and emotional well-being. This information incorporated harmful drinking and withdrawal from alcohol use. The question included prescribed statements that prompted either a positive or negative response.

In the context of current drinking, general health concerns among respondents was approached through statements that reflected on sleep, attending a general practitioner, being prescribed medication and having to be hospitalised, all for reasons directly, or indirectly, related to alcohol consumption. Mental health concerns, related to harmful drinking, were explored through three statements to do with alcoholic amnesia, nightmares and hallucination: emotional well-being was assessed through two statements, one about alcohol robbing the individual of being able to feel good about themselves, and another about irrational fear. Tables were created displaying the positive and negative responses to the statements that related to physical, mental and emotional well-being in turn.

Physical health

Table 7.1 contains the frequency of responses to statements that related to physical health, in relation to harmful drinking. The statements avoided specific medical conditions, whilst assessing the physical health of respondents.

Table 7.1 Physical health and harmful drinking

	yes %	no %
How has drinking affected your physical well-being?		
I have had to attend my GP for problems caused by harmful drinking	79	21
I have been prescribed medication for conditions caused by harmful drinking	70	30
I have been hospitalised as a result of harmful drinking	64	36
My sleep pattern is disrupted due to harmful drinking	86	14

The highest percentage of positive responses was recorded in relation to harmful drinking disrupting sleep patterns, with 86% of respondents declaring this was true for them. Over three-quarters (79%) of the respondents confirmed they had attended their doctor, with 70% having been prescribed medication as a result of their

attendance. Just under two thirds (64%) of the sample population had been

hospitalised as a result of harmful drinking.

Discussion

These percentages are not surprisingly high, in light of the fact that the sample

population had already declared having a problem with alcohol. Nevertheless, it is

reasonable to conclude that, any strategy aimed at helping harmful drinkers, must

include medical care, to a greater or lesser extent. Epstein (2001) points out that,

when diagnosing alcohol use disorders, the International Classification of Diseases

(2006), as used by the World Health Organisation, includes in its criteria for harmful

use any use that causes damage to health, where the damage may be physical.

Furthermore, there are ramifications for the use of health care service resources, in

providing for the physical needs of people who abuse alcohol, ramifications that

evoke responses from tax payers who question the cost such care requires.

Mental health

Table 7.2 contains the frequency of responses to three statements that related to the

mental health of the sample population. In this context, mental health means

evidence that the functioning of the brain is under stress.

Table 7.2 Mental health and harmful drinking

	yes %	no %
How has drinking affected your mental well-being?		
I have lost hours, even days, due to alcohol amnesia	82	18
I have had nightmares and horrors due to harmful drinking	67	33
I have hallucinated due to harmful drinking	51	49

The first of these statements reflected the amnesiac syndrome, as identified in the

International Classification of Diseases (ICD). ICD-10 (2006) includes a description

of alcohol amnesia as a prominent impairment of both recent and remote memory,

where recent memory is characteristically more disturbed than remote memory.

This condition is sometimes called a blackout, not unconsciousness, but an inability

to remember events, places or conversations. The individual concerned may well be

functioning in an apparently normal fashion, but later be unable to recollect

anything, filling the gap with his or her own version of events, a process called

confabulation. Writing about the long-term effects of harmful drinking on the brain,

Swinson and Eaves (1978) see the term amnesiac syndrome as another name for the

Korsakoff syndrome, named after the one who originally described the condition, in

1887. They affirm,

> The striking feature of the amnesiac syndrome is the loss of recent
>
> memory...a patient may well deny ever meeting someone to whom he was
>
> talking five minutes earlier. (Swinson and Eaves, 1978, p 137)

The second statement makes reference to nightmares or horrors, which are sleep

related and represent an unobtrusive enquiry that provides some tangible evidence of

the brain being under stress. The third statement refers to hallucinations, which

occur when the individual is still awake. Common experiences of alcohol related

hallucinations include a crawling sensation on the skin, hearing voices and seeing

objects change. This acute hallucinatory condition is clinically similar to

schizophrenia, and is of a different kind than those associated with the delirium

tremens (Swinson and Eaves, 1978).

The responses from the sample population demonstrate that all three phenomena,

suggesting brain functioning under stress, are common (defined here as 50% or more) experiences. By far the most frequent experience is that of alcohol amnesia, with over 80% of the sample population recording a positive response. Just over two-thirds (67%) were able to affirm they had experienced nightmares or horrors, and over half (51%) were able to identify with the hallucinatory condition, described clinically as being similar to schizophrenia.

Emotional health overview

Table 7.3 contains the frequency of responses to two statements that aim at assessing how the sample population have been impacted emotionally by harmful drinking.

Table 7.3 Emotional health and harmful drinking

	yes %	no %
How has your drinking affected your emotional well-being?		
I used to feel good about myself but alcohol has robbed me of that	78	22
I experienced irrational fear as a result of harmful drinking	77	23

The first statement identifies harmful drinking as the specific reason for a drinker no longer feeling good about him or herself. In the context of this research, feeling good about oneself refers to self esteem or self worth. The second statement enquires about whether or not the individual experiences irrational fear, referring to a general feeling of anxiety, nervousness or unease. It is not difficult to see how statements such as these, press towards personality character traits, but this issue is addressed later.

Levels of response to both these statements were very similar. In both cases, over three-quarters of the sample population agreed that harmful drinking removed their self esteem (78%) and that they became irrationally fearful (77%). Clearly, negative

emotional states, as well as cognitive impairment, co-occur in people with an alcohol dependency problem (Johnson-Greene, Adams, Gilman and Junck, 2002).

Discussion

Is the link between self esteem, irrational fear and harmful drinking so straightforward? Hall, Degenhardt and Teesson (2009) suggest that addiction services usually see patients that have anxiety, affective problems and personality disorders, conditions that often accompany substance abuse, which can go undiagnosed and untreated, and therefore, effect the success of treatment outcomes. Concurrent comorbid conditions that often arise are an alcohol dependency problem, schizophrenia and bipolar. Therefore, if harmful drinking is frequently accompanied by other symptoms, such as psychosocial problems and depression, ignoring one or more of these affective disorders, or wrongly linking them solely to substance abuse, may mean treatment approaches may mistake characteristics for one, when in reality they are evidence of another. It is significant that Ham and Hope (2003), in their discussion on alcohol and anxiety, spell out that social anxiety disorder and panic disorder are associated with an increased risk of substance dependency, suggesting that anxiety disorders come before alcohol use disorders. The significance is that helping such an individual stop drinking is only beginning to help them recover, and is likely to be unsuccessful, unless the anxiety issue is also addressed.

Primary consequences: withdrawal

In the context of withdrawal from alcohol use, general health concerns were prompted by statements about requiring supervised detoxification in a medical facility, experiencing shakes, sweating and having seizures. Mental health concerns

related to withdrawal were assessed by respondents having experienced delirium tremens; and emotional well-being was assessed through statements about having experienced irrational fear, mood swings and being irritable. Tables were created displaying positive and negative responses to the statements that related to physical, mental and emotional well-being in turn, and targeted information that related to alcohol withdrawal.

Physical health

Table 7.4 contains the frequency of responses to six statements designed to gather information relating to the alcohol withdrawal experiences of the sample population.

Table 7.4 Physical, mental and emotional health: alcohol withdrawal

	yes %	no %
How has drinking effected your...well-being?		
I have attended a medical facility for detoxification	44	57
I have had the "shakes and sweats" withdrawing from alcohol	78	22
I have had "grand-mal" type fits or seizures withdrawing	22	78
I have had the delirium tremens withdrawing	45	55
I have experienced extreme mood swings withdrawing	82	18
I have become very irritable withdrawing	83	17

The first statement distinguishes between those in the sample population who required medical care in withdrawal, and therefore, by implication, those who experienced withdrawal on their own without medical supervision. The second statement assessed the commonality of two of the most frequently reported symptoms of alcohol withdrawal, shaking and sweating. These two phenomena are described by Driessen, Lange, Junghanns and Wetterling (2005) as being among the most frequently experienced withdrawal symptoms, along with tachycardia, agitation and high diastolic blood pressure.

176

Less than half the sample population declared attending a medical facility for detoxification (44%) implying that the 57% who answered no to this statement went through withdrawal at home. Unsupervised withdrawal and home withdrawal need to be distinguished. Whereas home detoxification may be feasible and safe, unsupervised detoxification may not be safe. For individuals and agencies offering support for those attempting withdrawal, medical guidance needs to be sought so as not to put the drinker in unnecessary danger.

Over three-quarters (78%) of the sample population declared they had experienced shakes and sweats, a percentage not surprisingly high in view of the frequency with which these symptoms appear. However, it is worth noting that nearly one quarter of the sample population, who accept they have a problem with alcohol, did not identify with such symptoms. This demonstrates that it is important for people and agencies, involved in helping problem drinkers, not to have so fixed an understanding of the condition, that they are sceptical of anomalies or individual differences.

Mental health

Mental health in this context is assessed by the third and fourth statements in table 7.4. The third statement targeted the experience of grand-mal type fits, or seizures, in withdrawal. Darynani, Santolaria, Reimers, Jorge, Lopez, Hernandez, Reira and Rodriguez (1994), in their discussion on alcohol withdrawal syndrome and seizures, outline the characteristics of the syndrome as being tremors, hallucinations, false orientation and delirium tremens. Seizures usually occur during the latency period, that is, seven to 48 hours after cessation, but before other withdrawal symptoms, and

invariably, before delirium tremens. They debate the exact cause of seizures, whether it is the absence of alcohol or whether it is alcohol itself, in view of the fact that chronic alcohol intake leads to damage of the central nervous system. Either way, it occurs after cessation, which makes it an episode that must be considered by those helping individuals to stop drinking.

The fourth statement leads on to enquiring about the sample population's experience of delirium tremens. Knight (2001) explains that delirium tremens usually begin three to four days after drinking ceases. As the phrase suggests, delirium tremens is a combination of hallucinations and motor disturbances. Delirium describes low levels of consciousness, causing disorientation of time and place and disconnected thinking, not in touch with reality. Tremens describes considerable motor restlessness, combined with difficulties balancing and walking (Swinson and Eaves, 1978).

Less than one quarter (22%) of the sample population declared they had experienced seizures, and this is probably a fair reflection of the commonality of the characteristic. Similarly, less than half the sample (45%) recorded that they had experienced delirium tremens. Although not as common as some other characteristics, these two symptoms are potentially life threatening, and require helpers to engage appropriate medical support at all times.

Emotional health

The fifth and final statements aimed at probing extreme mood swings and irritability, and the responses to these two statements are the highest of the section

with 82% and 83% respectively.   Extreme mood swings refers to the individual having times when his or her mood is positive and upbeat, contrasted with times when he or she feels negative and downbeat, with such swings taking place within one day, or from one day to the next. Being very irritable refers to the way an individual relates to family members and close friends. This is marked by a lack of patience, fault finding and negativity. These figures demonstrate that the sample population identified closely with the statements regarding emotional health, and that more readily than either physical or mental health, with the exception of experiencing shakes and sweats, which drew over three quarters of the sample's positive responses.

Discussion

The results of the five statements that focus on the experience of withdrawal (this omits the first statement which is about how withdrawal is supervised) indicate how common such experiences are among the sample. In rank order of priority, these experiences are irritability, mood swings, sweats, delirium tremens and seizures. By far the two most common experiences in withdrawal are emotion based, and these points highlight the importance of considering emotional guidance in offering help in recovery.

As has been pointed out in a previous chapter on motivation to drink, changing negative emotions, or enhancing dull emotions, play important roles in the psychological dynamics behind individual drinking patterns. Negative emotions are a powerful driving force behind compulsive behaviour. The power behind negative emotions is generated by hurtful or stressful life experiences, channelled through

compliant cognitive processes and maintained by decisions based on assumptions. Recovery does not help drinkers feel better in the first instance; rather, recovery endeavours to uncover the assumptions underpinning drinking maintenance, reconfiguring the compliant cognitive processes that facilitated drinking, and helping the drinker find another way of managing hurtful or stressful life experiences.

This exploration of the sample population's experience of harmful drinking and withdrawal, in relation to physical, mental and emotional well-being, leads to another consideration. Are there any patterns to be observed in these findings if consideration is given to sex or age differences? This question is addressed by exploring these differences in harmful drinking and withdrawal

Profile patterns: sex

Harmful drinking and withdrawal: sex

The positive and negative responses to the 15 statements about harmful drinking and withdrawal were cross-tabulated with sex differences. The cross-tabulations sought to discover any associations between statements and sex and to indicate the strength of any such associations. Table 7.5 presents the summary of the results.

A review of the findings in Table 7.5 highlights the clear differences in percentage scores for males and females. For example, all the male scores are 72% or above, with an average of 76%; whereas all the female scores are 28% or less with an average of 24%. These figures suggest that approximately three-quarters of the male respondents can identify with all 15 statements relating to harmful drinking and

withdrawal, whereas approximately one quarter of female respondents could identify with them.

Table 7.5 Harmful drinking and withdrawal: sex

	male %	female %	χ^2	$p<$
How has drinking affected your well-being?				
I have had to attend my GP for problems caused by alcohol	79	79	0.00	NS
I have been prescribed medication for alcohol problems	71	66	0.41	NS
I have been hospitalised because of harmful drinking	68	54	3.34	.05
My sleep pattern is disrupted because of harmful drinking	87	84	0.25	NS
I have lost hours, even days, due to alcohol amnesia	83	80	0.15	NS
I have had nightmares and horrors due to harmful drinking	70	59	1.98	NS
I have hallucinated because of harmful drinking	56	36	6.71	.01
I used to feel good about myself but alcohol has robbed me	81	71	2.11	NS
I have irrational fear due to harmful drinking	77	79	0.07	NS
I have attended a medical facility for detoxification	47	34	2.70	NS
I have had shakes and sweats in withdrawal	83	64	7.94	.01
I have had grand-mal type fits or seizures in withdrawal	25	14	2.29	NS
I have had delirium tremens in withdrawal	52	29	8.53	.01
I have experienced extreme mood swings withdrawing	83	77	1.21	NS
I have become very irritable in withdrawal	82	86	0.52	NS

Table 7.5 also highlights four statements that reflect statistically significant differences in the sex specific responses, two statements relating to harmful drinking and two relating to withdrawal. Regarding harmful drinking, significantly more males than females had been hospitalised and had hallucinated. In relation to alcohol withdrawal, significantly more males and females had experienced shakes and sweats, and had the delirium tremens.

Discussion

These figures imply that a female's experience of harmful drinking and withdrawal may be quite different from that of their male counterparts, even though all the respondents declared they have or have had a problem with alcohol. Furthermore,

the same can be said for one quarter of male respondents, when their experience is compared to the remaining three-quarters.

There are two implications for those offering support in recovery. First, alcohol may be a problem for individuals, even though those individuals may not be displaying stereotypical consequences of harmful drinking or withdrawal. Second, it is prudent to anticipate that the majority of people coming for help will be displaying stereotypical consequences in physical, mental and emotional terms. If there are clear differences in relation to sex, perhaps there are also patterns that are reflected by age.

Profile pattern: age

As before a cross-tabulation was conducted aimed at testing for associations between age differences (under and over 40 years of age) and the 15 statements about physical, mental and emotional consequences of harmful drinking and withdrawal. The results are summarised in table 7.6.

A review of the percentages in table 7.6 shows clearly that higher numbers of those over 40 years of age positively identified with the 15 statements. No fewer than 60% of those over 40 years of age identified with the statements, whereas no more than 40% of those less than 40 years of age identified with the statements. Statistically, twice as many positive responses were recorded by those over 40 years of age than under.

Table 7.6 Harmful drinking and withdrawal: age

	under 40 %	over 40 %	χ^2	$p<$
How has drinking affected your well-being?				
I have had to attend my GP for problems caused by alcohol	71	83	3.38	.05
I have been prescribed medication for alcohol problems	63	73	2.25	NS
I have been hospitalised because of harmful drinking	60	66	0.65	NS
My sleep pattern is disrupted because of harmful drinking	81	88	1.83	NS
I have lost hours, even days, due to alcohol amnesia	79	84	0.91	NS
I have had nightmares and horrors due to harmful drinking	67	66	0.01	NS
I have hallucinated because of harmful drinking	46	53	1.06	NS
I used to feel good about myself but alcohol has robbed me	76	80	0.4	NS
I have irrational fear due to harmful drinking	76	78	0.15	NS
I have attended a medical facility for detoxification	41	46	0.18	NS
I have had shakes and sweats in withdrawal	74	80	0.75	NS
I have had grand-mal type fits or seizures in withdrawal	26	20	0.98	NS
I have had delirium tremens in withdrawal	50	43	0.9	NS
I have experienced extreme mood swings withdrawing	81	82	0.00	NS
I have become very irritable in withdrawal	84	82	0.21	NS

The table also demonstrates that there was only one statement that reflected a statistically significant difference reflected in age, significantly more people over 40 years of age had had to attend a GP for harmful drinking problems.

Discussion

These figures imply that the acuteness of the physical, mental and emotional consequences of harmful drinking and withdrawal are more evident in those aged over 40 years of age. Perhaps this is explained by considering that the older age band incorporates people with a longer drinking history, and reflects progressivity in the detrimental consequences of a drinking lifestyle.

Perceived needs

So far this investigation has explored the consequences of alcohol problems for an

individual by describing his or her physical, mental and emotional well-being, in harmful drinking and withdrawal. But, in terms of the consequences of having an alcohol problem, what are the sample population's perceived needs in regard to their addictive behaviour?

Table 7.7 contains the frequency of responses to six statements related to perceived pastoral needs that were consequential to an alcohol dependency problem.

Table 7.7 Perceived pastoral needs

	yes %	? %	no %
I need pastoral care in ...			
Helping me solve my alcohol addiction problem	68	5	27
Talking to someone about my alcohol addiction	76	2	22
Losing my desire for alcohol	57	6	36
Getting help to go through withdrawal	23	8	69
Getting sober	36	3	61
Staying sober	75	3	22

Each statement began with 'I need pastoral care in...' and referred to six specific issues related to overcoming consequential behaviours associated with alcohol problems. The statements focused on help with solving an addiction problem, talking about an addiction problem, losing desire for alcohol, help to overcome withdrawal, help to get sober and help to stay sober. These six statements encapsulate the essence of an alcohol dependency problem, and represent another kind of consequence to problem drinking, a consequence that is not only physical, mental or emotional but fundamentally behavioural. Behavioural problems associated with alcohol dependence, therefore, include having an addiction, needing to talk about that addiction, fighting the desire for alcohol, overcoming withdrawal as an initial step in recovery, and getting and staying free from alcohol.   Patterns in

perceived needs in relation to an alcohol dependency problem reflect sex and age were also considered.

The two lowest scores related to going through withdrawal and getting sober, with less than one quarter (23%) and over one third (36%), respectively, agreeing that these issues were important for them. The two highest positive scores related to talking to someone about addiction and staying sober with three-quarters or more of the sample population (76% and75% respectively) agreeing with these statements. Over two-thirds responded positively to the statement about solving an addiction problem, and over half the population agreed that they needed help in losing the desire for alcohol.

Discussion

The results from this overview highlight three perceived pastoral needs. First, there is the need to talk to someone specifically about addiction to alcohol. From this it is inferred that talking is important and helpful, adding credence to the case made by proponents of talking therapies. However, it must be born in mind that the sample population was made up of those who had an association with Stauros, and Stauros focuses on offering pastoral care on a one-to-one basis. Perhaps this result, therefore, simply reflects the audience from which it was derived.

Second, there is the perceived need to maintain sobriety. When set alongside the statement about getting sober, this result clearly demonstrates that more people struggle with staying sober than with getting sober. Perhaps this fact infers that respondents know how to stop drinking, may even have stopped on previous occasions, but do not know how to overcome the behavioural urges to drink, urges

that constitute their personal battle with addiction. Associated with staying sober are three of the remaining statements, one related to overcoming the desire to drink, one to breaking the pattern of drinking (getting sober) and one relating to the fear of immediate consequences of stopping (withdrawal). Here, therefore, is the subject matter for therapists. The subject matter includes living alcohol free, resisting or overcoming desires for alcohol, and changing behaviour patterns including managing the discomfort of withdrawal.

Third, there is the perceived need to solve the problem that is an alcohol dependency problem. This is a deceptively simple statement, for it belies the nature of the problem, which involves more than simply drinking too much. The problem of an alcohol dependency problem is exhibited in drinking behaviour, but is rooted in the human psyche. The psyche incorporates processes such as thinking, identity, values and experience; and it also incorporates qualities that are unique to mankind, qualities that are ineffable but which are echoed in self awareness, insight into truth, revelation of meaning and appreciation of beauty. James (1982) touches on such qualities by using the illustration of an iron bar that is magnetised,

> A bar of iron could never give you an outward description of the agencies
> that had the power of stirring it so strongly; yet of their presence, and of their
> significance for its life, it would be intensely aware through every fibre of its
> being. (James, 1982, p56)

The problem of alcohol addiction, therefore, requires an audit and review of the processes, influences and qualities that constitute the human psyche, and that are simultaneously contributors to and recipients of the condition.

Profile patterns: sex

Using a subjective health assessment tool, or health self-rating, Stranges, Notaro, Freudenheim, Calogero, Muti, Farinaro, Russell, Nochajski and Trevisan (2006) demonstrated that alcohol use that avoids intoxication maybe associated with better mental health in women and physical health in men, whereas a pattern of intoxication was associated with poorer mental health in women and poorer physical health in men. Evidence such as this confirms that patterns do emerge when consideration is given to sex and age differences in conjunction with an alcohol dependency problem. However, it also raises the question, are there patterns in perceived needs in relation to an alcohol dependency problem?

Table 7.8 contains a cross-tabulation aimed at testing for associations between sex differences and perceived pastoral needs in relation to an alcohol dependency problem.

Two of the six statements, in relation to perceived needs, showed statistically significant differences according to sex. Significantly more males than females agreed that they needed support through their alcohol dependency problem, and to lose their desire for alcohol. These results suggest that men perceive themselves in need of support more acutely than women. Alternatively, the results may show that women associate their drinking with other issues that fuel their need for alcohol, and that these are at the root of their drinking.

Table 7.8 Perceived needs: sex

	male %	female %	χ^2	$p<$
I need pastoral care in ...				
Helping me solve my alcohol addiction problem	72	57	4.13	.05
Talking to someone about my alcohol addiction	79	70	1.83	NS
Losing my desire for alcohol	62	45	5.02	.05
Getting help to go through withdrawal	24	21	0.15	NS
Getting sober	39	29	1.81	NS
Staying sober	77	70	1.07	NS

Profile pattern: age

Table 7.9 contains the results of a cross-tabulation aimed at testing for associations

between age differences (under and over 40 years of age) and perceived pastoral

needs.

Table 7.9 Perceived needs: age

	under 40 years %	over 40 years %	χ^2	$p<$
I need pastoral care in ...				
Helping me solve my alcohol addiction problem	78	63	5.01	.05
Talking to someone about my alcohol addiction	88	70	8.51	.01
Losing my desire for alcohol	65	53	2.67	NS
Getting help to go through withdrawal	25	23	0.10	NS
Getting sober	38	35	0.14	NS
Staying sober	88	68	10.24	.001

 Three of the six statements raised patterns that were age specific; one demonstrating

a link between age and solving an alcohol problem, one demonstrating a strong link

between age and talking with someone about an alcohol dependency problem, and

one demonstrating a very strong link between age and a perceived need for support

with staying sober. In each case significantly more people over 40 years of age

agreed with these three statements. The three perceived pastoral needs highlighted by the overview of responses now reappear as being age related.

Main findings

The main findings of this chapter address the immediate consequences of harmful drinking and withdrawal upon the physical, mental and emotional well being of the respondents. The research demonstrates first, that the most common consequences of harmful drinking are disruption of sleep patterns, periods of alcohol amnesia and negative self worth or self esteem. Second, it demonstrates that, in withdrawal, irritability with others, extreme mood swings and having the 'shakes and sweats' are the most common consequences. Third, there are some immediate consequences that are more common in males than females; for example, males are more likely to have been hospitalised and to have hallucinated than females, and males are more likely to have shakes and sweats and delirium tremens than females. Fourth, significantly more people over 40 years of age than under will have attended their general practitioner with problems caused by alcohol. Fifth, sex differences elicit more statistically significant variations in responses tonthe consequences of an alcohol dependency problem and withdrawal than age differences. Sixth, the greatest perceived needs in relation to having an alcohol dependency problem are being able to talk to someone about the problem and being able to stay sober. Seventh, significantly more males than females identified the need for help with solving their alcohol dependency problem and losing the desire for alcohol. Eighth, significantly more people over 40 years of age identified a need for help with staying sober, talking to someone about their alcohol dependency problem and solving their alcohol dependency problem. Ninth, age differences elicit more

statistically significant variations in responses related to perceived needs than sex differences.

Conclusion

This chapter has focused on the consequences of harmful drinking and withdrawal on the individual, first with regard to physical, mental and emotional health, and latterly with regard to perceived needs that reflect behavioural issues. In relation to health consequences, what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?

The findings demonstrate the seriousness of harmful drinking and withdrawal, a seriousness immediately reflected in brain functioning. Two issues are raised at the outset that carers do well to bear in mind. First, there is a need to allow for brain function to normalise before embarking on education or rehabilitation programmes, which require short term memory to retain information: and second, this normalising process, reversing the Korsakoff syndrome, is enhanced by the use of vitamin supplements, such as thiamine, alongside a fully nutritious and balanced diet.

Pastoral care, therefore, will be best characterised by several considerations. First, it is important for carers to be medically aware. In the context of talking to people with an alcohol dependency problem, understanding the significance of complaints about abdominal pain, vomiting, amnesia, anxiety, depression and the like is essential. Awareness of the potential dangers in withdrawal needs to inform decisions about how to approach the condition in the most appropriate way.

Second, it is important that helpers seek medical advice when trying to distinguish between the influence of alcohol on the mind, and comorbid or concurrent issues that may shadow or hide dependency, for example, with conditions such as schizophrenia and depression. Individuals displaying symptoms similar to the clinical condition of schizophrenia need to be cared for with medical expertise. The medical expertise helps to distinguish alcoholic symptoms similar to schizophrenia from schizophrenia proper. Swinson and Eaves (1978) make reference to a long term study of such cases carried out by Benedetti in 1952, where 90 out of 113 patients rapidly returned to normal after a time in hospital where they received pharmacological treatment. Of the remaining 23 cases, 10 became demented and 13 developed schizophrenia proper.

Locke and Newcomb (2001), carried out a longitudinal examination of alcohol involvement and dysphoria (depression) with a view to answering the question of which came first. Their findings revealed patterns in sex differences. Differences emerged in late adolescence, becoming less evident with increasing age. In men alcohol involvement in adolescence predicted depression in adulthood and the two had a synergetic relationship, i.e. there was cooperation of both alcohol and dysphoria to produce a combined condition greater than the sum of their separate effects.   In women dysphoria in young adulthood in some cases was associated with alcohol related problems, and specific aspects of dysphoria in adulthood, and again alcohol and dysphoria had a synergetic effect in adolescence and young adulthood. Third, this raises the question of comorbidity. Hall, Degenhardt and Teesson (2009) discuss the issue of comorbidity by exploring the link between substance use, anxiety and affective disorders. They explore this link from three angles. First,

perhaps one disorder produces another, for example, an alcohol dependency problem producing depression. Second, perhaps one disorder increases the risk of a substance use disorder, for example, those suffering from anxiety use alcohol as a medicine. Third, the link between substance use and mental disorders may have a common cause such as a shared genetic predisposition, family circumstances or an abusive environment. These angles have ramifications for treatment approaches and warrant careful consideration by carers.

Fourth, it is important for helpers to be aware of concurrent personality disorders and/or affective disorders. This research highlights affective considerations. Grossarth-Maticek, Eysenck and Boyle (1995), addressed the question whether an alcohol dependency problem preceded emotional and/or mental health issues, or vice versa. Their investigation introduced the centrality of personality into this question. People with self-regulatory personality characteristics, and who drink, tend to be positively correlated with health, being alive and being well; and tend to negatively correlate with chronic illness and mortality. This is equally true for people who are non-drinkers. Where there is an absence of self-regulatory personality characteristics there tends to be a higher level of neuroticism, which is associated with an alcohol dependency problem.

> The effect of alcohol on health is very dependent on the way alcohol affects
> people by improving or diminishing their scores on self-regulation.
> (Grossarth-Maticek, Eysenck and Boyle, 1995)

The centrality of personality is explored in later chapters.

Fifth, it is important for helpers to take into consideration patterns that emerge in relation to sex and age. For example, this research has demonstrated that males and females express their harmful drinking and go through withdrawal in different ways, and that those over 40 years of age experience consequences of harmful drinking and withdrawal more acutely than those under 40years of age.

Finally, it is important that helpers do not ignore the needs that drinkers themselves perceive to be important, for example, the need to talk to someone about their drinking dependency and the need to find a way to stay sober. In practical terms this may include talking about what it means to live alcohol free, how to combat thoughts that obsess about alcohol and thus to change behaviour.

This chapter addressed the primary consequences of an alcohol dependency problem upon the drinker. The following chapter addresses the secondary consequences of dependency upon the drinker, by exploring the impact drinking has had upon the context in which the drinker lives.

Chapter Eight

Secondary consequences of alcohol dependency

Chapter outline

Introduction

Theoretical context: external relational circumstances

> *Marital status*
>
> *Profile pattern: sex*
>
> *Profile pattern: age*
>
> *Family relationships*
>
> *Profile pattern: sex*
>
> *Secondary consequences for family relationships*
>
> *Profile pattern: age*

Internal moral considerations

> *Violence*
>
> *Profile pattern: sex*
>
> *Profile pattern: age*
>
> *Antisocial behaviour*
>
> *Profile pattern: sex*
>
> *Profile pattern: age*

Main findings

Conclusion

Introduction

In the previous chapter, attention focused on the primary consequences of an alcohol

dependency problem for the drinker, incorporating physical, mental and emotional

factors. This chapter addresses secondary consequences of drinking behaviour,

consequences that impact issues other than the physical, emotional and mental well-

being of the drinker. Secondary consequences, in this dissertation, refer to relational

and moral issues such as the external relational circumstances and the internal moral

considerations that a drinker has to contend with in recovery. These external

relational circumstances and internal moral considerations together constitute the context in which the drinker lives.

The chapter begins by addressing the external relational circumstances, which includes relational issues within families, for example, the drinker's relationship with his or her partner and with his or her children. After addressing the marital/partner relationship, there is a discussion that explores the pastoral issues carers may find necessary to raise. This discussion includes investigating profile patterns that relate to sex and age differences. Subsequently, family relationships are addressed, relationships other than marital/partner. As before this section is followed by a discussion of relevant pastoral issues and an investigation into patterns that are sex and age specific. Internal moral considerations include personal, social and moral issues such as violence and criminality or antisocial behaviour. Both violence and antisocial behaviour are followed by discussions relating to pastoral considerations including investigations for profile patterns that are sex and age specific.

All such issues relate to drinking behaviour, sometimes consequentially, sometimes causally and sometimes as a combination of both. It is important to address these secondary issues because they constitute part of the life experience of the drinker, and are, therefore, potential areas of pastoral concern. The chapter concludes with a summary of the main findings and how the key question underpinning this dissertation has been further answered.

Theoretical background: external relational circumstances

External relational circumstances refer, in particular, to the relationship between the drinker and his or her spouse/partner and his or her children. There is little doubt that the drinking behaviour of one person has far reaching consequences on others related by family ties. It is conservatively estimated that five million people in the United Kingdom suffer because of someone else's drinking behaviour (Taylor, Toner, Templeton and Velleman, 2002). They suffer, for example, negative life experiences, violence and social isolation. Their suffering is expressed in physical and psychological symptoms that include anxiety, depression, psychosomatic complaints, behavioural disturbances and other conduct-related disorders. An alcohol dependency problem in one family member can lead to the failure of family systems and structures, such as family rituals, roles, routines, communication, social life and financial security. For children of someone who has an alcohol dependency problem, it is often a secret problem they cannot share because of shame, embarrassment and/or family loyalty. Yet their distress may be expressed in antisocial behaviour, emotional difficulties and problems at school; they may exhibit friendship problems and have involvement with semi-deviant sub cultures (Taylor, Toner, Templeton and Velleman, 2002).

Dunn (1986) reflects upon the perception of someone who has an alcohol dependency problem, and his or her family relationships, be they marriage/partner relationships or otherwise. He attests that an alcoholic will lie to, abuse and cause suffering to family, albeit not intentionally. However, the person with alcohol dependency may come to see family as an obstacle to unrestricted drinking behaviour, and may therefore choose to abandon family relationships. Leonard

(1990) also makes reference to the litany of problems that are well known in

marriage/partner relationships, a list that includes marital conflict, divorce,

economic difficulties and domestic violence.

Marital status

Table 8.1 contains the frequency of responses from the research population in

relation to the marital status. From the table it is clear that, in the total sample

Table 8.1 Marital status

	% of total
Single	27
Married	34
Cohabiting	4
Widowed	1
Separated	11
Divorced	19
Remarried	5

population, more married people (34%) present for help with an alcohol dependency

problem than single (27). Combining the figures of those who are married (34%)

with those who have remarried (5%) and with those who are cohabiting (9%), it

becomes clear that 42% of the sample is currently in a marriage/partner relationship.

Furthermore, combining the figures of those separated and divorced demonstrates

that 30% had been married but were not in a relationship at the time of completing

the questionnaire. Although there are fewer single people (27%) who present for

pastoral support, it represents more than one quarter of the population.

The sample population is one where respondents have identified they have an

alcohol dependency problem, and each was asked questions that directly related to

the impact their drinking had had upon their marriage/partner relationship. Table

8.2 displays the frequency of responses to these questions.

Table 8.2 Impact of drinking on marriage/partner relationship

	yes %	no %
Drinking had a negative effect on my marriage/partner relationship	77	23
Drinking contributed to the breakup of a former relationship	47	53
Drinking caused me to feel guilty about my behaviour towards my family	92	8

It is clear that a large number of respondents (77%) were willing to confirm that

their drinking had had a negative effect on their marriage/partner relationship, and

almost half the sample (47%) confirmed their drinking had contributed to the

breakup of a former marriage/partner relationship.   An extremely large number of

respondents (92%) admitted to feeling guilty about their behaviour towards their

family, including their spouse or partner.

Discussion

These figures belie the issues that someone with an alcohol dependency problem

must contend with, if recovery is to be long lasting and rewarding. It is true that the

figures show that it is not only the person with alcohol dependency who may need

support, but also a spouse/partner and their children. Nevertheless, this research

targets the drinker, and focuses on the implications of the figures from the

perspective of that individual. The issues the drinker will have to face include the

obvious challenge to stop drinking.

However, these figures show that 77% may have the challenge of facing a

counteraction from a spouse/partner who resents the marriage/partnership having

been impacted in a negative way by unreasonable drinking behaviour.

Counteractions are not surprising, unexpected or unhealthy. However, for the drinker, if they are interpreted as being unnecessarily aggressive or abusive, they may contribute to emotional stress that nurtures inner conversations such as 'I can't handle this,' or 'just leave me alone,' and this in turn may prompt further drinking. Alternatively, sensitivity to this danger can force a spouse/partner to suppress their resentment for a time, only for it to surface later in more subtle ways, and often after a period of sobriety for the drinker. From the drinker's perspective, sobriety then appears not to enhance relationships with spouse or partner, but exacerbate tension.

The figures raise issues that are highlighted in the responses to questions about relationship break-ups and guilt. First, 47% of respondents have to resolve their culpability in their relationship break-up. Accepting culpability is a process that can lead to greater self awareness and honest self acceptance, laying a foundation for emotional maturity and relational stability. Alternatively, an acceptance of culpability can be too easily achieved in superficial reflection that says, 'it's my fault, but I am a person with alcohol dependency,' thus in reality absolving the drinker from taking responsibility for past actions.

Second, 92% of respondents have to dispel their guilt concerning their behaviour towards their family. Dispelling guilt is a process that can facilitate improving self-esteem and renewing hope for potential future happiness. For some, however, deserving to be free of guilt is a concept more difficult to embrace, and experiencing forgiveness from a spouse/partner, or other family members, may be, for them, a step too far.

Profile pattern: sex

Are these observations and reflections similar for men and women? Table 8.3

presents the frequencies for each sex category as a percentage of the total number of

male and female respondents, respectively.

Table 8.3 Marital status: sex

	male %	female %
Single	31	16
Married	34	35
Cohabiting	5	2
Widowed	0	4
Separated	8	18
Divorced	19	16
Remarried	3	9

These figures show that singleness is more common for males than females, with a

ratio of almost two to one. Male and female figures for those currently in a

relationship, that is, married, cohabiting or remarried, show that it is slightly more

common for females to be in a relationship than for males (compare 42% males with

46% females). Similarly, it is more common for females to record that they had

been in a relationship that had broken down, either separated or divorced, than

males, (compare 34% female with 27% male). The figures suggest it is more

common for males to be relationally detached from intimate relationships, compare

those males who are single, separated and divorced (58%) with females in the same

categories (50%).

Table 8.4 contains the results of a cross-tabulation carried out to test for associations

between sex and the impact of drinking on a marriage/partnership. The table shows

a strong statistical significance (.001) demonstrating that more males than females

recorded that their drinking contributed to the break-up of a former relationship. A

ratio of three to one males to females agreed that drinking had had a negative effect

on their marriage/partner relationship, and a similar ratio admitted they felt guilty

about their behaviour towards their family.

Table 8.4 Impact of drinking on marriage/partner: sex

	male %	female %	χ^2	$p<$
Drinking had a negative effect on marriage/partnership	79	71	1.35	NS
Drinking contributed to the break-up of former relationship	55	27	12.12	.001
Drinking caused me to feel guilty about my behaviour to family	92	93	0.30	NS

These figures raise other factors that may be more sex specific. For example, it may

be more common for male drinkers to have to come to terms with relational

isolation, or loneliness, than female drinkers, an issue that would have important

implications for carers offering counselling support to males endeavouring to

recover from an alcohol dependency problem. Furthermore, relational detachment

implies more males have to face recovery with a less intimate relational support

network than females.

Profile pattern: age

Table 8.5 contains the results of a cross-tabulation aimed at testing for associations

between age differences (those aged under and over 40 years of age) and the impact

of drinking on marriage/partnership.

Table 8.5 Impact of drinking on marriage/partner: age

	under 40 years %	over 40 years %	χ^2	$p<$
Drinking had a negative effect on marriage/partnership	68	81	4.16	.05
Drinking contributed to the break-up of former relationship	44	49	0.65	NS
Drinking caused me to feel guilty about my behaviour to family	91	93	0.12	NS

The table shows that significantly higher percentages of people over 40 years of age agreed that drinking had had a negative effect on their marriage/partnership. The figures representing those who admitted that drinking contributed to the break-up of a former relationship, and who felt guilty about their behaviour towards their family, were very similar in age comparison. This suggests that age does make a difference in relation to recognising the negative impact drinking may have upon a marriage/partnership, but not in terms of making a contribution to a break-up or of feeling guilty about behaviour. This means that, in dependency recovery, younger clients may be less likely to admit that their drinking is having a negative effect upon their relationships.

Family relationships

Attention now turns to considering the consequences of problematic drinking upon the children of individuals who have an alcohol dependency problem. Mention has already been made of the impact drinking can have upon family systems, and the link that has been established between parental drinking and antisocial behaviour in adolescents with their association with semi-deviant sub cultures. Shin, Edwards and Heeren (2009) have demonstrated a positive link between child maltreatment and neglect with subsequent adolescent binge drinking behaviour. Their study found that childhood maltreatment was a robust risk factor for adolescent binge drinking, alongside parental alcoholism. Developmental outcomes, such as emotional problems, behavioural problems, lowered social competence and lowered self-esteem, were demonstrated to be linked with multiple types of maltreatment in the context of excessive parental drinking.

There are important family based psychosocial factors that predict lower risk of alcohol use and/or dependency. These factors include parental monitoring, clear family rules and parental rewards for good behaviour (Mason, Kosterman, Haggerty, Hawkins, Redmond, Spoth and Shin, 2009), and they operate most effectively within the context of the bonding young people have with other family members, especially parents. Successful family interventions, aimed at preventing young adult harmful drinking, appear to be ones that enhance bonding by improving parenting and family interactions, thus strengthening or improving pro-social skills. Current parental person with alcohol dependency drinking potentially precludes effective bonding with children.

Bonding refers to communication, joint activities and family support, and it can be defined as closeness and intimacy towards one's parents (Kuendig and Kuntsche, 2006). Kuendig and Kuntsche (2006) attempted to predict frequent and excessive drinking in adolescents, by considering the possible link between such drinking and two factors, parental drinking and family bonding. They tested frequency of alcohol intake and drunkenness in adolescents, with the heaviness of parental drinking and the strength of family bonding. They found that there was a positive association between parental drinking and adolescent drinking: heavy parental drinking was associated with high levels of adolescent drinking. Furthermore, they found a negative association between the strength of family bonding, and high levels of adolescent drinking: the lower the level of bonding, the higher the level of drinking. The childhood experiences of children of a person with alcohol dependency problem may reflect failure on the part of a drinking parent to effectively establish such a bond.

The children of a person with alcohol dependency problem are vulnerable because they have been exposed to psychopathological parental models. Johnson and Rolf (1990) explain that exposure to home environmental factors that include alcohol abuse, produces an increased risk for children developing a variety of psychosocial and psychopathological disorders, especially in relation to cognition, personality and adaptation. They declare clear evidence to suggest, first, that the children of a father with alcohol dependency, and their mothers, both underestimate their cognitive abilities, and that this perception effects their motivation, self-esteem and academic performance. Second, the combination of certain personality traits, such as activity levels, emotionality and sociability, contribute to the development of psychosocial mal-adaptations. Third, adolescent children of parents with alcohol dependency reported being less happy with their lives than those living with recovering parents with alcohol dependency, they tended to perceive the problems they faced as being outside their control and they tended to use emotion focused coping strategies rather than problem-focused coping strategies.

Table 8.6 presents the frequency of responses in relation to the family relationships of the sample population by sex. Numbers have been rounded to the nearest whole number.

Table 8.6 Family relationships

	no %	yes %
Have you any children?	34	66
Drinking made family life unhappy	8	92
Drinking spoilt my relationship with my children	55	45
My family believed I no longer cared about them	31	69
Drinking caused my family embarrassment	14	86
My drinking caused my family financial difficulties	45	55

Two-thirds (66%) of the total sample population confirmed they were parents, which means the remainder (34%) declared they did not have children. Therefore, distinction must be made regarding the terminology of the questions presented to the sample population. Of the six questions included in table 8.6, four refer to family and only two refer to children. The broader term family may subsume children, though not necessarily, implying multiple relationships including, for example, parents and siblings of the drinker.

A high percentage of the total sample (92%) admitted that their drinking caused unhappiness in their family. Unhappiness is a deliberately broad term designed to capture the drinker's awareness of his or her contribution to the general well-being of their family. Over two thirds of the total sample (69%) declared awareness that their drinking had the effect of communicating emotional indifference towards their families, more specifically that the drinker no longer cared about them. A high percentage of the total sample (86%) declared that they were aware that their drinking caused their family embarrassment, which is associated with feelings of awkwardness and shame, while just over half the total sample (55%) was aware that their drinking had caused financial difficulties.

With specific reference to children, 45% of the total sample were aware that their drinking had spoilt their relationship with their children. Watkins, O'Farrell, Suvak, Murphy and Taft (2009) explored this area of parenting satisfaction. They suggest that parenting satisfaction is associated with care-giving, positive parent-child interactions and healthy attachment. They demonstrated that families of fathers with

alcoholism are at risk of problematic parenting and negative child outcomes: low parenting satisfaction in the person with alcohol dependency father resulting in him being less supportive and using harsh discipline techniques. At the onset of treatment for such person with alcohol dependency men, there was no overall improvement in parenting satisfaction, but that satisfaction was moderated by changes in alcohol consumption. This suggests that parenting satisfaction takes time to develop.

Discussion

These results provide some insight into the awareness the sample population has of the impact their drinking makes upon their families. In the context of pastoral care this awareness is important because of the reaction it prompts in each drinker. It is these reactions that are instrumental in marking the individual differences within the common condition of an alcohol dependency problem. For example, awareness that drinking made family life unhappy, compounds the feeling of culpability raised earlier in the context of marriage/partner relationships. Spoilt relationships with children intensifies feelings of failure: knowing that family members believe the drinker no longer cares about them, heightens a sense of detachment and being the cause of embarrassment. Financial difficulties also promote a sense of shame. Crucially, the drinker's response to culpability, failure, detachment and shame could lead to any one of a number of behavioural choices that either help or hinder the recovery process. Identifying an individual's self awareness, understanding what reactionary choices that awareness are likely to trigger, and helping choose responses that do not involve alcohol, or other destructive behaviours, is the kernel of pastoral care in this context. Perhaps the sex and/or age of drinkers seeking help

may provide carers with clues about their client's awareness of the impact their

drinking is having.

Profile pattern: sex

Table 8.7 contains the results of a cross-tabulation carried out to test for associations

between sex differences and the awareness drinkers have of the impact their

drinking has on their families. Two points are highlighted as having significance.

Significantly more men than women are aware that their family believed they no

longer cared about them; and significantly more men than women were aware that

their drinking caused financial difficulties. Potentially, therefore, men may have a

more profound sense of detachment from their family and of shame at having caused

financial hardship.

Table 8.7 Impact of drinking on family and children: sex

	male %	female %	χ^2	$p<$
Drinking made family life unhappy	94	87	2.53	NS
Drinking spoilt my relationship with my children	46	44	0.09	NS
My family believed I no longer cared about them	73	58	4.34	.05
My drinking caused my family embarrassment	89	80	2.56	NS
My drinking caused my family financial difficulties	61	38	8.21	.01

Profile pattern: age

Table 8.8 contains the results of a cross-tabulation aimed at testing for associations

between age differences (those under and over 40 years of age) and the impact of

drinking on family and children. The table shows that significantly more people

over 40 years of age are aware that their drinking spoilt their relationship with their

children than those under 40 years of age, potentially leaving those in the older age

category feeling they are failures at a more profound level.

207

Table 8.8 Impact of drinking on family and children: age

	under 40 years %	over 40 years %	χ²	*p<*
Drinking made family life unhappy	93	92	0.05	NS
Drinking spoilt my relationship with my children	36	50	3.50	.05
My family believed I no longer cared about them	74	67	1.05	NS
My drinking caused my family embarrassment	88	85	0.38	NS
My drinking caused my family financial difficulties	61	52	1.63	NS

Internal moral considerations

The secondary consequences of drinking behaviour include internal moral considerations. Moral considerations are important because they form part of the psychological setting in which sobriety finds its reward, and from which the process of recovery can emerge. These considerations are categorised as internal moral issues because each drinker must personally resolve what is right and wrong behaviour, and must judge past behaviour on the basis of that personal perspective. For the purposes of this research the moral issues had to be unambiguously right or wrong and, as far as possible, be unobtrusive for people completing the questionnaires. It was decided that the issues to be explored were violence and antisocial behaviour. These are issues closely related to harmful drinking, unambiguously right or wrong, and in keeping with the form of questions included in the rest of the questionnaire.

Violence

Violence is a behaviour closely associated with harmful drinking and, in particular, with the relationship between drinking patterns in males and intimate partner violence (Fals-Stewart, Leonard and Birchler, 2005). The association is a two-way

relationship, because aggression is both predicted and facilitated by harmful drinking. Longitudinal research carried out by Keller, El-Sheikh, Keiley and Liao (2009) assessed alcohol problems and aggression using self-report and partner report methods. In particular, they explored aggression as a predictor of alcohol use, and they found that a husband was more likely to abuse alcohol as a result of verbal and physical aggression in a marital context. Marital aggression included greater violence, abusive episodes, verbal aggression and poor communication. It also included greater relational negativity and hostility expressed in criticism, insults, blame, complaint and dogmatic contradictions.

Fals-Stewart, Leonard and Birchler (2005) researched variables that might moderate the relationship between intimate partner violence and male harmful drinking. The variables included examples such as hostility, marital discord and verbal aggression, and they constituted a multiple threshold model of intimate partner violence. They proposed that intimate partner violence occurred when an individual's threshold of aggression was exceeded. They found that male drinking was not associated with non-severe intimate partner violence, where the drinker did not have an antisocial personality disorder: alcohol did not increase the likelihood of non-severe violence from men who did not have an antisocial personality disorder. However, contrary to expectations, serious intimate partner violence was associated with men without an antisocial personality disorder: both men with and without an antisocial personality disorder were as likely to be seriously violent towards their intimate partners as a result of harmful drinking.

A similar report emerges from research into female alcoholism and violence in

intimate partner relationships. Weizmann-Henelius, Putkonen, Naukkarinen and Eronen (2009) point out that the relationship between alcohol and violence in women is equally complex as that in male drinkers, and is mediated by personality, experience and situational factors such as hostility, aggression and social norms: social background and personality characteristics contribute to violence in intoxicated women. More specifically the social background characteristics and experiences included were found in women who were marginalised, had a personality disorder, low educational levels, were unemployed with children in care and had a history of crime. They explain that alcohol contributes to violence because it adds to misunderstandings in verbal communication, and has a disinhibiting effect on behaviour.

Schumm, O'Farrell, Murphy and Fals-Stewart (2009), researching couples-based alcoholism treatment, predicted that aggression in female person with alcohol dependency would be greater than in the control sample before treatment; that it would decrease significantly in the first and second year after treatment; and that partner aggression would reduce to the level of the sample control population after treatment. Their research demonstrated that partner aggression and violence decreased after behavioural couple's therapy and that clinically significant violence dropped to a level comparable to the non-person with alcohol dependency sample while recipients of the therapy were in remission.

Timko, Moos and Moos (2009) confirm these findings in relation to male and female aggression and the link with harmful drinking. Heavy drinkers of either sex are six times more likely to be at risk of engaging in violence against an intimate

partner. Three personal characteristics, alongside harmful drinking, were highlighted in their research as playing a significant role in making violence more likely. First, high impulsivity scores meant that individuals were more likely to perpetrate physical assault; second, high self-efficacy scores, where individuals had confidence in avoiding problematic alcohol use, meant less likelihood of violence; and third, problem solving skills that involved making a plan before taking action, had better outcomes in relation to violence than avoidance coping methods that vented negative feelings, expressed wishful thinking and discharged pent-up emotions, which had poorer outcomes. Timko, Moos and Moos (2009) record that in both men and women less efficacy and problem solving coping skills, were related to more frequent trouble with the police due to drinking; whereas impulsivity and emotional discharge coping were more closely associated with assault and violent behaviour.

Using a self and partner report approach, the sample population was asked questions about the occurrence of violence and abuse in their experience. Table 8.9 contains the frequency of responses to statements used to glean information about violence, in the lives of the sample population. In the questionnaire statements about physical abuse as an adult, and about being a victim of violence, were designed to capture those respondents who felt that they had been subject to such behaviour. Reference to emotional abuse as an adult was made in order to include negative experiences that did not constitute a physical threat. The question about being a perpetrator of violence was designed to gather information about those who admitted they had been violent towards others. Finally, a question about accepting responsibility for

past behaviour was included so as to have a measure of the inner reflections of

individuals who had completed the questionnaire.

Table 8.9 Violence

	yes	?	no
	%	%	%
I need pastoral support with			
Physical abuse as an adult	12	4	84
Emotional abuse as an adult	25	5	70
Perpetrator of violence	22	4	73
Victim of violence	26	4	70
Accepting what I have done	76	3	21

This table demonstrates that a small percentage of respondents declared they had

suffered physical abuse as an adult (12%), whereas more than twice this number

declared they had suffered emotional abuse as an adult (25%). A higher percentage

again declared they had been the victim of violence (26%). This raises a question

about how respondents differentiated between being a victim of physical abuse and

of violence, and further investigation would be necessary for this distinction to

become clear. Table 8.9 also demonstrates that almost a quarter of the sample

population (22%) admitted that they had been the perpetrator of violence towards

others. Alternatively, it is worth noting that high percentages of respondents (70%

or more) were neither victims nor perpetrators of physical or emotional abuse or

violence. Furthermore, the high percentage of respondents (76%) who declared they

needed help with coming to terms with what they had done, may be referring to

issues other than being victims or perpetrators of abuse or violence.

Discussion

Three questions pertinent to the context of pastoral care emerge from these results.

First, is there a link between being a victim and a perpetrator: were those who

admitted to being perpetrators of violence also victims of physical and emotional

abuse and of violence? Second, is there a link between those who admitted being

perpetrators of violence and those who requested help in accepting what they had

done? Third, is there a sex and/or age bias in these issues? Table 8.10 contains the

results of a cross-tabulation aimed at testing for associations between those who had

been perpetrators of violence and those who had experienced violence or physical

abuse.

Table 8.10 Perpetrator of violence and being a victim

	perpetrator			
	yes	no	χ^2	$p<$
	%	%		
I need pastoral support with				
Physical abuse as an adult	44	8	28.34	.001
Emotional abuse as an adult	59	29	12.34	.001
Victim of violence	59	15	31.28	.001

This table demonstrates that there is a very strong statistical link between those who

declared they were perpetrators of violence, and those who had experienced physical

and emotional abuse as an adult and were victims of violence. Table 8.11 illustrates

that 91% of respondents who said they were a perpetrator of violence, also said they

needed pastoral support with accepting what they had done, a statistically significant

percentage (.05).

Table 8.11 Perpetrator of violence

	perpetrator			
	yes	no	χ^2	$p<$
	%	%		
I need pastoral support with				
Accepting what I have done	91	74	5.30	.05

Profile pattern: sex

Table 8.12 contains cross-tabulations aimed at testing for associations between sex

213

and violence.

Table 8.12 Violence: sex

	male %	female %	χ^2	*p<*
I need pastoral support with				
Physical abuse as a adult	13	24	2.93	NS
Emotional abuse as a adult	29	54	9.94	.01
Perpetrator of violence	23	17	0.60	NS
Victim of violence	24	28	0.41	NS
Accepting what I have done	83	61	9.72	.01

Table 8.12 demonstrates that sex bias is statistically significant with regard to two issues; significantly more women than men declared they had experienced emotional abuse, and significantly more men than women declared they needed help in accepting what they had done.

Profile pattern: age

Table 8.13 contains a cross-tabulation aimed at testing for associations between age differences and violence. This table demonstrates that age is statistically significant in relation to two issues. Significantly more people under 40 years of age declared they had been perpetrators of violence; and significantly more people over 40 years of age declared they had been the victim of violence.

Table 8.13 Violence: age

	under 40 years %	over 40 years %	χ^2	*p<*
I need pastoral support with				
Physical abuse as a adult	18	10	2.50	NS
Emotional abuse as a adult	33	22	2.48	NS
Perpetrator of violence	30	18	3.82	.05
Victim of violence	44	56	3.82	.05
Accepting what I have done	81	74	1.47	NS

Discussion

The importance for these results is in the implications they have for carers. In a pastoral care context these results highlight the need to consider the inner moral status of the one presenting for help with a view to helping him or her resolve negative self-worth.

First, the question of violence is a complicated one. Those who admitted they had been the perpetrators of violence were highly likely to have been the victims of physical and emotional abuse and of violence themselves. Coming to terms with such experiences, therefore, requires a carer's sensitivity in helping clients resolve the past from a victim's perspective. Based on the fact that a very high percentage of perpetrators (91%) expressed the need for help in accepting what they had done, carers must also help such clients to resolve guilt from a perpetrator's perspective.

Second, statistically it is as likely that women were perpetrators of violence as men, to have been the victim of violence and to have experienced physical abuse as an adult. However, statistically, women are more likely than men to have experienced emotional abuse as an adult, and men are more likely than women to need help coming to terms with what they have done in the past.

Antisocial behaviour

The relationship between alcohol use and antisocial behaviour, as in the case of violence, is not simple either. Young, Sweeting and West (2008) proposed three hypotheses to explain the relationship. First, alcohol may cause or facilitate antisocial behaviour, in the longer term resulting in neurological impairment within

individuals. Second, individuals may already be antisocial and their use of alcohol is an expression of that condition. Therefore, poor control by parents, aggression in childhood and inability to control behaviour, are genetically caused, and are not social factors, alcohol use being an expression of such a condition. Third, the relationship may be a combination of both of these factors, what Young, Sweeting and West (2008) call 'feed-back loop,' where genetics and social factors fuel each other. In the longer term, individual factors such as impulsivity, sensation-seeking and aggressive personality traits, interact with alcohol so increasing deregulation and problems with judgement, leading to further and worsening alcohol use and antisocial behaviour. In general, Young, Sweeting and West (2008) demonstrated that antisocial behaviour was a causal or predisposing factor to alcohol misuse. The exceptions to this general finding reflected sex differences, social class and drinking context. Wanner, Vitaro, Carbonneau and Trembly (2009) propose that gambling, substance use, theft and violence (delinquency) have causal antecedents that include behavioural disinhibiting (a personality trait), parental supervision (a social factor) and deviant peers, a proposal that echoes the conclusions drawn by Young, Sweeting and West (2008).

In this research three questions were included in the questionnaire to gather information about antisocial behaviour. These questions were couched in the language of criminality and reflected a progression from being arrested, to being convicted and finally serving a prison sentence. It was decided not to use the term 'antisocial behaviour' because respondents might have their own perception of what such a term entails. Rather, unambiguous factual information was sought and table 8.14 contains a summary of the frequency of responses.

Table 8.14 Antisocial behaviour

	yes %	no %
How has drinking affected your social behaviour?		
I have been arrested for an alcohol related offence	59	41
I have been convicted of a crime related to harmful drinking	53	48
I have served a prison sentence for alcohol related offence	17	83
I have been ashamed of my drunken behaviour in public	85	15

These results demonstrate two key points and raise a further question. First, over half the respondents (59%) admitted that their behaviour had been antisocial and that they had been arrested and convicted of such behaviour. Second, a high percentage of respondents (85%) admitted to being ashamed of their social behaviour. These results raise the further question of whether there is a sex and/or age bias in the figures: are these figures equally true for men and women, and for those under and over 40 years of age?

Profile pattern: sex

Table 8.15 contains the results of a cross-tabulation aimed at testing for associations between sex differences and antisocial behaviour. The table shows that significantly more men than women have been antisocial in their behaviour, arrested, convicted and sentenced to a custodial term in prison.

Table 8.15 Antisocial behaviour: sex

	male %	female %	χ^2	$p<$
How has your drinking affected your social behaviour?				
I have been arrested for an alcohol related offence	67	38	14.19	.001
I have been convicted of a crime related to harmful drinking	61	31	14.30	.001
I have served a prison sentence for alcohol related offence	21	4	9.11	.001
I have been ashamed of my drunken behaviour in public	84	86	0.07	NS

Profile pattern: age

Table 8.16 contains the results of a cross-tabulation aimed at testing for associations

between age differences and antisocial behaviour.

Table 8.16 Antisocial behaviour: age

	under 40 years %	over 40 years %	χ^2	*p<*
How has your drinking affected your social behaviour?				
I have been arrested for an alcohol related offence	67	56	2.21	NS
I have been convicted of a crime related to harmful drinking	58	50	1.17	NS
I have served a prison sentence for alcohol related offence	22	14	2.00	NS
I have been ashamed of my drunken behaviour in public	88	82	1.27	NS

The table shows that, statistically, there are no significant differences in antisocial

behaviour that are age specific.

Discussion

If the findings of researchers such as Young, Sweeting and West (2008) and

Wanner, Vitaro, Carbonneau and Trembly (2009) are accepted, the findings in this

current dissertation are important from a pastoral caring point of view. For example,

with over half the sample admitting to antisocial behaviour, the implication is that

this represents a causal predisposition to misuse alcohol, a predisposition that has its

roots in a disinhibiting personality trait, and which has a psychosocial element

represented by lack of parental control. Carers, therefore, may wish to address the

factors that seem to predispose individuals to harmful drinking, factors that

constitute the inner life context in which their sobriety has to be lived out.

Main findings

It was found that over a quarter of the sample population (27%) were single, of

which there were twice as many males as females, whereas 42% were currently in a relationship. Significantly more males than females agreed that their drinking had contributed to the break-up of a former relationship, whereas significantly more people over 40 years of age agreed that drinking had had a negative effect on a marriage/partnership.

High percentages (86% or more) of the sample agreed that drinking had caused their family embarrassment and that their drinking made their family life unhappy, and over two-thirds of the sample accepted that their family believed the drinker no longer cared about them, and significantly more males than females agreed with this statement. Furthermore, significantly more males than females also stated that their drinking caused their family financial hardship. Significantly more people over 40 years of age agreed that their drinking had spoilt their relationship with the children.

A quarter of the sample declared they had experienced emotional abuse as an adult and had been victims of violence, and over three quarters declared they needed pastoral help to accept what they had done in the past. Significantly more people who declared they had been perpetrators of violence said they need help to accept what they done; they also said they need help because they had experienced physical and emotional abuse as adults and had been victims of violence. Significantly more females than males had experienced emotional abuse as adults and significantly more males than females said they needed help with accepting what they had done. Significantly more people under 40 years of age declared they were perpetrators of violence, and significantly more people over 40 years of age said they were victims of violence.

Over half the sample population declared they had been arrested for an alcohol related offence, and, subsequently had been convicted of a crime related to alcohol. A high percentage (over 80%) of the sample population declared they had been ashamed of their drunken behaviour in public. Significantly more men than women had been arrested, convicted and given a custodial sentence for alcohol related crimes.

Conclusion

This chapter aimed at exploring the secondary consequences of an alcohol dependency problem. Secondary consequences are understood to be external relational circumstances and internal moral considerations. The purpose was to uncover issues that a person with alcohol dependency may have to contend with in their recovery process, if it is to be long lasting and rewarding.

The key question underpinning this dissertation is, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' In this chapter carers need to be aware that male and female respondents display specific issues that they may find helpful to consider. For example, female respondents were more likely to have experienced emotional abuse than male respondents, whereas male respondents were more likely to be relationally detached and experience isolation as a result of the breakup of previous relationships. Males are more likely to have to come to terms with negative emotions such as guilt and failure as a parent. Both male and female respondents recorded their feeling of shame when considering their drunken behaviour in public and male respondents

declared their need of pastoral support in coming to terms with being perpetrators of violence. Further consideration of the implications of having been guilty of antisocial behaviour raises two associated issues that pastoral carers may find important, namely personality traits, such as disinhibiting behaviour elements, and psychosocial considerations such as parental control.

Finally, much has been said here about the emotional hurdles harmful drinking may have to contend with as a result of broken family relationships and social delinquency. Some recovery practitioners, however, have sought to include the family in the process of helping an individual find sobriety. Fernandez, Begley and Marlatt (2006) provide a helpful summary of family intervention approaches and two such approaches are worthy of mention.

This chapter concludes phase two in the development of this dissertation, a phase which has concentrated on the consequences of harmful drinking. Having explored some broader issues that relate to the consequences of an alcohol dependency problem, two issues have been raised in this chapter that warrant further investigation. These issues relate to potential causal factors underlying alcohol dependency problems. One concerns the influence of growing up in a family where harmful drinking was prevalent; and the second concerns the more specific question of the perceived bond an individual drinker may have had with his or her mother and/or father. These become the topics for the following two chapters.

Chapter Nine

Family background and alcohol dependency

Chapter outline

Introduction

Theoretical background

The influence of alcohol

Familial density and harmful drinking

      Profile pattern: sex

      Profile pattern: age

Familial harmful drinking and drinking motives

Familial harmful drinking and children

Familial harmful drinking and adolescents

Main findings

Conclusion

Introduction

The previous chapter drew to a close the second phase in the development of this

dissertation. It raised two issues that warrant further investigation, issues that mark

the beginning of phase three of the dissertation. First, the chapter highlighted how a

drinker's relationship with his or her children can be spoilt by parental drinking

behaviour; and second, it highlighted how the bonding process between a parental

drinker and child can be weakened or hindered. Phase three of this dissertation

begins with two chapters that investigate these psychosocial perspectives as they

relate to people with an alcohol dependency problem. In this context a psychosocial

perspective refers to family background and to the perceived bonding with parents,

as reported by individual drinkers. It is assumed that psychosocial factors such as

these play an important part in shaping individual differences through childhood

experiences, personal and social values, behaviour patterns, coping mechanisms and

personality. It is proposed that an understanding of such experiences will prove helpful to people engaged in pastoral care of people with an alcohol dependency problem. To this end, this chapter addresses the general topic of the importance of family background in shaping individuals who have developed a problem with alcohol. The following chapter explores the bond such individuals reported having with their parents. In each chapter, a review of literature pertinent to the topic will parallel a description of the research findings.

This chapter begins with a review of the theoretical background to an alcohol dependency problem within the families of those who have recognised their own alcohol problem. The chapter proceeds by establishing whether or not alcohol use, in the family background of the sample, had a positive or negative influence. The extent of familial harmful drinking is explored by investigating how many relatives had a drinking problem, and familial density of harmful drinking is explored in relation to sex and age differences within the sample population.

The influence of such factors on the drinking behaviour of the sample population is then explored in two ways. First, did harmful drinking in families influence the drinking motives of the sample population: second, does harmful drinking in families influence children in a different way from adolescents? At the end of each section there is a discussion of the implications of the findings for carers offering support to people trying to stop drinking. A summary of the main findings of the chapter precedes the conclusion. In the conclusion, factors that relate to the key question underpinning this dissertation, 'what does a carer need to consider when he

or she is asked to help a person who has an alcohol dependency problem?' are outlined.

Theoretical background

The subject matter of this chapter is family history of harmful drinking within a sample population of people who have recognised their own alcohol dependency problem. Drawing observations related to pastoral care of such a population, requires recognition of their perception of such things, and so a self report methodology best facilitates the gathering of appropriate information.

Benet and Wolin (1990) accepted earlier suggestions (Gomberg and Lisansky, 1984) that people were led into problem drinking by events that occur in certain combinations and sequences, and they endeavoured to establish what such combinations and sequences were. They describe the combinations and sequences occurring within family culture, by which they mean family patterns of behaviour, belief systems and language, thought, action and materials. Family rituals were considered symbolic forms of communication that contribute to a family's collective sense of itself, and include mealtimes, holidays, evenings, weekends and visitors. The presence of a person with alcohol dependency within this context mean rituals may become subsumable; they are absorbed into, and are changed by, person with alcohol dependency behaviour. As a result, for example, meals deteriorate because of negative experiences, as do family holiday times such as Christmas, which become haphazard and disorganised. It was observed that where rituals were subsumable, and not distinct (i.e. routines were disrupted by the behaviour of a

person with alcohol dependency), there was a greater incidence of intergenerational continuity of an alcohol dependency problem.

The experience of parental drinking in the family history of people with an alcohol dependency problem, suggests there are mechanisms that operate on children, and their use of alcohol in later life. Capone and Wood (2008) demonstrated the importance of considering familial density of alcohol problems, not just parental drinking but also that of other members of the family. They demonstrated that higher levels of familial history, where there was more than one family member who abused alcohol, were associated with increased alcohol problems in children who grew up in such an environment. This association was mediated by three risk factors, age at onset of drinking, behavioural under control, for example, impulsivity, aggression and extraversion, and current cigarette use. However, this raises questions pertinent to the current research, for example, do sex and age differences constitute risk factors that mediate between family history of harmful drinking and individual an alcohol dependency problem?

The combinations and sequences of family events, and the mechanisms that operate within families, both in immediate and wider family circles, all contribute to increase the risk of alcohol dependency problems in later life. Kestilä, Martelin, Rahkonen, Joutsenniemi, Pirkola, Poikolainen and Koskinen (2008) concluded that the childhood circumstances found to be associated with unhealthy alcohol use in adulthood included parental divorce, poor family functioning, high family economy, parental mental health problems and parental harmful drinking. This suggests that there is a transition between family experiences and upbringing, and the

development of an alcohol dependency problem; but what exactly is this transition? In light of the motivational model discussed in chapter six, perhaps this transition is facilitated by the emergence of specific drinking expectancies and motives in the children of person with alcohol dependencies that lead them on into alcohol problems.

Beseler, Aharonovich, Keyes and Hasin (2008) researched links between family history of harmful drinking and drinking motives. They began by clarifying the differences between drinking expectancies and drinking motives. Expectancies precede drinking and remain constant; they are largely developed through the observation of the effects alcohol has upon others. For a person growing up in a family influenced by harmful drinking, drinking expectancies that relate to problem solving or celebration may develop. Motives, however, may change during drinking, and between one age group and another, and are directly linked to alcohol dependency problems. Beseler, Aharonovich, Keyes and Hasin's (2008) research demonstrated that family history moderated the effects of two drinking motives, namely, drinking to reduce negative emotions and drinking to facilitate social interaction. Those with a family history of an alcohol dependency problem had above average scores for drinking to facilitate social interaction and to reduce negative emotions and they had a four-fold increased risk for early onset of an alcohol dependency problem. Adults with a family history of alcoholism and high scores on the 'reason for drinking scale' were more likely to develop an alcohol dependency problem and this was especially true for those who drank to cope with negative emotions.

Discussion

Five topics related to family history and alcohol dependency problems, specifically relevant to this research project, emerge from these discussions. First, the self report methodology means that the sample population have been able to present their perceptions of their family background in relation to harmful drinking. What is of interest here is whether or not these perceptions are positive or negative towards alcohol: do drinkers perceive alcohol as having a positive or negative influence on their family life? This perception indicates prevailing opinion in the mind of the drinker and helps a carer understand the individual drinker more accurately.

Second, having the freedom to identify more than one member of the family as having been an abuser of alcohol, means that the sample population was able to indicate the density of harmful drinking within his or her family. Assuming the observations of Capone and Wood (2008) are correct, if the sample population identified more than one member of their family as having been an abuser of alcohol, carers may look to the mediating factors that are associated with familial density of harmful drinking, for example, early onset, impulsivity and aggression.

Third, are there sample profiles and patterns to the influence of familial harmful drinking has had, that are reflected in the sex and age of respondents? Carers, in their endeavours to understand those who come for help with an alcohol problem, can observe sex and age as two of the fundamental individual differences in people with an alcohol dependency problem.

Fourth, does having a family history of harmful drinking influence drinking motives? This question explores the transition between family experiences and upbringing, and the emergence of specific drinking expectancies and motives within a drinking population, thus enabling carers to appreciate the underlying psychological processes that facilitate drinking behaviour.

Fifth, does family history of harmful drinking impact children differently from teenagers? This question further helps carers understand the relationship dynamics as they vary according to the age of the child or young person.

The influence of alcohol

How did the problem drinkers in the research population perceive the influence alcohol had upon their family and home as they grew up? This question was asked in a way that focused attention on the substance, rather than a person responsible for either positive or negative influences. In this way the relationship between the drinker and his or her parents, and whether or not they were harmful drinkers, could be addressed in a following chapter.

Table 9.1 contains the frequency of responses to two statements about the influence of alcohol on home and family life. It is recognised that alcohol used in an appropriate way may make a positive contribution to family life, and so respondents were asked if this were the case. Subsequently they were asked if alcohol had had a negative influence on home and family. They reflected on these questions according to age groups that allow for more specific discussions related to the transition of growing up from childhood, through adolescence, into young adulthood.

Table 9.1 Influence of alcohol on family and home

	yes %	no %
Alcohol had a POSITIVE influence on home and family		
5 to 7 years	12	88
8 to 10 years	12	88
11 to 13 years	13	87
14 to 16 years	16	85
17 years and over	16	84
Alcohol had a NEGATIVE influence on home and family		
5 to 7 years	35	65
8 to 10 years	44	56
11 to 13 years	49	51
14 to 16 years	57	44
17 years and over	57	44

Discussion

The responses to the statement about alcohol having a positive influence are

unambiguous. In the childhood years (5 to 10 years of age) 88% of respondents

denied that alcohol had had a positive influence on home and family. In the years

that correspond to adolescence (11 to 16 years of age) the perception changed

slightly with an increase in numbers of those who saw a positive influence from

alcohol, from 12% to 16%. Nevertheless, the overall numbers of those who saw a

positive influence from alcohol were low in all age groups. Possibly the increase in

numbers who recognised a positive influence represents an increase in the awareness

of the respondents as they matured from 5 years old to adolescents in their late teens.

Alternatively, the reality of their childhood and adolescent years may be coloured by

their current negative experience of alcohol, and their retrospective viewpoint

representative of subjective bias.

The responses to the statement about alcohol having a negative influence are also

unambiguous. In reflecting back to their early childhood (5 to 7 years of age) almost

three times the number of respondents declared that alcohol had had a negative influence, compared to those who declared it had had a positive influence. For those in later childhood (8 to 10 years of age) almost four times the number remembered alcohol having a negative influence. In other words, almost a third of the sample population, who now declare they have a problem with alcohol remember their early childhood years being influenced negatively by harmful drinking. This ratio rises to over one third (44%) of those who recall alcohol's influence, when they were still in primary education, 8 to 10 years old. By adolescent years (11 to 16 years of age) the ratio changed again from slightly under to well over half the sample population who declared a negative influence of alcohol upon home and family. Again, the increase in the number declaring a negative influence, may represent a growing awareness of the relational dynamics within the family, and the influence alcohol had upon them. Alternatively, it could be that as the respondents began drinking themselves during adolescent years that their perception of home and family was coloured by their own experience. In both positive and negative cases numbers remained constant between adolescence and young adulthood, perhaps inferring that perceptions had been formed by then and were fixed.

Familial density of harmful drinking

Do the respondents have more than one family member who abused alcohol? Table 9.2 contains the frequency of responses related to harmful drinking in the lives of relatives of the respondents.

Table 9.2 Family history and density of harmful drinking

	yes %	no %
Was harmful drinking a feature of the lives of your family?		
Grandfather	29	72
Grandmother	8	92
Father	53	47
Mother	23	77
Brother	30	70
Sister	19	81
Significant other	30	70

The positive responses to this question demonstrate that over half the respondents (53%) had a father or step father who abused alcohol. Just under one quarter (23%) had a mother or step mother who abused alcohol, and just under one third had a grandfather, a brother or a significant other relative with a harmful drinking problem. Only 8% reported having a grandmother who abused alcohol.

Cross-tabulations relating to those respondents who had more than one relative who abused alcohol were carried out. In the first instance, the family history of those who had a father who abused alcohol was revisited, to indentify other relatives with the same problem, and subsequently those who had a mother who abused alcohol was revisited. The results of these investigations are recorded in table 9.3 and table 9.4 respectively. Table 9.3 shows that well over one third of respondents (41%) who had a father who abused alcohol, also had a brother with the same problem, and almost one third (35%) had a mother who abused alcohol. The table demonstrates that, for the respondents who declared that their father abused alcohol, there was a strong statistical link with also having mothers, brothers and sisters who abused alcohol.

Table 9.3 Father and one other relative

	father yes %	father no %	χ^2	$p<$
Grandfather(s)	33	23	2.16	NS
Grandmother(s)	7	4	0.43	NS
Mother	35	11	12.25	.001
Brother	41	20	8.11	.01
Sister	32	4	19.27	.001
Significant other	33	31	0.07	NS

Table 9.4 shows that almost half of respondents (45%) who had a mother who abused alcohol had a brother with the same problem, and well over one third (40%) had a sister who abused alcohol.

Table 9.4 Mother and one other relative

	mother yes %	mother no %	χ^2	$p<$
Grandfather(s)	30	28	0.07	NS
Grandmother(s)	8	5	0.38	NS
Brother	45	27	4.5	.05
Sister	40	13	13.74	.001
Significant other	35	31	0.21	NS

The table demonstrates a strong statistical link between harmful drinking in the mothers, brothers and sisters of respondents.

Discussion

These results imply that there is a stronger association between male members within a family, for example, three of the highest scores for relatives who abused alcohol were reported for fathers, brothers and grandfathers, although almost one-third also identified a significant other relative that was not sex specific. Furthermore, within the sample population, those who had fathers or mothers with alcohol problems were more likely to have other members of their immediate family

displaying similar behaviour patterns. This suggests that, in pastoral terms, there

may be multiple psychosocial concerns that individual drinkers have to address, all

of which carry the potential for unhappiness if not resolved appropriately.

Profile pattern: sex

 Do sex and age differences reflect profile patterns in those who have a family

background in an alcohol dependency problem? Table 9.5 contains a summary of

the first of these explorations.

Table 9.5 Family history: sex

	male %	female %	χ^2	$p<$
Was harmful drinking a feature of the lives of members of your family?				
Grandfather(s)	30	23	0.76	NS
Grandmother(s)	5	7	0.23	NS
Father	56	58	0.09	NS
Mother	29	37	4.93	.05
Brother	30	35	0.31	NS
Sister	19	21	0.05	NS
Significant other	28	44	3.92	.05

The table demonstrates that over half the male and female respondents had fathers

who abused alcohol. Paternal harmful drinking scored the highest figures in this

investigation, inferring that it may have a more obvious role in contributing to the

transition of harmful drinking from one generation to the next. It was as significant

a factor for one sex as for the other. However, significantly more female

respondents had mothers and significant other relatives who abused alcohol, which

suggests that, for a female person with an alcohol dependency problem, there may

be a significant link with the harmful drinking of individual family members other

than fathers.

Profile pattern: age

Table 9.6 contains a summary of cross-tabulations carried out to test for a profile

pattern that related to age. An observation of the results indicates that there are no

significant differences that are age related. Indeed the comparable similarities

between the percentage scores indicate that there are no profile patterns that are

discernable for those under or over 40 years of age.

Table 9.6 Family history: age

	under 40 years %	over 40 years %	χ^2	$p<$
Was harmful drinking a feature of the lives of members of your family?				
Grandfather(s)	32	29	0.14	NS
Grandmother(s)	5	6	0.08	NS
Father	63	56	0.63	NS
Mother	29	24	0.52	NS
Brother	32	32	0.00	NS
Sister	17	24	0.34	NS
Significant other	34	37	0.08	NS

Familial harmful drinking and drinking motives

Accepting the motivational model of harmful drinking, can any light be shed on the

transition from growing up in a family with harmful drinking, and the development

of drinking motives?   More specifically, is there any suggestion that having a father

or mother who abused alcohol has any influence on drinking motives? Table 9.7

contains the results of a cross-tabulation aimed at testing for associations between

those whose fathers were harmful drinkers, and motives for drinking.

One motive, 'drinking helped me overcome shyness' was shown to be statistically

significant, in that it was less likely for respondents who had fathers who were

harmful drinkers to state they drank to overcome shyness. This is an interesting finding because it suggests that children of person with alcohol dependency fathers do not drink for lack social confidence.

Table 9.7 Alcohol abusing father and drinking motives

	father yes %	father no %	χ^2	$p<$
Why did you drink alcohol?				
All my friends drink socially	73	82	1.87	NS
I felt pressurised into drinking	28	24	0.26	NS
Drinking was expected of me	43	41	0.07	NS
Drinking made me feel good	99	97	0.65	NS
I was curious about what drinking was like	73	76	0.26	NS
Drinking helped me overcome shyness	73	89	6.46	.01
I drank because I had difficulty sleeping	23	27	0.29	NS
I drank to cope with stress	66	77	2.58	NS
I drank to forget the past	66	66	0.00	NS
Drinking helped me feel better about myself	84	76	1.4	NS
Drinking helped me relate to others socially	88	89	0.03	NS
I drank because I felt rejected	52	52	0.00	NS
I drank to cope with what people did to me	55	48	0.8	NS
I drank to cope with what happened to me	62	54	1.05	NS
I drank because my mind was troubled	74	79	0.6	NS
I drank because my feelings were troubled	85	82	0.25	NS
I drank to cope with my insecurities	81	83	0.09	NS
I drank because my life was meaningless	58	54	0.36	NS

Table 9.8 contains an analysis of cross-tabulations testing for associations between motives for drinking and those respondents who declared their mother abused alcohol. Four motives emerge as having a statistically significant link with maternal harmful drinking, drinking to forget the past, to feel better about ones' self, to cope with what people did and with what happened. These four motives lie strongly in the domain of the emotions. The inferences here are, first, for those with mothers who abused alcohol, alcohol was used to cope with negative emotions. Second, they were more vulnerable to deeply impacting experiences in the past regarding either circumstances (what happened) or specific people (what people did).

Table 9.8 Alcohol abusing mother and drinking motives

	mother yes %	mother no %	χ^2	$p<$
Why did you drink alcohol?				
All my friends drink socially	75	77	0.7	NS
I felt pressurised into drinking	33	24	1.2	NS
Drinking was expected of me	50	39	1.4	NS
Drinking made me feel good	100	98	1.0	NS
I was curious about what drinking was like	75	74	0.02	NS
Drinking helped me overcome shyness	83	79	0.27	NS
I drank because I had difficulty sleeping	18	27	1.48	NS
I drank to cope with stress	78	69	1.09	NS
I drank to forget the past	78	62	3.11	.05
Drinking helped me feel better about myself	90	77	3.19	.05
Drinking helped me relate to others socially	88	89	0.03	NS
I drank because I felt rejected	63	48	2.4	NS
I drank to cope with what people did to me	65	48	3.68	.05
I drank to cope with what happened to me	70	54	3.13	.05
I drank because my mind was troubled	80	75	0.48	NS
I drank because my feelings were troubled	90	81	1.7	NS
I drank to cope with my insecurities	85	81	0.3	NS
I drank because my life was meaningless	68	53	2.77	NS

Discussion

These three elements of family history of harmful drinking highlight important
factors that relate to those in the sample population who fall into this category. For
example, there seems to be a link between parental harmful drinking and the
intergenerational transition of an alcohol dependency problem, a link that increases
when more than one parent is dependent. The transition at times seems the same for
both sexes, and yet at times displays sex specific characteristics. The transition
involves recognising the negative influence alcohol can have on families, but also
the development of specific motives that lie behind individual drinking behaviour.

The motives appear parentally specific, in that those with fathers who abused
alcohol were less likely to drink to overcome shyness, reflecting no lack of self

236

confidence in social contexts. Those with mothers who abused alcohol drank to cope with negative emotions. From a pastoral perspective, helping such people will be facilitated by a deeper understanding of the impact a family history of an alcohol dependency problem has had upon children belonging to that family. But this raises the question, does a family history of harmful drinking impact on children differently from adolescents?

Family harmful drinking and children

Brown (1988) wrote of how parental alcoholism adversely affected the family environment and the psychological well-being of person with alcohol dependency offspring. Yet he suggested that growing up in a home of a person with alcohol dependency was not a sufficient condition on its own to explain the development of psychosocial disturbances in children. Bijttebier, Goethals and Ansoms (2006) investigated the factors that mediate the relationship between alcohol problems in the family and child adjustment, exploring the contributing variables. They explain that the emotional climate created by parents has a significant impact on child outcomes, and they demonstrated that families with alcohol problems are less cohesive, less expressive, less harmonious (more conflict driven) and less supportive. They concluded that parental drinking impacted the perceived family environment in terms of cohesion, organisation and conflict and that, in turn, this environment impacted children from ten to 14 years of age, by substantiating negative emotions, anxiety and depression, and by undermining feelings of competence and self-esteem. Their research clearly demonstrated that it was not parental drinking per se that caused child maladjustment, rather family dysfunction. Because the family was less cohesive, the children of a person with alcohol

dependency had a lower sense of self-worth.

Burstein, Stanger, Kamon and Dumenci (2006) confirmed that children of substance abusing parents were at increased risk of having psychological difficulties, for example, externalising problems (problems of behaviour and conduct) were more prevalent in such children. Parents who internalise problems increase the risk of similar problems in children, because such children also exhibited internalising symptomatology when compared with a community control sample. For example, 21% presented with emotional disorders, compared to 5% of community sample, and 24% with anxiety disorders, compared to 13% of community sample. Burstein, Stanger, Kamon and Dumenci (2006) suggested several factors that may contribute to the development of psychological difficulties in the children of person with alcohol dependency, including pre-existing factors, environmental contexts, mechanisms of risk, but especially parental psychopathologies and parenting practices. They demonstrated that the children of fathers with substance dependency, and other psychopathologies such as antisocial personality disorder, had greater internalising problems (anxiety, affective disorders and depression) than children of fathers with substance dependency alone. Furthermore, parent antisocial personality disorder was not a significant predictor of child anxiety, when the effects of parental alcoholism were controlled. Crum, Storr, Ialongo and Anthony (2008) demonstrated that higher levels of depression in children were associated with the risk of early onset of drinking without parental permission, and that this finding was particularly true for boys.

Burstein, Stanger, Kamon and Dumenci (2006) and Tildesley and Andrews (2008)

explored the importance of parenting practices on the early onset of drinking behaviour. Burstein, Stanger, Kamon and Dumenci (2006) demonstrated that poor parenting practices, such as poor monitoring and inconsistent discipline, mediated between parental internalising problems and child affective problems, although not anxiety problems, and predicted internalising problems among adolescents. Their research demonstrated a link between the sex of the parent and internalising problems; female substance abusing parents reporting higher levels of internalising problems than males. Tildesley and Andrews (2008) showed that increased parental monitoring and good discipline reduced adolescent alcohol use, and that positive parenting (communication, nurturance and support) proved to be a protective factor towards initiating alcohol use. They demonstrated that when parents abuse alcohol, parental monitoring of their children, good discipline and positive parenting characteristics are absent, and this predicts higher levels of intention to use alcohol in their children.

Discussion

Two elements of the impact of a family history of alcoholism on children, specifically relevant to this research project, emerge from these discussions. First, is there evidence to suggest an association between parental harmful drinking and psychological difficulties, mental health issues (such as depression) and anxiety issues (such as fears and phobias)?

Table 9.9 contains the frequency of responses from the sample population in relation to broad issues that represent internalising psychological symptomatologies.

Table 9.9 Internalised psychological symptomatologies

	yes %	? %	no %
I need pastoral support with			
Psychological difficulties	24	8	68
Mental illness	17	6	77
Fears and phobias	42	6	53

Almost one quarter of the sample (24%) declared they needed pastoral support for

what they understood as psychological difficulties. Only 17% declared a need for

support with a mental illness and well over one third (42%) identified fears and

phobias as an issue with which they needed help.

In the context of this chapter are there associations between these declarations and

having either a father or mother who abused alcohol? Table 9.10 contains the results

of a cross-tabulation testing for associations between having an alcohol abusing

father and experiencing internalised psychological symptomatologies. These results

do not indicate any statistically significant association between having an alcohol

abusing father and having internalised psychological issues. Perhaps these findings

are in keeping with the observations of Brown (1988) who suggested

Table 9.10 Alcohol abusing father and psychological difficulties

	father yes %	father no %	χ^2	$p<$
I need pastoral support with				
Psychological difficulties	23	27	0.41	NS
Mental illness	17	20	0.27	NS
Fears and phobias	46	35	2.23	NS

that it was not parental harmful drinking per se that created psychological

difficulties in children, but the home and family environment when it proves

dysfunctional.   If this is so, the implication here must be that, although respondents

identified that their father abused alcohol, their homes were not dysfunctional. Furthermore, Burstein, Stanger, Kamon and Dumenci (2006) alluded to the emotional climate within a home and family as being more influential on the psychological well being of children. Perhaps then a statistical association may be found between psychosocial difficulties in children and having an alcohol abusing mother.

Table 9.11 repeats the cross-tabulation testing for an association between having an alcohol abusing mother and experiencing internalised psychological symptomatologies.

Table 9.11 Alcohol abusing mother and psychological difficulties

	mother yes %	mother no %	χ^2	$p<$
I need pastoral support with				
Psychological difficulties	33	22	1.74	NS
Mental illness	25	16	1.78	NS
Fears and phobias	60	36	7.4	.01

Although no statistical significance was found linking maternal alcohol dependency problems with psychological issues and mental health issues, a strong association was found with fears and phobias. This is partly in keeping with the conclusions drawn by Beseler, Aharonovich, Keyes and Hasin's (2008), who saw an association between family history of harmful drinking and negative emotions, of which fears and phobias are examples. The inference here is that maternal harmful drinking has a more direct influence on the well being of family and home, and, as a result, on the psychological well being of the children growing up there.

Secondly, parental harmful drinking has an influence on the way children are treated in their childhood years. Table 9.12 demonstrates clear association between having a father who abused alcohol, and the experience of physical and emotional abuse.

Table 9.12 Paternal alcoholism and childhood abuse

	father yes %	father no %	χ^2	$p<$
I need pastoral support with				
Physical abuse as a child	22	11	2.97	.05
Emotional abuse as a child	52	21	18.36	.001

Table 9.13 demonstrates clear association between having a mother who abused alcohol, and the experience of emotional abuse.

Table 9.13 Maternal alcoholism and childhood abuse

	mother yes %	mother no %	χ^2	$p<$
I need pastoral support with				
Physical abuse as a child	24	15	1.61	NS
Emotional abuse as a child	66	29	17.07	.001

Shin, Edwards and Heeren (2009) considered maltreatment such as this, as a robust risk factor in adolescent binge drinking, although they were careful to point out that one type of maltreatment did not demonstrate such an association. Furthermore, this concurs with Griffin, Scheier, Botvin and Diaz (2001) who suggested that psychological well being was a mediating role facilitating adolescent substance abuse. The mediating principle that is particularly pertinent to this research is the link that exists between childhood maltreatment, the absence of psychological well being and drinking motives, which all play their part contributing to an alcohol dependency problem and the associated behaviours.

Family harmful drinking and adolescents

Chassin, Pillow, Curran, Molina and Barrera (1993) proposed that parental harmful drinking influenced adolescent substance users through stress and negative emotional pathways, through decreased parental monitoring and through increased temperamental emotionality and its association with personality. Negative emotions and decreased monitoring were also associated with adolescents having a peer network that supported substance use. Their research demonstrated that father's monitoring was statistically significant in these circumstances and that maternal monitoring was only marginally significant. Furthermore, parental alcoholism was associated with increased negative uncontrollable life events which, in turn, were associated with negative emotions and with links to substance using peers. These mechanisms were seen to operate over and above other factors, such as temperament and parenting variables. They concluded that substance use in adolescents was stress related, and was a coping mechanism to manage negative emotions. However, as stated above, alcoholism in parents is, by itself, not an adequate explanation for substance use in adolescents. Barnow, Ulrich, Grabe, Freyberger and Spitzer (2007) concluded that teenage children of person with alcohol dependency had higher levels of delinquency, aggression and attention problems only when their parental alcohol problems were exacerbated by antisocial personality disorder in the family history.

Barnes (1990) gives a helpful summary of the theoretical basis for the observations such as the ones referred to above. She makes reference to earlier work (Parsons, 1955 a and b) that proposed family socialisation being responsible for the formation of personality that could tend towards harmful drinking. In this sense, personality is made, not born, in a person. The process of socialisation takes place during

childhood when the child internalises the cultural system expressed in the family. This internalisation represents the child's ability to fulfil roles, or to survive, and the process facilitates the maintenance of social order. Socialisation mediates between the individual and his or her culture, from the psychological and biological to the socio-demographic and structural.

Alternatively, family background and adolescent drinking may be explained using problem behaviour theory. Drinking behaviour is learned in the context of the larger cultural setting, derives from particular experiences and reflects psychosocial influences such as personality, perceived environment and behaviour. For some individuals, psychosocial influences are prone to problems. For example, personality can be prone to problems, as seen in low value being placed on academic achievement, high value on independence, tolerance to deviance and less religiosity. Perceived environment is prone to problems, as seen in low compatibility with parental expectations, greater influences from friends not parents, friends' approval of problem behaviour and friends' models for problem behaviour. Finally, behaviour is prone to problems when it involves other prone behaviours such as delinquency. Developmental theory endeavours to explain adolescent drinking by targeting the influences that promote drinking behaviour. Influences include socio-cultural and community, primary and secondary groups (parents and peers) and intra-individual influences such as temperament, genetics, attitudes and beliefs.

Chassin, Rogosch and Barrera (1991) demonstrated that parental alcoholism's prediction of alcohol use in children could reflect social learning theory and mechanisms, whereby children imitated their parent's drinking and had more

opportunities to sample alcohol. Or, it could be that children of people with alcohol dependency are more prone to experience negative mood states, higher emotional arousal and less sooth-ability, and that alcohol use is, therefore, self medication for negative emotions. This links to their observation that parental alcoholism was associated with general parental impairment and poor role functioning, to the extent that it impaired the quality of the family environment and the stability of the child's life.

Elements such as general parental impairment and poor role functioning were explored in more detail by Shin, Edwards and Heeren (2009) as they considered childhood maltreatment as a robust risk factor for adolescent binge drinking. Their investigation showed that the traditional method of classifying maltreatment by enquiring about an individual's experience of one type of maltreatment, did not demonstrate an association with adolescent binge drinking. However, childhood maltreatment was strongly associated with adolescent binge drinking when co-occurrence of multiple categories of maltreatment was included. Their studies found greater developmental difficulties (including emotional and behavioural problems), lowered social competencies and lowered self esteem as the number of maltreatment types increased.

Psychological well being was the factor investigated by Griffin, Scheier, Botvin and Diaz (2001) and in particular the mediating role it had in adolescent substance use. Their research targeted personal competence skills in adolescents, and built upon previous investigations by Caplan (1980) and by Caplan, Weissberg, Grober, Sivo, Grady and Jacoby (1992). Competence refers to learned attitudes and aptitudes,

manifested as capacities for confronting, actively struggling with and mastering life problems, through the use of cognitive and social skills. Social and personal competence skills, refer to broad based interpersonal skills and cognitive and behavioural self management strategies, such as self-regulation and self control, respectively, and echo the references above to drinking motives relating to shyness and dealing with negative emotions.

Griffin, Scheier, Botvin and Diaz (2001) demonstrated that competence skills required the mediating role of psychological well-being and that personal competence skills were a precursor to positive outcomes through promoting feelings of satisfaction and well-being. Good competence skills protected youth by enhancing well-being, and this in turn predicted less substance use. However, adolescent development involves facing a variety of new challenges, developmental tasks, physical and biological changes, and growth in emotional, cognitive and social functioning, and doing so with a lack of or low levels of competence means failure to meet them. Repeated experiences of failure among poorly competent youth leads to low self esteem, decreased task persistence and feelings of hopelessness and distress, and adolescents with such feelings use substances to regulate their negative emotions.

Discussion

The key element emerging from the impact of a family history of alcoholism on adolescents relates to parental alcoholism and its influences. This is important for two reasons; first, because parental alcoholism has an association with early onset of

adolescent drinking. Table 9.14 demonstrates a positive statistical association

between having a father who abused alcohol and early onset of alcohol drinking.

Table 9.14 Paternal alcoholism and age at onset

	father yes %	father no %	χ^2	$p<$
I began drinking before the age of 15	60	48	2.97	.05

Second, table 9.15 demonstrates a positive association between having a mother who

was not a person with an alcohol dependency problem and early onset of drinking.

Table 9.15 Maternal alcoholism and age at onset

	mother yes %	mother no %	χ^2	$p<$
I began drinking before the age of 15	30	74	3.24	.05

These figures suggest that an adolescent with a father with alcohol dependency is

more likely to commence drinking before the age of 15, whereas an adolescent who

has a mother who is a person with alcohol dependency is more likely to commence

drinking after the age of 15 years.

Main findings

First, the sample population predominantly (84% or more) denied that alcohol had

had a positive influence upon home life between five and 17 years of age. The

sample population were less emphatic (between 35 and 57%) about declaring that

alcohol had had a negative effect on home life between the same ages. This implies

that there were those in the sample population who would have considered that alcohol had had neither a positive or negative influence on home and family.

Second, over half the sample (53%) declared that their father had abused alcohol, and almost one-third declared that their brother (30%), significant other (30%) and grandfather (29%) abused alcohol. Almost one quarter (23%) declared that their mother abused alcohol.

Third, females with alcohol dependency problems were more likely to have mothers and significant others who abused alcohol than males with alcohol dependency problems.

Fourth, there was a statistically significant negative association between having a father that abused alcohol and drinking to overcome shyness; significantly more respondents declared they did not drink to overcome shyness. Alternatively, significantly more respondents who accepted that their mother abused alcohol, declared they drank to forget the past, because drinking helped them feel better about themselves, to cope with what people did and to cope with what happened in the past.

Fifth, respondents whose mother's abused alcohol were almost twice as likely, than those whose mother's did not abuse alcohol, to need pastoral support with fears and phobias.

Sixth, respondents who declared their father abused alcohol were significantly more likely to need pastoral support for physical and emotional abuse as a child. Furthermore, they were significantly more likely to begin drinking before 15 years of age.

Seventh, respondents who declared their mother abused alcohol were significantly more likely to need pastoral support for emotional abuse as a child. Furthermore, they were significantly more likely to begin drinking after 15 years of age.

Conclusion

This chapter accepts the underlying assumption that psychosocial factors such as family history and parental harmful drinking shape individual differences in problem drinkers. Two perspectives can be adopted when considering psychosocial factors; the perspective of one trying to help an individual currently dependent on alcohol, and the perspective of one trying to prevent the development of an alcohol dependency problem in those who are vulnerable.

From the perspective of one helping others with alcohol dependence understanding the processes that shape individual differences is helpful for two reasons. First, it helps the carer know which sociological factors are worth exploring. The sociological factors worth exploring consist of the family mechanisms that operated on the child, mechanisms such as family routines and rituals and parenting skills, habits and shortcomings. A negative family environment and functioning mechanisms contributes to negative emotions and anxiety within individual drinkers,

and carers will have the opportunity to recognise a change agenda in relation to such negative emotions.

Second, it helps a carer know how such factors have influenced the individual's personal behaviour in relation to alcohol. Drinking motives indicate how sociological factors influence individual drinking behaviour. The specific issues for problem drinkers that arise from parental harmful drinking are most likely to be categorised into two groups, one that is characterised by negative emotions closely linked to self esteem and self worth, and one that is characterised by unresolved issues from the past. These two categories, negative emotions and unresolved issues from the past, are what constitute the inner context in which drinking motives find their energy. Emotional well-being and healthy maturation will help increase remove negative emotions and resolve past issues, so disarming the context in which drinking motives exist.

From a prevention perspective an appreciation of the importance of family mechanisms may prove helpful. If healthy family routines, rituals and social exchanges can be encouraged, nurtured and implemented, children who would otherwise be more vulnerable to early onset of harmful drinking and later alcohol problems could be extricated from the experiences that prove threatening.

The key question underlying this dissertation is 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' From this chapter, five issues may be identified as being relevant in a pastoral context. First, growing up with alcohol abuse has an impact on children that transfers into adulthood; being aware of this helps carers be alert to potential areas

of unresolved negative emotions so powerful in exerting influences on motives for drinking. Second, when people with an alcohol dependency have had both a mother and father who abused alcohol, they are much more likely to have suffered emotional abuse that if they had not. Emotional abuse, therefore, with its implications for behavioural and psychological expression, could be tackled by carers to positive effect. Third, clients who had a father who abused alcohol may have to address the further issues of physical abuse, as individuals in this category are more likely to have experienced this phenomenon. Fourth, females who had a mother who abused alcohol were demonstrated to have been more likely to drink because of emotional abuse, to forget the past, especially what people did and what happened to them. Here are issues from their childhood or earlier life which will require carers to help them resolve. Finally, females whose mothers abused alcohol are more likely to have low self esteem, and carers could address this to positive effect.

In conclusion, this chapter explored the importance of family history and parental harmful drinking as some of the psychosocial factors that contribute to individual differences in problem drinkers. It may prove advantageous to explore in more depth the relationships such drinkers may have had with their parents, to gain a deeper insight into specific issues that arise from them. The next chapter embarks on such an exploration.

Chapter Ten

Parental image and alcohol dependency

Chapter outline

Introduction

Theoretical background: attachment theory

> *Parental image*

Parental image: maternal carer

> *Maternal availability*
>
> *Maternal persona*
>
> *Maternal function*

Parental image: paternal carer

> *Paternal availability*
>
> *Paternal persona*
>
> *Paternal function*

Harmful drinking and perceived parental image

Parental alcohol abuse

> *Profile pattern: sex*
>
> *Profile pattern: age*

Main findings

Conclusion

Introduction

The last chapter addressed harmful drinking in family background, and discussed

how that abuse had an influence on those in the sample population. The review of

literature and the research results in that chapter demonstrated that a parental alcohol

dependency problem does have an influence on some of the individuals in the

sample. Such influences were expressed in terms of negative emotions and

unresolved emotional issues, which in turn, constituted the affective context where

unhealthy drinking motives found strength.

The purpose of this chapter is to explore in more detail, the influence a family background of harmful drinking has upon people who now declare they have a dependency upon alcohol. The details of this exploration are found, first, in the relationships drinkers perceived they had with their mother/maternal carer and their father/paternal carer. Second, the detail of the exploration is also found in testing for differences indentified when mother/maternal carer or father/paternal carer were harmful drinkers. Third, the chapter draws conclusions about the potential impact emotions associated with these relationships have upon drinking motives.

The chapter begins with the theoretical background in which the research is carried out. This incorporates a brief review of attachment theory, justifying the selection of parental relationships for more detailed exploration. It incorporates a justification of using a perceived parental image approach, in exploring the perceptions respondents had of their parental relationships. The chapter progresses by presenting a record of the research findings. This record of findings differentiates between the perceived image of maternal and paternal figures, respectively, and it describes these images in three ways: as characteristics, first, of parental availability, second, parental persona and third, parental function. The next section in the chapter explores the influence parental alcohol dependence has upon perceived parental images, and this is followed by profile patterns of responses based on sex and age differences in respondents. There is a discussion of the significance of the findings after each of these explorations. Before drawing conclusions, the chapter includes a summary of the research findings. In conclusion, the key question underlying this dissertation, 'what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' is considered in more detail.

Theoretical background: attachment theory

The name John Bowlby stands out in the field of research into the dynamics of parent-child relationships. Initially researching the effects of parent-child separation, and taking his inspiration from the natural world of animals, Bowlby, along with others such as Ainsworth, contributed to the understanding of parent-child relationships by developing a theory of attachment. Ainsworth and Bowlby (1991) have provided a brief historical summary of their work in this field, and of the conclusions which they drew from the research they carried out. This summary highlights two key concepts, personality development and inner security, the latter referring to an awareness of being without care or without anxiety. The foundation of attachment theory is the belief that personality development is linked to early interactions between children and parents. An awareness of being secure within oneself begins with an immature dependent security. This infantile security is based in reliance upon parental figures to take care of them and to take responsibility for their actions. With exploration comes fear, but this is overcome by retreating to parents for comfort. Children thus develop knowledge of their world and learn the skills to cope. Independent security emerges in conjunction with emancipation from parental control, and mature security is demonstrated through mutual contribution and give-and-take in peer relationships.

There appears to be associations between unhealthy drinking motives and the psychosocial well being of a person with alcohol dependency on the one hand, and the concepts of personality development and emotional security, as described by Ainsworth and Bowlby, on the other. For example, parental harmful drinking influences offspring by instilling negative feelings, and by creating emotional issues

254

that can remain unresolved for many years. Poor attachment can leave children

growing up with feelings of insecurity and in need of pseudo-security: pseudo-

security refers to defence mechanisms, what Blatz (1966) called deputy agents,

which would provide a temporary kind of security without dealing with the source of

insecurity. In the absence of more appropriate coping skills, alcohol is used by

many as one such defence mechanism, or deputy agent. Insecurities come through

social challenges, inner feelings and unresolved issues.

The investigation in this dissertation, into the origin of an individual's social and

psychological wellbeing, must therefore target the relationship respondents with an

alcohol dependency problem have had with their parents. The origins of well-being

lie in the childhood years. Bowlby writes,

> So long as a child is in the unchallenged presence of a principle attachment-
>
> figure, or within easy reach, he feels secure. A threat of loss creates anxiety,
>
> and actual loss sorrow; both moreover, are likely to arouse anger. (Bowlby,
>
> 1969, p 209)

Therefore, this chapter focuses on respondent's perception of their childhood years,

and the emotions they associate with their parental figures. The assumption is that

negative emotions, associated with parental figures, indicate potential inadequacies

in psychosocial wellbeing: that these negative emotions in adults with an alcohol

dependency problem, necessitate exploration in the context of pastoral care. Carers

may therefore target such perceptions in the therapeutic setting to good effect.

Parental image

Respondent's perception of their childhood years, and the emotions associated with

their parental figures, may be assessed by exploring their parental images. The exploration of parental images has been used to positive effect in the context of research into clergy formation and into ministerial job satisfaction among Anglican clergy in England (Turton and Francis, 2006).

It is deemed appropriate to investigate parental images in this dissertation for a number of reasons. First, this approach has integrity because it draws on the most fundamental of psychodynamic principles, that adult mental processes and forces have their roots in childhood experiences and memories, conscious or unconscious. Like attachment theory, parental images provide an insight into the nature of the relationship a respondent has had with his or her mother/maternal carer or father/paternal carer. Studies have already demonstrated a relationship between insecure attachment and enhanced likelihood of internalising problems in adolescents such as depression, emotional disturbance, anxiety and even higher risk of suicidal behaviour (Allen, Moore, Kupermine and Bell, 1998). Insecure attachment is also related to externalising problems such as delinquency, hostility, marijuana use and hard drugs use. Insecurely attached people use alcohol as a method of coping with negative emotions, which in turn can lead to harmful drinking. The lower the individual perceives the quality of the attachment relationship, the more likely the adolescent consumes alcohol at an early age (Vorst, Engels, Meeus, Deković, and Vermulst, 2006). Negative responses to parental images, in the context of this dissertation, are understood as evidence of insecurely attached relationships.

Second, the approach requires respondents to express a retrospective perception, which is a necessary characteristic in some therapeutic processes. It is perception

that is telling. Individuals asked to describe significant others, and their relationship with them, provide an insight into the relationship, for example, between attachment and affective style. Perception of negative affective style in parents may be characterised by a high degree of criticism, intrusiveness and/or guilt inducing remarks (Diamond and Doane, 1994).

Third, the approach targets parental behaviours and attitudes towards respondents, thus facilitating observations and conclusions about the psychosocial wellbeing of those respondents. Negative relationship experiences, such as unavailability or insensitivity of caretakers, may lead people to perceive themselves as unworthy of love, and others as emotionally unavailable or unresponsive (Overbeek, Vollebergh, Meeus, de Graaf and Engels, 2004).

Fourth, the approach allows specific perceptions of parental relationships to be explored alongside respondents' motives for drinking. This is most clearly understood in the context of coping with stress, and how it relates to perceived parental images. The socialisation of coping takes place when parenting behaviours communicate to children possible ways of coping with stress. Abaied and Rudolph (2010) describe various coping methods that are communicated through the parental relationship. For example, engagement coping, which refers to voluntary responses directed at the source of stress, including problem solving, positive thinking, reflection and expressions of emotions. Some voluntary responses can be directed away from the source of the stress, responses such as deliberate cognitive avoidance (trying not to think about something), behavioural avoidance (staying away from upsetting situations) and denial (pretending the problem is not there). These are

described as disengagement coping methods. Voluntary coping strategies may be socialised as parents encourage children to select certain strategies over others. Alternatively, involuntary responses, such as broodiness, rumination and heightened emotional arousal, are all classified as deregulated and compulsive responses to stress sources. Involuntary responses directed away from the source of stress include compulsive avoidance and escape, emotional numbing and emotional freezing. Involuntary responses may be influenced by temperament or modelling of parental emotional expressivity or parent's responses to children's emotional displays.

In both voluntary and involuntary responses, a parental relationship allows the infant to elicit the caregiver's responses when experiencing stress. Infants develop internal representations of such relationship, or attachment, experiences which influence their approach to stress, and these representations include implicit beliefs about the caregiver and about the self. Secure internal representations facilitate flexible and capable response patterns to confront and resolve stress; whereas an avoidant working model reflects a deactivated pattern of responding to stress, as evidenced by a distancing from emotions and a disengagement from coping strategies. Abaied and Rudolph (2010) demonstrated that mothers, who were preoccupied, were more angry and intrusive than secure mothers, when helping their children face stress, and that insecure attachment led mothers to encourage greater disengagement and less effective engagement coping skills. They proposed two reasons: first, insecure adults are at risk of maladaptive patterns of coping with stress, and second, encouraging children to engage with stress implies the parent is available as a source

of support, a situation that is not likely when a mother, or father, abuses alcohol. In the pastoral context these issues may be addressed to positive effect.

Fifth, the approach allows differentiation between mother and father roles. The quality of the attachment bond, reflected in perceptions of parental image, finds its origin in the parent's responsiveness and availability to the child's signals. Attachment bonding is important in the development of children's emotional and psychosocial wellbeing. Good attachment bonds, or positive perceptions of parental image, support the development of social and cognitive competence while enhancing the child's self-worth. Poor attachment bonds, or negative perceptions of parental image, result in less optimal behaviours such as aggression, substance dependency and impulse control problems (Michiels, Grietens, Onghena, and Kuppens, 2010). Richard Bowlby, carrying on the research begun by his father, explains that children who excel in social situations as young adults, had mothers who provided an enduring secure base and a positive model for intimate relationships, and fathers who provided exciting play and interactive challenges (Newland and Coyl, 2010).

Parental image: maternal carer

Parental image was explored by asking respondents the question, 'how would you describe your mother/maternal carer?' and subsequently, 'How would you describe your father/paternal carer?' Each question was followed by 19 pairs of adjectival descriptors, each pair representing positive and negative extremes of the descriptor in question. Respondents were asked to circle one of seven numerical options that represented their perception of that aspect of their parental image. The numerical options were so arranged as to have a sliding scale of intensity, with high intensity at

extreme ends of the spectrum for both positive and negative perceptions, and a

neutral position midway between the extremes, for example,

Harmful drinker   3   2   1   0   1   2   3   Non-drinker

Table 10.1 contains the summary of results of the individual perceptions of maternal

carers. The figures demonstrate that over a quarter (27%) of respondents perceived

their maternal figure as one who abused alcohol. The remaining 18 descriptors

demonstrate each respondent's perceptions of three related areas of their image of

their maternal figures, namely, availability, persona and function, a conclusion

drawn by the respondent about themselves from their maternal figure.

Table 10.1 Perception of mother/maternal carer

Negative parental image	%	% ?	%	Positive parental image
Harmful drinker	27	14	59	Non-drinker
Strict	40	11	49	Lenient
Distant	28	8	64	Close
Uninvolved	25	4	71	Involved
Uncaring	8	4	88	Caring
Insensitive	23	3	73	Sensitive
Unsupportive	18	4	78	Supportive
Never there	15	5	81	Always there
Judgemental	51	12	37	Non judgemental
Selfish	23	7	70	Unselfish
Hating	7	8	85	Loving
Critical	55	7	38	Uncritical
Rejecting	16	8	77	Accepting
Ungiving	9	6	85	Giving
Damning	18	10	72	Saving
Demanding	48	7	45	Not demanding
Restricting	52	7	41	Freeing
Disapproving	34	11	55	Approving
Unforgiving	20	6	74	Forgiving

Maternal availability

Respondents had the opportunity to reflect upon maternal availability in two senses,

physical proximity and emotional availability. A high percentage (81%) perceived their maternal carer to have been always there, representing physical proximity in the respondent's childhood. Alternatively, 64% perceived their maternal carer as being close, representing that she was perceived to have been emotionally available. Alternatively, over a quarter (28%) described their maternal figure as being distant or emotionally unavailable; and 15% described her as never there.

Statistically, therefore, a carer may reflect that approximately one quarter of people presenting with an alcohol problem may perceive their relationship with their maternal carer to have been dysfunctional to a great or lesser extent.

Maternal persona

Persona is defined as 'the kind of person that others perceive someone to be,' that is, their personal characteristics in relating to others. A consideration of maternal image, therefore, includes a respondent's perception of the kind of person their maternal figure presented towards them. Positive images describing persona included lenient, caring, sensitive, non-critical, unselfish, giving, loving, accepting, saving, approving and forgiving. These positive images were paired with negative images including strict, uncaring, insensitive, critical, selfish, ungiving, hating, rejecting, damning, disapproving and unforgiving. Very high percentages (85% or more) of respondents perceived their maternal figure positively as being caring (88%), giving (85%) and loving (85%) and high percentages (70% or more) perceived them to be sensitive (73%), unselfish (70%), accepting (77%), saving (72%) and forgiving (74%). However, almost one quarter of respondents (23%) perceived their maternal figure to be insensitive and selfish; and one third (33%) as

being disapproving of them as their children or wards. Furthermore, 40% of respondents perceived their maternal figure to be strict, and over half the respondents perceived her to be critical (55%).

Statistically, therefore, a carer may reflect that, potentially, between almost one quarter (23%) to over half (55%) of people, presenting themselves for help with an alcohol problem, will be people who perceive their maternal figure as being insensitive, selfish, disapproving, strict and critical. In the pastoral context, valid questions to consider include, what impact might such perceptions have had upon the individuals' self-worth, and what conclusions might those individuals draw about themselves and their life?

Maternal function

Function is defined as the parental role, that is, the perceived interaction between the respondent and his or her maternal figure. Positive maternal functions described included being involved, supportive, not demanding, freeing and non-judgemental: negative functions included being uninvolved, unsupportive, demanding, restricting and judgemental. High percentages (70% or more) of respondents perceived their maternal figure's function positively, for example, being involved (71%) and supportive (78%). However, exactly one quarter perceived her to have been uninvolved, almost half perceived her to have been demanding (48%), and over half perceived her to have been restricting (52%) and judgemental (51%).

Statistically, therefore, carers helping people with alcohol dependency problems may expect between one quarter (25%) and over half (52%) of their clients to have

perceived their maternal carers as being uninvolved, demanding, judgemental and restricting. In the pastoral context a valid question to consider would be what impact might such perceptions have upon the individual's behaviour, and what survival mechanisms might they be employing?

Parental image: paternal carer

Table 10.2 contains the summary of results of individual respondent's perceptions of paternal carers. These figures demonstrate that well over half (59%) of respondents perceived their paternal figure as one who abused alcohol.

Table 10.2 Perception of father / paternal carer

Negative parental image	%	% ?	%	Positive parental image
Harmful drinker	59	14	28	Non-drinker
Strict	56	6	39	Lenient
Distant	58	5	37	Close
Uninvolved	51	8	41	Involved
Uncaring	23	7	71	Caring
Insensitive	36	9	55	Sensitive
Unsupportive	30	9	60	Supportive
Never there	40	10	50	Always there
Judgemental	56	10	34	Non judgemental
Selfish	44	8	47	Unselfish
Hating	18	14	68	Loving
Critical	59	9	32	Uncritical
Rejecting	34	8	58	Accepting
Ungiving	28	7	65	Giving
Damning	35	17	48	Saving
Demanding	49	10	41	Not demanding
Restricting	54	11	35	Freeing
Disapproving	46	15	41	Approving
Unforgiving	27	10	63	Forgiving

Paternal availability

As before respondents had the opportunity to reflect upon paternal availability in terms of physical proximity and emotional availability. Exactly half of respondents

perceived their paternal carer to have been always there, and 40% reported him to have been never there. Furthermore, over one third (37%) described him as being close and over half as being distant (58%). These figures represent a different perception of the paternal figure compared to the maternal figure. The paternal figure is perceived as being less available in physical proximity and more distant in emotional terms.

Statistically, therefore, between 40% and 58% of people presenting with an alcohol problem will potentially perceive their relationship with their paternal carer as having been dysfunctional in terms of availability.

Paternal persona

A consideration of paternal image includes a respondent's perception of the kind of person they perceived him to be. The same positive images describing persona were included, and again these were paired with negative images. A high percentage (70% or more) of respondents perceived their paternal figure as being caring (71%) and almost two thirds as giving (65%) and forgiving (63%). Over half the respondents perceived him positively as accepting (58%) and sensitive (55%) and less than half as lenient (39%), unselfish (47%), saving (48%) and approving (41%). However, over one third (36%) of respondents perceived their paternal figure to be insensitive and selfish (44%) and 46% as being disapproving. Furthermore, 56% of respondents perceived their paternal figure to be strict and 59% perceived him as being critical of them.

Statistically, therefore, a carer may reflect that, potentially, between 36% and 59%

of people presenting themselves for help with an alcohol problem will be people who perceive their paternal figure as having been insensitive, selfish, disapproving, strict and critical. In the pastoral context what impact might such perceptions have had upon the individuals'?

Paternal function

Positive paternal functions were limited so that only one, being supportive (60%), was identified by more than half the respondents. In all other examples of paternal functioning, approximately half of the respondents identified a negative function, for example, being uninvolved (51%), judgemental (56%), demanding (49%) and restricting (54%). Statistically, therefore, carers helping people with alcohol problems may expect half or more of their clients to perceive their paternal carer as having been uninvolved, demanding, judgemental and restricting.

Harmful drinking and perceived parental image

Before investigating harmful drinking and parental image it is important to clarify the percentages of the sample population who had one or both parental figures who abused alcohol. Table 10.3 contains a summary of these percentages. These results show that 45% of the sample population had either a paternal (42%) or maternal (3%) figure who abused alcohol, with a very clear bias towards having a paternal figure who abused alcohol. They show that almost a quarter (24%) of the sample

Table 10.3 Paternal / maternal harmful drinkers

Harmful drinker	%
Paternal figure only	42
Maternal figure only	3
Both paternal and maternal figures	24
Neither paternal nor maternal figures	31

had both paternal and maternal figures who abused alcohol, and that almost one third (31%) had neither paternal nor maternal figures who abused alcohol. The figures demonstrate that over two thirds (69%) of the sample declared harmful drinking in either one parental figure or both.

In the previous chapter it was demonstrated that there is a link between familial harmful drinking and harmful drinking in children from such a background. Various explanations may contribute to an understanding of this observation, for example, there may be genetical factors that predispose children of a person with alcohol dependency problem to harmful drinking or, alternatively, harmful drinking may be a learned behaviour. In this chapter the focus is on the emotional well-being of people with an alcohol dependency problem, because emotional elements play a very prominent role in drinking motives (Cooper, Frone, Russell and Mudar, 1995).

According to attachment theory, emotional well-being is grounded in the relationship children have with their parents; by exploring parental image insight has been gained into the characteristics of the relationship respondents had with their maternal and paternal carers, and from these images observations may be made regarding the emotional well being of respondents. Their emotional well-being, in turn, provides clues for carers to explore that have a bearing on drinking motives. Cross-tabulations were carried out to test for associations between negative parental images and parents who abused alcohol.

Table 10.4 contains a summary of the results from a comparison of having a mother who abused alcohol and the perceived negative image of the maternal figure. Of the

266

18 negative images that described maternal carers, cross-tabulations identified ten that were significantly associated with the fact that the maternal carer abused alcohol. The children of mothers who abused alcohol were significantly more likely to feel their mother was distant, uninvolved, insensitive, unsupportive, never there, selfish, ungiving, damning, disapproving and unforgiving.

Table 10.4 Alcohol abusing mother and maternal image

	alcohol abuser %	non-drinker %	χ^2	$p<$
How would you describe your mother/maternal carer?				
Strict	27	43	2.62	NS
Distant	46	17	10.85	.01
Uninvolved	39	17	7.09	.01
Uncaring	9	3	1.73	NS
Insensitive	36	13	8.16	.01
Unsupportive	36	10	11.85	.01
Never there	36	4	21.74	.001
Judgemental	52	49	.07	NS
Selfish	55	12	24.01	.001
Hating	12	3	3.47	NS
Critical	55	49	.31	NS
Rejecting	24	12	2.67	NS
Ungiving	24	3	12.96	.001
Damning	39	11	12.71	.001
Demanding	55	42	1.48	NS
Restricting	55	51	0.11	NS
Disapproving	55	30	6.27	.01
Unforgiving	39	11	12.71	.001

Table 10.5 contains a summary of the results from a comparison of having a paternal carer who abused alcohol and the corresponding negative images of that figure.

Of the 18 characteristics, that described each perceived negative paternal image, respondents identified 15 that were significantly associated with the fact that their paternal carer abused alcohol. The children of fathers who abused alcohol were significantly more likely to feel their father was distant, uninvolved, uncaring,

insensitive, unsupportive, never there, selfish, hating, rejecting, ungiving, damning, demanding, restricting, disapproving and unforgiving.

Table 10.5 Alcohol abusing father and paternal image

	alcohol abuser %	non-drinker %	χ^2	$p<$
How would you describe your father/paternal carer?				
Strict	68	53	2.09	NS
Distant	79	28	23.67	.001
Uninvolved	70	31	12.88	.001
Uncaring	33	6	8.48	.01
Insensitive	54	9	17.75	.001
Unsupportive	52	6	19.41	.001
Never there	65	6	29.64	.001
Judgemental	62	59	.06	NS
Selfish	71	16	26.51	.001
Hating	37	6	10.02	.001
Critical	71	53	3.14	NS
Rejecting	59	9	21.21	.001
Ungiving	52	13	14.19	.001
Damning	65	13	23.53	.001
Demanding	62	38	5.08	.05
Restricting	79	50	8.63	.01
Disapproving	65	38	6.54	.01
Unforgiving	49	16	10.17	.01

Discussion

The significance of results such as these is clear. As George, Cummings and Davies (2010) explain, research has demonstrated that parents' responses to their children have important implications for children's emotional functioning. There is a link between responsiveness in parents, and emotional functioning in children, where parental warmth is more closely linked with social competence and functioning, and lack of social competence and functioning is linked to drinking motives as a coping method. The result is that with perceived positive images that represent secure

attachment, children are able to regulate anxiety and distress (Muris and Maas, 2004). But, negative images in parent/child relationships, representing insecurely attached children, are more likely to develop anxiety disorders. Some of the sample population in this current research display insecure attachment, as illustrated by their perceived parental image, in several ways.

First, their responses demonstrate a link between the harmful drinking of their maternal and/or paternal figures and their perception of them not being available. As Overbeek, Vollebergh, Meeus, de Graaf and Engels, (2004) speculate,

> It might be that alcohol and drug dependence and abuse arise mainly as a
>
> consequence of young adults' relatively unattached relationship status.
>
> (Overbeek, Vollebergh, Meeus, de Graaf and Engels, 2004)

This is the theme developed by de Minzi (2010) when she explains that, in the early years of life, attachment relationships provide the foundations for emotional, cognitive and social development. Her research demonstrated a link between unhealthy attachment with maternal figure, especially availability, and children's loneliness; and a link between unhealthy attachment with paternal figure, especially availability, and children's depression. Alternatively, secure paternal attachment and positive affection predicted pro-social behaviour and good peer relationships. Clinical descriptors of parenting in person with alcohol dependency families, including lack of nurturance, denial of children's feelings and needs and physical and emotional abuse, are the same characteristics Bowlby used to describe insecure attachment relationships (Jaeger, Hahn and Weinraub, 2000).

Second, the research demonstrates that parents who abuse alcohol are not perceived

in a positive light, for example, parents are insensitive, selfish and ungiving. Attachment theory offers a way of understanding how parent-child relationships effect a child's early psychological organisation, and subsequent development. Bowlby suggested children construct a system of representational models of their attachment figures and themselves, on the basis of their early and ongoing interactions with care givers. These internal working models contain information about how attachment figures are likely to respond when needed, and, on the basis of these responses, the individual draws conclusions about how acceptable their self is in the eyes of the attachment figures. If parental responsiveness is absent or intermittent, the child is likely to develop a model of the parent as being unavailable, and of the self as being unworthy. This research demonstrates that the respondents who had a mother or father who abused alcohol declared their respective parent to be never there and distant, and are, therefore, more likely to conclude they themselves are, in some sense, unworthy or inadequate.

Third, the research demonstrates that the sample population's negative perception of their parental figures function, as a parent, was also statistically linked to that parental figure abusing alcohol. In both maternal and paternal images, the perception was that they were uninvolved, unsupportive, damning, disapproving and unforgiving: furthermore, fathers were perceived as hating, rejecting, demanding and restricting. Child rearing behaviours associated with the development of healthy self esteem include parental support, low levels of parental control, low levels of harsh parental discipline and high levels of family cohesion. Parental support includes open communication, acceptance, interest and warmth, and control includes decisions made for their child, supervision and the extent and severity of rules. This

270

contrasts markedly with the perceptions of the sample population. Birditt, Rott and Fingerman (2009) developed the theme of parent-child tension by exploring the coping strategies employed in the face of such tension. They identified three strategies commonly seen, destructive strategies which include shouting, constructive strategies such as working together and avoidant strategies such as not talking. Destructive and avoidant strategies resonate with familial circumstances that include harmful drinking.

Main findings

The main findings in this chapter may be summarised in a number of points. First, over two thirds of the sample population (69%) reported that, their maternal or paternal figures, abused alcohol, and almost one quarter (24%) reported that both their maternal and paternal figures abused alcohol.

Second, the majority of respondents (50% or more) had positive perceptions of their maternal figure as a non-drinker, close, involved, caring, sensitive, supportive, always there, unselfish, loving, accepting, giving, saving, approving and forgiving. This number of positive images represented 14 of the 19 pairs of adjectives describing their parental figures. The majority (50% or more) had negative perceptions of their maternal figure in three of the 19 pairs of adjectives, and these included being judgemental, critical and restricting.

Third, the majority of respondents (50% or more) had positive perceptions of their paternal figure in eight of the 19 pairs of adjectives, including being caring, sensitive, supportive, always there, loving, accepting, giving and forgiving. The

majority of respondents (50% or more) had negative perceptions of their paternal figure in seven of the 19 pairs of adjectives, including being someone who abused alcohol, who was strict, distant, uninvolved, judgemental, critical and restricting.

Fourth, there was a strong statistical link ($p< = .001$) between five negative images of the maternal figure when this carer abused alcohol: maternal carers who abused alcohol were more likely to have been perceived as being unsupportive, judgemental, ungiving, damning and unforgiving.

Fifth, there was a strong statistical link ($p< = .001$) between ten negative images of the paternal figure when this carer abused alcohol: paternal carers who abused alcohol were more likely to have been perceived as being distant, uninvolved, insensitive, unsupportive, never there, selfish, hating, rejecting, ungiving and damning.

Conclusion

This chapter made a more detailed investigation into the influence alcohol abusing parental figures have upon the following generation, and it has demonstrated that over two-thirds of the sample population declared they belonged to this category. The more detailed investigation took the form of an exploration of the perceived parental images respondents indentified, and resulted in the identification of several negative perceptions for both maternal and paternal carers. Three negative perceptions, judgemental, critical and restricting, were identified in both maternal and paternal figures by over 50% of respondents, respectively. A further three negative perceptions were identified in paternal figures only, strict, distant and

272

uninvolved, by over 50% of respondents, respectively. The assumption underlying

these findings is that poor relationships with either parent, or both, reflected in the

expression of negative perceptions of parental image, lays a weak emotional

foundation in the following generation.

The underlying question in this research is 'what does a carer need to consider when

he or she is asked to help a person who has an alcohol dependency problem?' What

emerges from this chapter is a procedural sequence of clues and issues that may

prove beneficial topics for discussion in the process of pastoral care. First, the sex

of the person with the alcohol problem alerts the carer to potential differences in

parental perception, and in the life experiences of those individuals. These

differences between male and female responses may prove important. As Furnham

and Cheng (2000) suggest, parents may be controlling or demanding. They may be

child centred, and therefore accepting and responsive: or they may be parent-centred

and therefore rejecting and unresponsive. In ideal circumstances parents that are

authoritative but not authoritarian or permissive, and who combine control,

acceptance, child-centred involvement and who value the child's point of view, are

contributing positively to their child's development. Therefore, children who do not

have this parenting experience fail to develop emotionally as they might and are

therefore susceptible to difficulties of self esteem and social competence later in

adult life. The focus of pastoral conversations is, therefore, negative experiences.

Barth (2010) explains, contemporary theory sees negative or hostile feelings about

parents as deeper and more important. In this view, and in light of the current

differences between male and female responses to parental image, pastoral

discussion should focus on male relationships with their father and female

relationships with both mother and father. However, Barth (2010) suggests talking

therapies can be derailed if negative attachment experiences are allowed to dominate

discussions, and she highlights defensive idealisation as equally important. Perhaps

the male responses concerning their perception of their maternal carer are an

idealisation of their relationship, and if so, this process carries equal importance in

the therapeutic agenda.

Second, enquiries about whether or not one or both their parents abused alcohol

raises issues relating to negative emotions and self-worth, issues that may be

sustaining a psychosocial environment where a conviction of the need for alcohol is

nurtured and maintained. Third, honest conversations about perceptions of both

maternal and paternal figures may help target key experiences, emotions, memories

and beliefs that constitute the emotional and cognitive processes that prevail in the

individual requesting help. Current behaviour patterns may be the survival skills

individuals have developed since early childhood, but that are now proving the cause

of unhappiness. Emotional defences erected in childhood, initially to protect, may

later in adulthood become walls that isolate. Fifth, tendencies to blame or idealise

parents need to be resolved.

Finally, it is important to return to Ainsworth and Bowlby (1991) and to their two

key concepts in relation to attachment theory, personality development and inner

security. This chapter, by exploring the perception of parental image, has targeted

one of these key concepts, inner security. In the next chapter attention turns to the

other key concept, that of personality development.

<center>**Chapter Eleven**</center>

<center>**Personality dimensions and alcohol dependency**</center>

Chapter outline

Introduction

Theoretical context: personality models

Personality models and alcohol dependence

Justification for using Eysenck

Eysenck's personality dimensions

Personality dimensions and drinking motives

Main findings

Conclusion

Introduction

The last chapter focused on perceived parental images in order to explore the

relationship between participants psycho-social well being and their perception of

their parental figures. The chapter addressed issues such as parental harmful

drinking, and the effects it had on the perceived image of the parental figure. The

importance of positive relationships with parental figures was highlighted by a

summary of Bowlby's attachment theory (Ainsworth and Bowlby, 1991), a theory

that explored the links between the formation of personality and relationships with

parental figures. In this chapter, attention turns towards exploring personality and drinking motives.

It is important to investigate personality and drinking motives for a number of reasons. First, mention of personality has arisen in earlier chapters to such a degree that it warrants closer investigation. For example, personality has been identified as an antecedent factor in the development of alcohol problems because high-risk personality traits are genetically influenced (Elkins, King, McGue and Iacono, 2006). Predetermining personality factors, such as anxiety and aggression, represent dispositions that predict drinking because they influence behaviour (Acuda and Alexander, 1998); more specifically they influence the subjective decisional framework within which choices are made. In this way personality traits have been linked to drinking motives.

Second, personality characteristics are integral to individual differences. This dissertation has highlighted the importance of individual differences among people with alcohol problems. So far those individual differences have been illustrated by reviewing the drinking history and practice of problem drinkers, their motives for drinking, the consequences of their drinking and the psycho-social background from which they come. In summary, individual differences occur as a combination of a person's drinking behaviour, his or her personal profile and his or her personality.

 Finally, personality influences the way individuals view life, including the past, the present and the future, and is therefore an important consideration for carers trying to help people change their manner of living by seeing life from a different

perspective. For this reason personality is not explored from a causal perspective, but as a way of understanding an individual's unique outlook on life, in particular the individual's drinking motives, so that pastoral carers will be better informed to help the individual recover from an alcohol dependency problem.

The chapter begins with an exploration of the theoretical context in relation to personality models. The theoretical context begins with an introduction to the personality assessment model that is most commonly used with people who have an alcohol dependency problem, the Minnesota Multiphasic Personality Inventory (MMPI). This introduction leads to a very brief examination of the Mac Andrew Alcoholism Scale (MAC Scale), which is derived from the MMPI. The theoretical exploration is developed in more detail by examining the contribution made by Eysenck and his three factor model and concludes by introducing proponents of a five factor model of personality.

The brief statement about each of these models provides a back-drop for a review of how Eysenck's model and the five factor model have been applied in the context of alcohol dependence research. This exploration of the link between personality and an alcohol dependency problem serves as an introduction to a justification of the use of the Revised Eysenck Personality Questionnaire (Abbreviated) (Francis, Brown and Philipchalk, 1992) in this dissertation. The results of the research carried out among this sample population are presented in terms of Eysenck's personality dimensions, and in particular investigates potential links between these dimensions and drinking motives. A summary of the research findings is included before conclusions are drawn. The conclusion includes pastoral implications from the

research findings as they relate to the key question underpinning this dissertation, 'What does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?'

Theoretical context: personality models

The Minnesota Multiphasic Personality Inventory (MMPI)

The MMPI assesses both personality traits and psychophathologies. Originally developed by Hathaway and McKinley (1951), this test had more than 550 items and was designed to assess mental health problems in psychiatric and medical settings. Morey, Roberts and Penk (1987) used the MMPI, along with other measures, in the context of alcohol dependency to establish three alcoholic typologies or drinking subtypes. These subtypes they described as early-stage problem drinkers, affiliative problem drinkers and schizoid problem drinkers. As an objective personality measure, MMPI suggested that pre-alcoholics were impulsive, rebellious, independent, non-conforming and uncontrolled (Cox, Yeates, Gilligan and Hosier, 2000).

The initial MMPI test has been superseded by a number of versions, for example, MMPI-2 developed by Graham (1990). This version is still widely used because of the large research base which it has established, and it consists of 567 true/false questions. Stein, Graham, Ben-Porath and McNulty (1999) demonstrated the value of the MMPI-2 test in detecting substance abuse in an outpatient mental health setting. In their research the test proved valuable as a way of identifying potential drug abuse problems in outpatients attending a clinic for mental health issues other than substance abuse. For example, in cases where a client is not honest about drug

abuse in a face-to-face interview, it was demonstrated he or she was more inclined to tell the truth in a test that did not involve face-to-face contact.

The MAC Andrew Scale

The MMPI, originally used to test hospitalised psychiatric patients, formed the basis for the development of the Mac Andrew Alcoholism Scale (MAC Scale), so called because it was developed by Craig Mac Andrew (Peele, 1990). The MAC Scale was developed to differentiate alcoholic from non-alcoholic psychiatric patients. Using the MAC Scale with alcoholic and non-alcoholic patients Mac Andrew observed that alcoholics had a higher MAC score.

> High scorers...seemed to be bold, uninhibited, self-confident, sociable people who mix well with others. They show rebellious urges and resentment of authorities...yet their answers show they are drawn to religion. (Finney, Smith, Skeeters and Auvenshine, 1971, p 1058)

Peele (1990) explains that Mac Andrew described individuals who had high MAC scores as having "an assertive, aggressive, pleasure-seeking character" comparable to "criminals and delinquents" (Mac Andrew, 1981, p 617). In later research, when the MAC Scale was used with female subjects, a similar picture of an alcoholic personality in women emerged (Peele, 1990). The MAC Scale, however, was not found to be without limitations Mac Andrew found that 15% of alcoholics were not correctly identified (Peele, 1990) and his explanation was to make a distinction between "primary" and "secondary" alcoholics, where primary alcoholics scored highly in the MAC Scales and secondary alcoholics remained unidentified (Mac Andrew,1986).

Furthermore, Miller and Streiner (1990) tested the efficiency of the MAC Scale to discriminate independently defined alcoholics with psychiatric diagnoses from other psychiatric patients, by comparing it with the Scale B of the Millon Clinical Multiaxial Inventory (MCMI). They found that there were a number of "false positives" in both the MAC Scale and the MCMI. The operating characteristics of Scale B showed that it was not as efficient as the MAC Scale in identifying alcoholics. They suggested the MAC Scale should be used cautiously to discriminate alcoholics with psychiatric disorders from patients without alcoholism.

Eysenck

Eysenck's contribution to discussions on personality structure emerged from his conviction that there was a need to integrate the disciplines of developing theories of individual differences and carrying out empirical research into personality (Maltby, Day and Macaskill, 2010). Eysenck described how personality traits represented stable and long-lasting characteristics. Using factor analysis he concluded that personality traits could be subsumed into three personality dimensions. His methodology included observing both specific and habitual behavioural responses by individuals in particular settings. For example, by observing a person talking in a social setting certain specific responses may be noted. From specific responses emerge habitual responses, which refer to the ways that an individual typically behaves in certain circumstances. From habitual responses conclusions may be drawn about the personality traits that individual possesses. Eysenck grouped together traits that were highly correlated, and these groups of traits formed super-traits or personality dimensions.

Initially Eysenck identified two super-traits or personality dimensions, one describing sociability which he called extraversion and identified with the letter E: and one describing emotional stability which he called neuroticism and identified with the letter N. Later, Eysenck added a third super-trait, or personality dimension, which he called psychoticism and identified with the letter P. Each of these dimensions will be explored in more detail later in the chapter.

A fundamental problem with the use of any psychometric tests using questionnaires is the issue of truthfulness. Have respondents answered the questions truthfully: is the information collected by the questionnaire accurate and fit for purpose? To address this issue Eysenck and Eysenck (1991) introduced a further scale which they identified with the letter L and which they referred to as the Lie scale. This scale was introduced because, in certain circumstances governing the administration of the Eysenck Personality Inventory, it was noted that some participants had a tendency to 'fake good.' This scale was introduced in an attempt to measure an individual's propensity towards dissimulation, to fake good by hiding their true thoughts and feelings. The condition governing the administration of the questionnaire, where this tendency was particularly marked, was in a face-to-face interview situation.

First, genuine truthfulness in questionnaire responses would require participants to have the desire to be truthful to the exclusion of all other considerations; to be able to be self-aware enough to identify ulterior motives, setting them to one side, and to believe that failing to tell the truth would carry serious enough consequences as to make it inadvisable. Having such expectations of any sample population seems

unrealistic, and indeed Michaelis and Eysenck (1971) demonstrated that differing situations elicited inconsistent lie scale scores.

Second, if truthfulness cannot be guaranteed, can a degree of truthfulness be measured? To put the question another way, is it possible to assess the extent to which respondents have presented truthful answers in psychometric questionnaires? Eysenck believed that it was. Therefore, his solution was to include questions in his questionnaire which had answers that illuminated the degree of truthfulness with which respondents had approached an investigation. The selected questions had answers that could be anticipated from the perspective of scrupulous truthfulness or from the perspective of reflecting social norms.

If questions are included which assess scrupulous truthfulness as understood by social norms, do the answers they elicit reflect the degree of truthfulness with which participants have approached an investigation? The answer may be "no". Participants may perceive and reflect social norms in such questions and so respond correctly, if not truthfully, as they interpret the question. In this instance respondents are demonstrating their understanding of social norms. Paulhus and Reid (1991) identified socially desirable responding as one motive behind the questions in the Lie scale.

Investigations into the nature of this Lie scale, for example by Michaelis and Eysenck (1971) and Eysenck, Nias and Eysenck (1971), have demonstrated, therefore, that it not only measures dissimulation on the part of a sample population,

but also a "stable personality factor which may possibly denote some degree of social naivety or conformity" (Eysenck and Eysenck, 1991, p 13).

The Five Factor Model

Furnham and Heaven (1999) explain that many personality psychologists now accept that there are five orthogonal, or statistically independent, personality traits, although the labelling of these five traits is not consistent. The five factor model, therefore, is a term used to describe the five broad personality factors generated by systematic research over the last few decades.

Fiske (1949) was the first to declare being unable to find anything more complex than five factors that included social adaptability, conformity, will to achieve, emotional control and an enquiring intellect. Fiske's work was not influential but was reintroduced into discussions by subsequent researchers such as Norman (1963), Digman and Takemoto-Chock (1981) and Goldberg (1981). Goldberg (1990) recognised that the five personality super-traits reflected five major features of personality, love, work, affect, power and intellect.

Maltby, Day and Macaskill (2010) explain that the most influential researchers, in promoting a five factor personality structure, were Costa and McCrae (1985, 1989, 1992 and 1997), who coined the phrase "the Big Five," a model they proposed based upon a data-derived hypothesis as opposed to a theoretically based hypothesis: the big five factors emerged from the data they reviewed. Costa and McCrae identified openness, conscientiousness, extraversion, agreeableness and neuroticism as the big

five personality factors. Table 11.1 details the five personality factors and outlines the description of high and low scores for each.

Table 11.1 The Big Five Model Personality

Factors	Individuals with high scores	Individuals with low scores
Openness	unconventional, independent thinker	prefers familiar to the new
Conscientiousness	determined, organised planner	careless, easily distracted, not dependable
Extraversion	sociable, energetic, optimistic friendly, assertive	introverted, reserved independent rather than sociable
Agreeableness	trusting, helpful, sympathetic	suspicious, antagonistic
Neuroticism	prone to mood swings, volatile	calm, well adjusted, stable

Discussion

In the context of this research it was decided not to use the MMPI or the MAC scales for a number of reasons. First, despite its common use, the MMPI is not without criticism. For example, Allan, Fertig and Mattson (1994) criticised its emphasis on disordered behaviour, the complexity of the concepts it endeavours to measure and its tendency to view people from an intrapersonal rather than interpersonal perspective. Second, the MMPI assessment tool is a protected psychological instrument, meaning it can only be given and interpreted by a psychologist trained to do so. Third, the MAC scale operates as a screening test to help identify whether or not an individual has an alcohol problem. In this research all participants have already concluded they have a problem with alcohol. Furthermore, the MAC scale was developed for use in a psychiatric setting which is not the case with this research dissertation. Consequently, the exploration of the

links between personality models and alcohol dependence focuses on Eysenck's contribution and that of the five factor model.

Personality models and alcohol dependence

Eysenck

Using Eysenck's Personality Questionnaire (EPQ) with a sample population of drug addicts was first considered by Gossop and Eysenck (1980), when they compared the questionnaire responses of 221 drug addicts to those of 310 normal subjects (Eysenck and Eysenck, 1991). The findings led to the formation of an Addiction Scale consisting of 32 items, a scale that was used initially with people who had eating disorders, for example, Feldman and Eysenck (1986) and De Silva and Eysenck (1987). However, using the EPQ with people with an alcohol dependency problem has not been limited to the use of the Addiction scale entirely.

Rankin, Stockwell and Hodgson (1982) used the Eysenck Personality Questionnaire to investigate the link between personality factors in people with alcohol dependency with specific reference to the severity of the dependency. Their research demonstrated that people in their sample had raised Neuroticism scores, although they were unable to clarify whether such scores were as a consequence of alcohol abuse, or a cause of alcohol abuse. They observed that people with a severe alcohol problem, both men and women, had significantly raised Psychoticism scores above those who were normal subjects and those who had a less severe alcohol problem. Furthermore, they demonstrated that both men and women (although to a lesser degree than men) with severe alcohol problems recorded lower than normal Extraversion scores.

285

Allsopp (1986) used Eysenck's Personality Questionnaire, and an additional assessment tool for measuring impulsiveness, venturesomeness and empathy, to investigate the link between personality traits and beer and cider consumption in young men, some of whom were craftsmen employed in skilled manual occupations, and some of whom were full-time students. His findings demonstrated significant observations that were highlighted by contrasting scores recorded from the personality assessment. For example, from the total sample of both craftsmen and students, those who had high extraversion scores were likely to consume twice as much alcohol as those with low extraversion scores, as were those who had high psychoticism scores. In the sample of craftsmen, those who had high Impulsiveness scores consumed twice as much alcohol as those with low Impulsiveness scores, and in the sample of students they consumed three times as much alcohol. Only the student population recorded a significant connection with high venturesome scores where twice as much alcohol was consumed compared to students with low venturesome scores. Neither sample recorded any significant link between neuroticism scores and consumption, although Allsopp suggested this may be a reflection on the location where consumption was recorded, that is in pubs or clubs.

Ogden, Dundas and Bhat (1989) used the Eysenck Personality Questionnaire to assess a sample of people with alcohol dependency problems who were not hospitalised subjects. Their research findings they described as being "almost identical to the moderately dependent males and females reported by Rankin, Stockwell and Hodgson (1982)" (Ogden, Dundas and Bhat, 1989, p 266). Specifically this meant that the men had significantly lower extraversion scores and both men and women had significantly higher neuroticism scores.

Rosenthal, Edwards, Ackerman, Knott and Rosenthal (1990) used the Eysenck

Personality Questionnaire to illicit data from a sample of people with diverse

chemical addictions. They demonstrated that there were differences in personality

traits in relation to the substances that were being used. For example, all substance

abusers scored highly in psychoticism and neuroticism scores and lowly on

extraversion scores, in comparison with normal subjects. Alcohol and opoid users

had the lowest psychoticism scores, and alcohol abusers had the highest neuroticism

and lie scores. This research categorises diverse chemical addictions into two

groups, where those who use stimulants and uppers demonstrated high psychoticism

and extraversion and low neuroticism scores, whereas those who use depressants

and downers demonstrated low psychoticism and extraversion and high neuroticism

scores.

Eysenck (1997) investigated the link between addiction, personality and motivation.

He suggested that a personality profile influences the function alcohol plays in an

individual's life. A person repeatedly uses alcohol to fulfil a certain function, for

example, to cope, to enhance mood or to facilitate social interaction, and this

behaviour becomes a habit through the way the brain functions. For example,

excessive dopamine functioning is associated with having a psychotic personality

characteristic. People drink because it serves a purpose and the purpose it serves is

related to their personality.

The Five Factor Model

Loukas, Krull, Chassin and Carle (2000) investigated the mediational role of

personality in the relationship between parental alcohol dependency and young adult

alcohol dependency, and the influence personality had on alcohol abuse. In their

research Loukas, Krull, Chassin and Carle (2000) used the Five-Factor model

measuring neuroticism, extraversion, openness to experience, agreeableness and

conscientiousness (Costa and McCrae, 1992). They sought to discover which

personality variables, if any, mediated or moderated other causal variables that

contribute to the development of an alcohol dependency problem. Their research

demonstrated that, of the five factors, three personality characteristics were related

in some way with drinking motives. For example, neuroticism, characterised by

people who are moody and emotionally unstable, was positively related to coping,

social and enhancement motives, i.e. those who had high N scores declared their

motives for drinking to be coping, social and enhancement motives. Agreeableness,

characterised by people who are trusting, compliant and who value interpersonal

relationships, was negatively related to coping motives, i.e. people low in these

characteristics are aggressive, self-centred and indifferent to others and did not

declare coping motives for using alcohol. Conscientiousness, characterised by

people who are determined, organised and planners, was negatively related to

coping, social and enhancement motives, i.e. people who are impulsive, careless

and disorganised declared coping, social and enhancement drinking motives.

Therefore, parental alcoholism was associated with raising levels of neuroticism and

lowering levels of agreeableness and conscientiousness.   This conclusion is in

harmony with Hampson's (1995) constructivist approach to personality theory,

where personality is constructed through social interaction and interpersonal

relationships. Loukas, Krull, Chassin and Carle (2000) also demonstrated that N

scores were not related to the three reasons for limiting drinking, i.e. upbringing, self

control and performance. However, their initial analysis did demonstrate that

agreeableness and conscientiousness were both positively related to all three reasons for limiting drinking.

Theakston, Stewart, Dawson, Knowlden-Loewen and Lehman (2004), explored the relationship between the Big Five personality domains and drinking motives among young adult drinkers. Their research demonstrated that personality domains did predict both external and internal drinking motives. For example, high neuroticism scores (low emotional stability) predicted coping motives for drinking, high extraversion and low conscientiousness scores predicted enhancement motives, low extraversion predicted coping motives and high imagination and low agreeableness predicted enhancement motives.

Mezquita, Stewart and Ruipérez (2010) investigated the relationship between personality domains and internal drinking motives, alcohol use (drinks per month) and alcohol-related problems. Their research demonstrated that coping-depression motives were predicted by high neuroticism scores, coping-anxiety motives were predicted by high neuroticism and low conscientiousness scores and enhancement motives were predicted by high extraversion and low conscientiousness scores. They also demonstrated that heavier drinking was predicted by enhancement motives and alcohol related problems were predicted by coping-depression and coping-anxiety motives.

Discussion

From these examples it is clear that exploring the links between a five factor personality model and issues related to alcohol use and abuse makes a positive

contribution to an exploration of personality and alcohol dependence. However, in this research dissertation it was decided not to adopt this approach for a number of reasons. First, there has not been unanimity in relation to the labelling of the factors, for example the agreeableness trait has also been labelled conformity (Fiske, 1949).

Second, there has not been unanimity in relation to the number of traits that have been identified. For example, Zuckerman, Kuhlman, Joireman, Teta and Kraft (1993) compared the factors from three models, Eysenck's Three Factor model, Costa and McCrae's Big Five and the Alternative Five. They observed that extraversion and Neuroticism were similar across all three models and that there was overlap between some of the factors, e.g. Eysenck's psychoticism trait could be compared with conscientiousness and impulsive sensation-seeking from the other two models.

Third, Benet and Waller (1995) challenged the Big Five structure and its comprehensiveness in describing personality. They explained that the Big Five excluded "evaluative terms and state descriptors," and they went on to defend their adoption of the Big Seven structure first presented by Tellegen and Waller (1987). Tellegen and Waller (1987) so named their model because it included the Big Five but added two further dimension which they called positive and negative valence which include aspects of self evaluation such as joy and fear, respectively.

Justification for using Eysenck

Eysenck's personality assessment approach is used in this research for a number of reasons. First, the link between alcohol dependence and genetic make-up, which has

already been referred to in chapter five (Acuda and Alexander, 1998), is a factor

Eysenck's approach to personality assessment takes into consideration.   It is

deemed important that the personality assessment tool employed in this dissertation,

working as it does in the context of people with alcohol dependency, can be seen to

take cognisance of genetic mechanisms, a fact Eysenck's approach recognises, even

if the nature of the link has been debated (Eysenck, 1997).

> There seems little doubt that personality plays a prominent part in relation to
>
> addiction, regardless of the type of addiction, and that dopamine plays a
>
> large mediating role between DNA and personality. (Eysenck, 1997, p 85)

Furthermore, Janowsky (1999) demonstrated that personality and temperament

variables were linked to biological and genetic mechanisms. For example,

Janowsky (1999) refers to 'Linnoila's 1983 landmark research paper on 'Serotonin,

fire-setting and violence,' which demonstrated that the 'serotonin-mediated

psychopathologies' of suicide, alcoholism and aggression were linked by

impulsivity. Finally, Jang, Vernon and Livesley (2000) and Ebstein, Benjamin and

Belmaker (2000) point out that personality is a biologically based genetic substrate;

a substrate that influences the relationship between personality and an individual's

environment or situation.

Second, Eysenck presented his model of three orthogonal dimensions as being

independent of intelligence and as consistently emerging as super-traits from large

scale factor analytical studies. The super-traits emerge from first order traits which

are intercorrellated and, most importantly, empirically derived (Gillespie, Zhu,

Evans, Medland, Wright and Martin, 2008). Therefore, Eysenck's assessment

approach has an empirical base that has been widely used and is replicable.

Third, Francis (1996) has demonstrated that Eysenck's dimensional model predicts individual differences in attitude to drugs and alcohol. For example, Francis (1996) demonstrated that the strongest predictor of a tolerant attitude towards substance use was high psychoticism scores, and the second strongest predictor was low lie scores, that is, low social conformity meant more tolerance towards substance use. The third strongest predictor was extraversion, where high extraversion scores represented more tolerance towards substance use, whereas high introversion scores were more proscriptive, that is, more likely to denounce or forbid. The least strong predictor was neuroticism, where high neuroticism scores meant more tolerant attitudes to substance use whereas low neuroticism scores meant more proscriptive attitudes.

Finally, there remains one methodological question that relates to personality measurement and people who have an alcohol dependency problem. The question arises because individuals with an alcohol dependency problem often have other issues in their life with which they contend, for example, anxiety, depression or schizophrenic disorders (Sher and Trull, 1994). If the purpose of this research was the measurement of personality characteristics in relation to alcoholism *per se*, then a methodology would have to be found that isolates common comorbid issues. But the purpose of this research is not the measurement of personality characteristics in relation to alcoholism, but in relation to people with an alcohol dependency problem. The purpose is to gain a deeper understanding of the people who present

themselves for help, rather than a deeper understanding of the condition with which they suffer. To this end Eysenck's assessment approach is considered appropriate.

Eysenck's personality dimensions

In this research the Revised Eysenck Personality Questionnaire (Abbreviated) was used with the sample of people who have declared they have an alcohol dependency problem. The questionnaire consisted of 24 questions aimed at measuring the three personality dimensions of extraversion, neuroticism and psychoticism and included a lie scale aimed at measuring social conformity. Responses to the questionnaires were analysed to reveal the percentage of participants who agreed with a particular statement. The analysis also produced information that related to the reliability of the results, and Cronbach's alpha coefficient (α) was recorded for each construct. The interpretation of the alpha coefficient may vary according to what is being measured. For example, Kline (1993) explains that in cognitive tests, such as intelligence tests, an alpha value of .80 is an appropriate score to indicate an underlying construct, whereas in other tests, such as ability tests, a score of .70 would be considered appropriate. Furthermore, an alpha value may be low if the number of items in the scale is low, or when dealing with psychological constructs where there are diverse factors being measured. The following outlines each of Eysenck's dimensions in turn and then presents the findings for the sample population.

Extraversion

Initially, Eysenck suggested there were two super-traits of personality, each at opposite ends of a single continuum of sociability, with extraversion at one extreme

and introversion at the other. In his description of extraverts, people who had high scores, Eysenck suggested that typically he or she is someone who is

> ...sociable, likes parties, has many friends, needs to have people to talk to, and doesn't like reading or studying by himself. He craves excitement, takes chances, often sticks his neck out, acts on the spur of the moment and is generally an impulsive individual. He is fond of practical jokes, always has a ready answer, and generally likes change: he is carefree, easy-going, optimistic and likes to laugh and be merry. (Eysenck and Eysenck, 1991, p 4)

On the other hand, typically an introvert is described as a person who is quiet, introspective, tender minded, serious and inhibited, and is demonstrated by low scores on the extraversion scale.

Eysenck (1995) summerised the traits that inter-correlate with each other to give rise to extraversion as illustrated in *Figure 1* below.
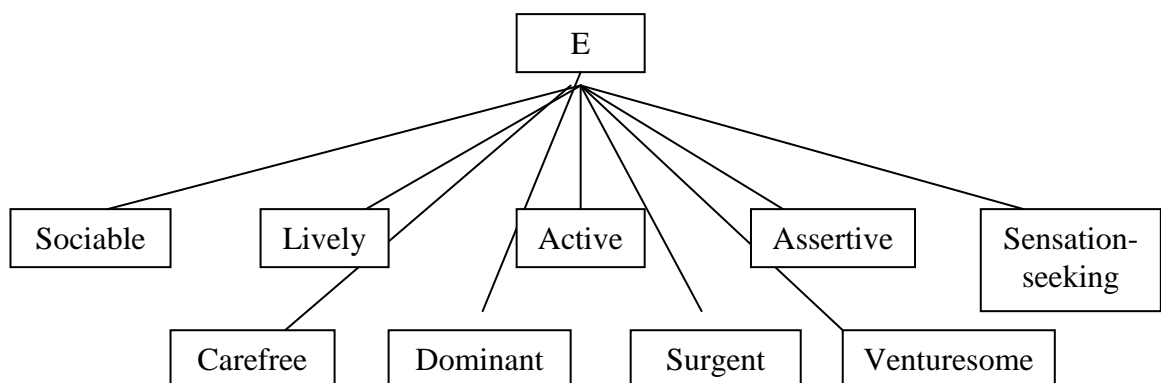
Figure 1

Table 11.2 presents the percentage item endorsement and item rests of test in relation to extraversion.

Table 11.2 Extraversion

	Yes %	r
Are you a talkative person?	62	.41
Are you rather lively?	64	.43
Can you easily get some life into a dull party?	57	.53
Do you tend to keep in the background on social occasions?*	37	.43
Are you mostly quiet when you are with other people?*	52	.52
Do other people think of you as being very lively?	61	.60
Alpha		.72

Please note these items have been reverse coded for the r value

First, this table presents the number of positive responses from the sample population to each of the six questions. For example, just under two-thirds of the sample population describe themselves as talkative (62%), lively (64%) and believe other people consider them lively (61%). Over half declared they could get some life into a dull party (57%) and that they were mostly quiet when they were with other people (52%). Just over one-third reported that they tended to keep in the background on social occasions (37%), when it may have been anticipated that extraverts may have reported that they were at the forefront on social occasions.

Second, the table includes the item rest of test correlations (r) for each of the questions. These scores indicate that there is a good relationship between the way individuals answered each question and the way he or she answered the rest of the questions.

Third, the alpha coefficient of .72 suggests that the reliability of the personality dimension of extraversion - introversion has been demonstrated in this sample population.

Discussion

The extravert – introvert personality dimension is a measure of sociability and people with high and low scores may demonstrate differing relationships with alcohol. For example, extraversion implies having a high degree of activity, expressed in terms such as lively, active and sensation-seeking. This suggests that actions emerge from habits of behaviour that are more likely to be based in personality traits than on reasoned decisions or choices. In the context of this dissertation it is not surprising that respondents recognise that habit rather than reasoned decision making prompts behaviour.

Extraversion also implies having a strong draw towards being sociable, an observation supported by remembering that 74% of participants in this sample recorded they drank because all their friends drank socially. Alcohol plays an obvious role in social contexts and the process of socialising and again this observation is not considered surprising.

Furthermore, traits such as carefree and venturesome imply a tendency to overlook consequences, not thinking through potential danger. These traits reflect the second characteristic of the Alcohol Dependent Syndrome (outlined in chapter one), where salience of drink seeking behaviour takes precedence over competing demands like time, money and family commitments.

Alternatively, introversion implies a high degree of cerebral activity and of being socially isolated. This suggests that such individuals may drink because they feel isolated, even lonely, unable to socialise with others without alcohol. Furthermore,

introspection and inhibition may suggest a tendency to over-think things and lead to

using alcohol as a way of switching off from daily concerns. Later, an investigation

into the link between this personality dimension and drinking motives may shed

more light on the contrast between extraversion and introversion.

Neuroticism

Eysenck's second personality dimension is neuroticism. Individuals can be placed

on this dimension according to the degree of neuroticism they possess (Maltby, Day

and Macaskill, 2010), where neuroticism is defined as emotional instability.

Typically, a person who scores highly can be described as neurotic and,

> ...is an anxious, worrying individual, moody and frequently depressed. He is
>
> likely to sleep badly, and to suffer from various psychosomatic disorders.
>
> He is overly emotional, reacting too strongly to all sorts of stimuli, and finds
>
> it difficult to get back on an even keel. (Eysenck and Eysenck, 1991, p 4)

Alternatively, someone who has a low score in this personality dimension has

demonstrated emotional stability and maybe typified by someone who has a sense of

well-being, who is not easily upset and who is easy going.

Eysenck (1995) summarises the traits that inter-correlate with each other to give rise

to neuroticism as illustrated in *Figure 2* below. Table 11.3 presents the percentage

item endorsements and item rests of test in relation to neuroticism.

First, a high percentage of respondents reported that their mood often went up and

down (83%), over three-quarters said that they would describe themselves as

297

worriers (78%) and over two-thirds declared they often felt 'fed up' (69%). Under

two-thirds of the sample identified they often felt lonely (60%) and just over half

said they would describe themselves as nervous (51%). The sample made a

distinction between being nervous and suffering from nerves as just under half

confirmed they suffered from nerves (48%).
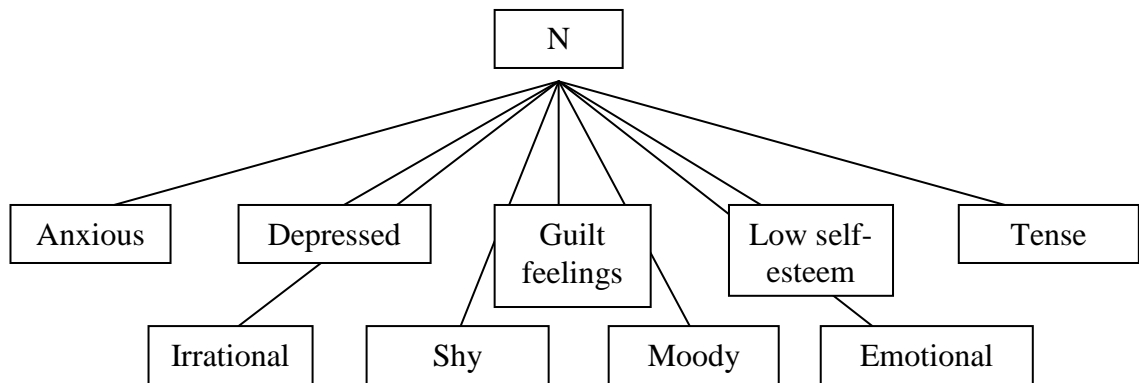
Figure 2

Table 11.3 Neuroticism

	Yes %	r
Does your mood often go up and down?	83	.33
Do you often feel 'fed up'?	69	.41
Would you call yourself a nervous person?	51	.49
Are you a worrier?	78	.39
Do you suffer from nerves?	48	.55
Do you often feel 'lonely'?	60	.51
Alpha		.72

Second, the item rest of test correlations (r) indicate that there is a good relationship

between the way individuals answered each question and the way he or she

answered the rest of the questions.

The alpha coefficient of .72 suggests that the reliability of the personality dimension

neuroticism has been demonstrated in this sample population.

Discussion

One important consideration to note is Eysenck's observation that there is a link between neuroticism and difficulty in coping with environmental stress. These traits demonstrate individual responses to perceived environmental stress and give expression to a negative temperament.

Reflecting on the implications for drinking behaviour of those with high scores prompts three observations. First, traits such as anxiety, guilt and depression express a negative inner affect. Kumar and Clark (1990) defined an anxious personality as,

> An anxious personality is an individual who has a lifelong tendency to experience tension and anxiety, and to have a worrisome attitude towards life and a constant anticipation of setback and stress. (Kumar and Clark, 1990, p 985)

Inebriation offers temporary relief from the prevalence of negative affect but, in the longer term, also contributes to it.

Second, traits such as low self-esteem and shyness represent a negative inner state that implies an individual does not have the resources to overcome environmental stress. The effect of alcohol is to lower inhibitions effectively over-ruling this kind of negative inner state.

Third, traits such as moodiness, emotionality and irrationality imply that an individual does not have the necessary cognitive or life skills to resolve negative environmental stress.

In summary, these three observations combine to maintain a perceived need for alcohol in people who have an alcohol problem and who are neurotic. Even if such characteristics are consequential of an alcohol dependency problem, they do not immediately disappear with cessation of drinking behaviour.

Alternatively, for those who have low scores on the neuroticism scale, and who develop alcohol problems, there will be quite different implications for their drinking behaviour. In such instances the motives for drinking lie elsewhere, not in negative or unstable emotionality.

Psychoticism

Eysenck's third personality dimension is psychoticism. Maltby, Day and Macaskill (2010) explain that it is the severity of this disorder that distinguishes psychoticism from neuroticism. Typically, a person who scores highly as psychotic,

> ...is solitary, not caring for people; he is often troublesome, not fitting in anywhere. He may be cruel and inhumane, lacking in feeling and empathy, and altogether insensitive. He is hostile to others, even his own kith and kin, and aggressive, even to loved ones. He has a liking for odd and unusual things, and a disregard for danger; he likes to make fools of other people and to upset them. (Eysenck and Eysenck, 1991, pp 5-6)

Alternatively, people with low psychoticism scores tend to be tender-minded, they are caring, co-operative and most likely wish to conform to social norms. Eysenck (1995) summarises the traits that inter-correlate with each other to give rise to psychoticism as illustrated in *Figure 3* below.
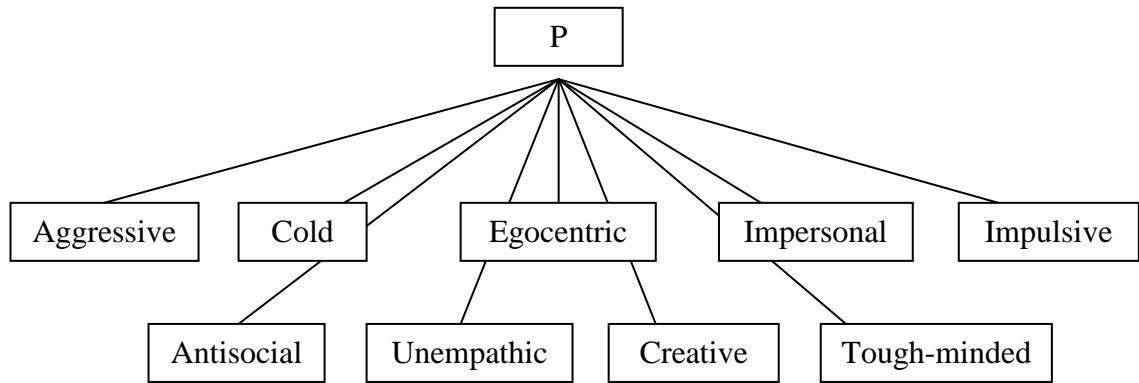
Figure 3

Table 11.4 presents the percentage item endorsements and item rests of test in relation to psychoticism.

Table 11.4 Psychoticism

	Yes %	*r*
*Would being in debt worry you?**	82	.16
Would you take illegal drugs?	40	.20
*Do you enjoy cooperating with others?**	94	.27
Do you think marriage is old fashioned?	4	.17
*Do you try not to be rude to people?**	95	.28
Would you like other people to be afraid of you?	7	.22
Alpha		.41

Please note these items have been reverse coded

First, very high scores of over 90% were recorded in two of the six questions aimed at measuring Eysenck's psychoticism dimension. For example, 95% said they tried not to be rude to people and 94% said they enjoyed working with others. A high percentage declared that being in debt would worry them (82%) and less than half (40%) said they would not take illegal drugs that might have a strange or dangerous effect on them.

Second, two of the item rest of test correlations ($r = .16$ and $.17$) indicate that there

is a poor relationship between the way individuals answered these questions and the way he or she answered the rest of the questions.

Third, the alpha coefficient of .41 suggests that the reliability of the personality dimension of psychoticism has not been demonstrated as strongly as the two previous dimensions in this sample population.

An explanation as to the failure to demonstrate the reliability of this construct may lie in one of two areas. First, perhaps these results reflect a fundamental problem when trying to replicate the reliability of the psychoticism construct (Eysenck, Eysenck and Barrett, 1985). Indeed, problems have emerged in relation to the psychoticism scale when using the short-form revised Eysenck personality questionnaire. For example, Francis, Brown and Philipchalk (1992) identified alpha coefficients of 0.31, 0.41 and 0.51 in cross-cultural samples from the United States of America, Canada and England respectively. Second, perhaps the results reflect the fact that traits giving rise to psychoticism are not those typical of people who come to Stauros for pastoral support with alcohol dependency. For example, being cold, impersonal, unempathic and tough-minded are characteristics that not common among people who seek to talk others in a setting of pastoral care using counselling skills.

Discussion

Reflecting on the implications for drinking behaviour for those with high scores prompts a number of observations. First, traits such as aggression, coldness, being impersonal and antisocial are traits that characterise drinkers who appear determined

to drink despite the negative impact their behaviour has on close family and friends.

Second, six questions in this construct drew responses that are not typical of

psychotic personality dimension. For example, 94% of the sample declared they

enjoyed co-operating with others, 95% declared they tried not to be rude to other

people and 93% said they did not want other people to be afraid of them. These

stand in direct contrast to psychotic characteristics such as antisocial, unempathic,

aggressive and cold and reflect lower psychoticism scores typified by people who

are tender minded. These observations suggest that the inter-correlated traits that

represent a psychotic personality dimension are not ones that have been strongly

demonstrated by this sample population.

Lie Scale

Table 11.5 presents the percentage item endorsements in relation to the lie scale.

Table 11.5 Lie: percentage item endorsements

	Yes *%*	*r*
Were you ever greedy by helping yourself to more than your share of something?*	72	.41
Have you ever blamed someone for something you knew was really your fault?*	80	.50
Have you ever taken anything (even a pin or a button) that belonged to someone else?*	85	.32
Have you ever cheated at a game?*	77	.44
Have you ever taken advantage of someone*?	80	.45
Do you always practise what you preach?	17	.06
Alpha		.63

*Please note these items have been reverse coded

First, high percentages of positive responses to three questions indicate the

willingness of this sample population to admit to personal shortcomings. For

example, 85% admitted to stealing, 80% to blaming others and taking advantage of

others respectively. In two other questions which target being a cheat and greedy, 77% and 72% respectively responded positively.

Second, one of the item rest of test correlations ($r = .06$) indicates that there is a poor relationship between the way individuals answered this question and the way they answered the rest of the questions. It is suggested here that this score is poor because there is little spread in the percentage endorsement.

Third, the alpha coefficient of .63, although lower than extraversion and neuroticism, is considered high enough to suggest the reliability of the Lie scale as a measurement of social conformity.

Discussion

Francis has demonstrated that the Lie scale does measure truthful reporting, but not consistently. For example, Pearson and Francis (1989) used the Lie scale with 15- to 16- year-old teenagers and student teachers respectively and demonstrated on both occasions it consisted of two components, one measuring socially conforming behaviour and one measuring a propensity to fake goodness. However, Francis, Fulljames and Kay (1992) concluded that the Lie scale demonstrated truthful reporting when used with a population of Bible College students.

The Lie scale measures social conformity with three questions relating to issues such as stealing, cheating and taking advantage of other people. Second, the scale measures propensity to fake goodness with three questions relating to issues such as being greedy, blaming others and practising what is preached. It is reasonable to

conclude that different sample populations respond to the Lie scale questions in different ways. This leads to the question regarding the sample population in this research: how has it responded to the Lie scale questions? Does it demonstrate truthful reporting, demonstrating the absence of a propensity to fake goodness, or does it represent cognitive processes that demonstrate a desire to socially conform? It is suggested that the sample's responses in the Lie scale demonstrate a willingness to show social conformity because high percentages of respondents were willing to admit personal shortcomings reflected in stealing, blaming others and taking advantage of others, which shows they were not trying to fake goodness.

The alpha coefficient of .63 suggests a degree of reliability in demonstrating social conformity.

Personality dimensions and drinking motives

Having demonstrated the reliability of Eysenck's personality dimensions, attention now turns to exploring the question of possible relationships between these dimensions and the drinking motives declared by this sample population. Chapter six detailed the research carried out into the drinking motives of this sample population. The question "Why did you drink alcohol?" was followed by 18 statements indicating a number of reasons, and a Likert scale was used as a response mechanism. Crosstabulations were carried out aimed at testing for associations between each of Eysenck's personality dimensions and drinking motives. The findings for each dimension were recorded and are discussed. The Pearson correlation provides two pieces of information; first, whether or not there is a correlation between the two variables (Eysenck's personality dimension and

drinking motives): a score of 0 would mean there was no correlation. Second, it demonstrates whether a correlation is positive or negative. A positive correlation means that if one variable increases the other variable will increase; a negative correlation means that if one variable increases the other variable will decrease (Field, 2003).

Table 11.6 demonstrates there are five drinking motives that significantly correlate with Eysenck's extraversion personality dimension test, one where the correlation is positive and four where it is negative.

Table 11.6 Drinking motives and Extraversion

	r	$p<$
Why did you drink alcohol?		
All my friends drank socially	+.11	NS
I felt pressurised into drinking	-.02	NS
Drinking was expected of me	+.01	NS
Drinking made me feel good	-.03	NS
I was curious as to what drinking was like	+.15	.05
Drinking helped me overcome shyness	-.17	.05
I drank because I had difficulty sleeping	-.26	.001
I drank to cope with stress	-.06	NS
I drank to forget the past	-.01	NS
Drinking helped me feel better about myself	+.05	NS
Drinking helped me relate to others socially	+.02	NS
I drank because I felt rejected	-.28	.001
I drank to cope with what people did to me	+.00	NS
I drank to cope with what happened to me	-.03	NS
I drank because my mind was troubled	-.06	NS
I drank because my feelings were troubled	-.15	.05
I drank to cope with my insecurities	-.07	NS
I drank because my life was meaningless	-.03	NS

This table demonstrates that participants who scored highly on Eysenck's extraversion dimension were more likely to be motivated to drink alcohol out of curiosity. Typically, extraverts crave excitement, take chances, act on the spur of

the moment, are carefree and like to laugh and be merry, and these characteristics are in keeping with drinking out of curiosity (Eysenck and Eysenck, 1991).

The four negative correlations demonstrate that some participants had low extravert scores, indicating they tended towards being introvert. This means that the table demonstrates that participants who displayed characteristics akin to Eysenck's introverted traits were more likely to be motivated to drink alcohol to overcome shyness, because they had difficulty sleeping, because they felt rejected and because their feelings were troubled. Typically, introverts are quiet and retiring people who may well drink to overcome shyness. They may have difficulty sleeping because they treat everyday life with great seriousness, and they may feel the need for help with relating to others socially, as they are naturally introspective, socially distant and fond of books rather than people. Typically they keep their feelings under close control and this is in keeping with them drinking because their feelings are troubled (Eysenck and Eysenck, 1991).

Table 11.7 demonstrates there are ten drinking motives that significantly correlate with Eysenck's neuroticism personality dimension test in a positive way. This means that the higher an individual scored in Eysenck's test for neuroticism, the more likely they were to be motivated to drink for the reason stated. Typically, individuals who score highly on Eysenck's neuroticism dimension are anxious and, generally, are worriers and this is in keeping with them drinking to overcome shyness or being nervous and timid in the company of others. Furthermore, they are likely to sleep badly which prompts the use of alcohol to overcome this difficulty. Drinking to overcome stress is in keeping with neurotics who typically suffer from

307

various psychosomatic disorders, i.e. disorders caused or aggravated by a mental factor such as internal conflict or stress. Drinking to forget the past and to cope with what people did or what happened in the past is consistent with neurotics who typically respond in an over emotional way to stimuli and who over-react in a way that is irrational. Drinking because of a troubled mind or troubled feelings is further evidence of being moody, overly emotional and depressed. Feelings of insecurity and meaninglessness may well be derived from an acute awareness of what might go wrong (Eysenck and Eysenck, 1991).

Table 11.7 Drinking motives and Neuroticism

	r	p<
Why did you drink alcohol?		
All my friends drank socially	+.13	NS
I felt pressurised into drinking	+.05	NS
Drinking was expected of me	-.08	NS
Drinking made me feel good	+.05	NS
I was curious as to what drinking was like	-.09	NS
Drinking helped me overcome shyness	+.61	.05
I drank because I had difficulty sleeping	+.23	.001
I drank to cope with stress	+.24	.001
I drank to forget the past	+.20	.001
Drinking helped me feel better about myself	+.12	NS
Drinking helped me relate to others socially	-.03	NS
I drank because I felt rejected	+.02	NS
I drank to cope with what people did to me	+.16	.05
I drank to cope with what happened to me	+.15	.05
I drank because my mind was troubled	+.22	.001
I drank because my feelings were troubled	+.24	.001
I drank to cope with my insecurities	+.20	.001
I drank because my life was meaningless	+.18	.01

Cyders, Flory, Rainer and Smith (2009) elaborated on these themes in their research into the role personality disposition plays in predicting drinking behaviour in college students. They demonstrated that personality disposition plays an important role in influencing behaviour especially when people move into new contexts in life, such

as going to college, where there are new levels of behavioural freedom. In the context of this dissertation, a neurotic personality disposition, with all its emotionality, anxiety, moodiness and worry, will be further harassed by the prospect of giving up alcohol. When confronted by a new life context such as cessation of drinking, such people are likely to be greatly influenced by their inability to face new challenges with perseverance and strength of will.

Table 11.8 demonstrates there is only one drinking motive that is significantly correlated with Eysenck's psychoticism personality dimension test in a negative way. The negative score indicates that respondents had low scores in Eysenck's psychoticism dimension indicating that they were more likely to be tender-minded than tough-minded, which would typically characterise a psychotic temperament. Typically, individuals who score highly on psychoticism scales are solitary people, not caring for others, troublesome and who do not fit in anywhere, whereas those who score low scores are typically more likely to be sociable. This result demonstrates that there is a significant link between people who are tender-minded and who drink to cope with stress.

Rankin, Stockwell and Hodgson (1982) characterised the Clinical Alcohol Personality as being typified by High-Neuroticism, High-Psychoticism and Low-Extraversion scores. In this research dissertation two of these three characteristics have been demonstrated, High-Neuroticism and Low-Extraversion scores, but High-Psychoticism scores have not been demonstrated. Three observations may be made about the lack of positive correlations between high P scores and drinking motives.

First, perhaps there is a procedural explanation whereby the analytical process failed

to capture or represent the appropriate responses from the sample population.

Table 11.8 Drinking motives and Psychoticism

	r	p<
Why did you drink alcohol?		
All my friends drank socially	+.07	NS
I felt pressurised into drinking	+.09	NS
Drinking was expected of me	+.05	NS
Drinking made me feel good	-.02	NS
I was curious as to what drinking was like	+.04	NS
Drinking helped me overcome shyness	+.01	NS
I drank because I had difficulty sleeping	-.03	NS
I drank to cope with stress	-.27	.001
I drank to forget the past	-.07	NS
Drinking helped me feel better about myself	+.24	NS
Drinking helped me relate to others socially	+.01	NS
I drank because I felt rejected	+.00	NS
I drank to cope with what people did to me	+.05	NS
I drank to cope with what happened to me	+.03	NS
I drank because my mind was troubled	-.11	NS
I drank because my feelings were troubled	-.10	NS
I drank to cope with my insecurities	-.09	NS
I drank because my life was meaningless	+.06	NS

Second, perhaps the results simply echo the inconsistencies sometimes demonstrated

in the psychoticism scale when the test is replicated. Third, perhaps people with the

character traits of high Psychoticism scorers are not likely to consider coming to an

organisation like Stauros to ask for help. Gossop and Eysenck (1983) demonstrated

that a sample of drug dependent people scored significantly higher on Psychoticism

and Neuroticism than prisoners, but lower on Extraversion and Lie. They

commented on the influence high Psychoticism scores may have on the success or

otherwise of conventional therapeutic processes, concluding that people with high

Psychoticism scores may profit more from practical aspects of rehabilitation, rather

than conventional therapeutic processes.

Table 11.9 demonstrates that there are six drinking motives that are significantly correlated with Eysenck's lie scale in a negative way.

Table 11.9 Drinking motives and Lie scale

	r	p<
Why did you drink alcohol?		
All my friends drank socially	+.04	NS
I felt pressurised into drinking	-.08	NS
Drinking was expected of me	-.09	NS
Drinking made me feel good	-.14	.05
I was curious as to what drinking was like	-.14	.05
Drinking helped me overcome shyness	-.12	NS
I drank because I had difficulty sleeping	+.03	NS
I drank to cope with stress	-.06	NS
I drank to forget the past	-.10	NS
Drinking helped me feel better about myself	-.18	.01
Drinking helped me relate to others socially	-.20	.001
I drank because I felt rejected	-.12	NS
I drank to cope with what people did to me	-.03	NS
I drank to cope with what happened to me	-.06	NS
I drank because my mind was troubled	-.11	NS
I drank because my feelings were troubled	-.06	NS
I drank to cope with my insecurities	-.21	.001
I drank because my life was meaningless	-.16	.05

The negative scores on the six items indicate that the respondents had low Lie scores and were more likely to be demonstrating truthful responses and high level of social conformity. Perhaps respondents considered certain drinking motives, for example feeling good, curiosity, feeling better, being more sociable, dealing with insecurities and meaninglessness, as being socially more acceptable than others, for example, because of rejection or having a troubled mind.

Discussion

Having investigated the possibility of relationships between Eysenck's personality dimensions and drinking motives three observations are worth noting. First, links

between drinking motives and introversion were more readily found than between drinking motives and extraversion. This is illustrated by the fact that four motives were demonstrated to have significant links with introversion, while only one motive had a significant relationship with extraversion.

Second, a search for links between drinking motives and neuroticism produced important results. Clearly people who demonstrated the characteristics of neuroticism, as described by Eysenck, could identify with ten of the drinking motives outlined in the research. Bearing in mind that neuroticism depicts characteristics that represent emotional instability, these findings suggests that emotional welfare and alcohol dependence are affiliated. The research demonstrates that individuals make decisions to drink based on their feelings, for example, because their feelings are troubled and because they feel insecure. Furthermore, the research implies that individuals drink because their thoughts are disturbed, for example, they want to forget past events and because their mind is troubled. The basis of decision making for people with alcohol dependence is further explored in the following chapter.

Third, the results suggest there is an overlap between introversion and neuroticism. This overlap is illustrated by the observation that three of the four drinking motives identified by introverts were also identified by people who scored highly in the neuroticism scale. Furthermore, the fourth drinking motive identified by introverts, drinking because they felt rejected, could be understood to have some associations with other drinking motives linked to neuroticism, motives such as drinking to forget to what people did, because their feelings were troubled and because they felt

insecure.

Main findings

This chapter set out explore for Eysenck's personality dimensions within a sample

of people who had declared they had an alcohol problem, and to investigate links

between Eysenck's personality dimensions and drinking motives. Two broad

observations may be declared, first, Eysenck's extraversion and neuroticism

personality dimensions have been demonstrated to function with higher reliability

than his psychoticism dimension in this sample. Second, there are some links

between Eysenck's personality dimensions and drinking motives.

Further reflection highlights some important points. First, extraverts are less likely

to drink as a result of reasoned decision making processes. Drinking occasions for

extraverts provide an opportunity for social interaction, and for enhancing the

dynamics of this interaction. Decisions to drink are about immediate experiences,

effectively side-stepping longer term consequences of inappropriate drinking

behaviour. Based on the positive correlation between Eysenck's extraversion

personality dimension and one drinking motive, extraverts are more likely to drink

out of curiosity.

Second, based on the negative correlations between Eysenck's extraversion

personality dimension and drinking motives, this research has demonstrated that

introverts drink to overcome shyness and to help them sleep. It has also

demonstrated that introverts drink because they feel rejected and because they had

troubled feelings.

Third, based on Eysenck's inter-correlated personality traits, neurotics are more likely to drink to gain relief from moodiness and negative emotions such as guilt. Drinking also offered them a way of coping with negative thought processes that were characterised by anxiety, worry, and irrationality. Furthermore, neurotics are more likely to drink to mask self-disparaging beliefs characterised by low self-esteem and shyness.

Fourth, based on the positive correlations between Eysenck's neuroticism personality dimension and drinking motives, this research has demonstrated that neurotics drink as a way of coping with general life situations such as stress and feelings of insecurity. It has also demonstrated that neurotics drink for quite specific purposes. For example, they were able to identify that they drank to forget the past, because of something someone did to them, because of something that happened to them, because they had troubled thoughts and because they had troubled feelings.

Fifth, based on Eysenck's theory concerning the personality traits underpinning the psychoticism dimension of personality, psychotics are more likely to drink as an expression of coldness, egocentricity, impulsivity and tough-mindedness, and drinking may facilitate expressions of aggression and unempathic antisocial behaviour. These personality traits were not, however, as strongly demonstrated in the sample as extraversion and neuroticism.

Sixth, based on the negative correlation between Eysenck's psychoticism personality dimension and one drinking motive, this research has demonstrated that tender-minded people are more likely to drink to cope with stress.

Finally, of the eighteen motives for drinking, there were six that were statistically not significantly correlated to any of Eysenck's personality dimensions. It might have been expected that extraverts would have been motivated to drink because their friends drank socially, because it made them feel good, that it made them feel better about themselves or that it helped them relate to others socially, yet this was not demonstrated. There was no statistical significance demonstrated between any personality dimension and being pressurised into drinking or drinking because it was expected.

Conclusion

In conclusion, attention now focuses on the key question underpinning this dissertation, 'What does a pastoral carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?' The answer to this question, in the context of Eysenck's personality dimensions and drinking motives, lies in two broad areas, the social environment of the drinker, and his or her frame of mind.

Social environment

Extraversion highlighted the importance for pastoral carers to consider the social environment of individuals who seek for help with an alcohol dependency problem. Four issues in particular emerge from this finding.

First, pastoral carers must take cognisance of an individual's need for, and enjoyment of, social occasions, but appreciate that such occasions, without alcohol, will prove to be very different experiences for their client. Balance between social

isolation, perhaps necessary for a time to ensure clients are not being put in a tempting situation, and social inclusion, which may require thorough planning on the part of the person endeavouring to break alcohol dependency. This is a challenging balance to find, particularly if an individual drinker's joy in living revolves around social interactions. Pastoral carers may find that a client needs support in changing his or her social circle, or in finding new ways to behave in social settings. Becoming incorporated into a new social network, a characteristic outlined in an earlier chapter in relation to religious conversion experiences, may prove to be the answer to many of the issues raised by exploring the social environment of the drinker.

Second, pastoral carers may find it helpful to address the way extraverts make decisions. An approach of re-education may prove valuable in helping them discover a rational way of making choices, one where long term consequences are given due consideration as well as short term experiences.

Third, introversion highlighted the need for pastoral carers to explore their client's inner feelings in relation to perceived social inadequacies. For over three-quarters of the sample, shyness proved to be a motivation behind drinking, shyness that indicates a sense of social inadequacy. Pastoral carers may find it helpful to consider the root cause of a client's shyness, and, more particularly, how it might be overcome. This may well involve investigating a client's self-talk and inner emotional and rational processes.

Fourth, introversion also highlighted the need for pastoral carers to address fundamental emotional issues such as feelings of rejection. The origins of perceived rejection, and its impact on current emotional welfare, are worthy of exploration by pastoral carers. Deep seated feelings of rejection may be expressed in terms of social isolation and a dull sense of not belonging anywhere.

Frame of mind

Neuroticism highlighted the importance for pastoral carers to consider the frame of mind of an individual who seeks for help with an alcohol dependency problem. Again, there are particular approaches that pastoral carers could pursue.

First, negative emotions, such as guilt, and negative thought patterns, such as worry and anxiety, combine to create a frame of mind where continued drinking seems inevitable. Pastoral carers may find it necessary to consider helping a client deal with such issues that influence his or her frame of mind. In the context of alcohol dependence guilt, worry and anxiety are issues of immense magnitude.

Second, neuroticism highlighted the need for practical ways of helping clients manage stress. It was noted that clients with a neurotic personality dimension, and those who are tender-minded, respond negatively to stress, and that they develop two generally common frames of mind, low self-esteem and being insecure. Clients may find it helpful, therefore, to explore the cognitive processes that contribute to such issues, and to develop the resources necessary to overcome them.

Third, neuroticism highlighted the need for pastoral carers to be aware of quite

317

specific issues that neurotics may have identified as significant points in their

experience of alcohol abuse. More precisely pastoral carers may need to ask about a

client's past, what others may have done to them and what things may have

happened to them. These precise areas of investigation may hold key concerns that

maintain a drinking lifestyle.

This chapter has explored Eysenck's personality dimensions and their link with

drinking motives. The following chapter continues on the theme of personality but

explores it from the perspective of psychological type theory.

Chapter Twelve

Psychological type and alcohol dependency

Chapter outline

Introduction

Theoretical context: psychological type theory

Psychological type dynamics

       Dominant function

       Auxiliary function

       Inferior function

       Tertiary function

Uniqueness and commonality

Psychological type reliability

       Extraversion / introversion

       Sensing / intuition

       Thinking / feeling

       Judging / perceiving

Psychological type distribution

       Type preferences

       Type dynamics

       Psychological type profiles

Psychological type and drinking motives

Main findings

Conclusion

Introduction

The previous chapter introduced personality theory by referring to key words such
as traits and dimensions. The chapter explored dimensions of personality, as
understood by Eysenck, in some detail and drew conclusions relevant to the
underlying theme of this dissertation. The chapter went on to search for links
between Eysenck's personality dimensions and drinking motives.

In this chapter the investigation continues in the field of personality and explores it from the perspective of psychological type, as understood by Jung, and operationalised by the Francis Psychological Type Scales (FPTS) (Francis, 2005). The chapter will also compare the personality types as presented in this sample to the population norms and, more specifically, consider links between personality types and drinking motives.

The chapter begins with an introduction to psychological type theory. This includes an exploration of psychological type dynamics, with an explanation of dominant, auxiliary, inferior and tertiary functions and a discussion of the tension between uniqueness and commonality.

The research findings are presented in three sections. First, there is an investigation into the reliability and internal consistency of the findings as presented in the four psychological functions. Second, there is an exploration of the dichotomous pairs of preferences within these four functions, with comparisons made to the United Kingdom population norms. Third, complete psychological type profiles are presented, again with comparisons to the United Kingdom population norms. Following each of these presentations of results there is a discussion that relates to how the findings might be understood in the light of alcohol dependency.

The chapter continues with an exploration of the psychological type profiles of male respondents from the sample population, compared to the appropriate United Kingdom population norms. This exploration includes a discussion of the significance of the results in relation to men who have alcohol dependency.

The chapter includes a summary of the main findings before drawing conclusions that relate to the underlying key question of this dissertation, 'What does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?'

Theoretical context: psychological type theory

Psychological type theory is based on the work of Jung originally published in German in 1921 (Jung, 1990). Psychological type theory is based on the concept of preference: Jung's description of types began with what he called 'the two basic types' which he termed introvert and extravert (Jung, 1990). He further identified four basic functions, two of which related to how people take in information, and two of which related to how people make decisions. Individuals demonstrate preferences in these two aspects of life, for example they perceive the world by sensation or intuition, and they judge or make decisions by thinking or feeling. People demonstrate preferences in these three areas of psychological functioning, in each area a preference being made between two alternatives.

Myers and Myers (1995) extended Jung's theory after highlighting that Jung only described the rare and 'pure' types, and they comment,

> In addition to their dominant process, people have an auxiliary developed well enough to provide a balance between judgement and perception and between extraversion and introversion. Nowhere in his book does Jung describe these normal, balanced types with an auxiliary process at their disposal. (Myers and Myers, 1995, p 17)

As a result they introduced a fourth preference demonstrated by people, a judgement-perception preference and this, they proposed, completed the structure of type. These four areas of psychological functioning, therefore, give rise to 16 potential combinations or types, and these types constitute patterns in personality preferences. The four areas of psychological functioning, where preferences can be expressed, are described by Francis (2005) and Myers and Myers (1995) with reference to Jung.

First, orientation reveals where people prefer to focus their attention, and their preferences are between introversion and extraversion. Jung used the terms to describe an individual's source of energy. Jung suggested that introverts look to the inner world of ideas for their energy, while extraverts looked to the outer world of people and things. Therefore an introvert, who has doubts about a decision, will instinctively pause and think things through deeply: an extravert who has doubts about a decision will instinctively act. Preferences such as these can be misinterpreted from time to time; for example, introversion can be misinterpreted as shyness and inadequacy, whereas extraversion can be misinterpreted as openness and adequacy. Introverts may appear withdrawn and extraverts may appear shallow.

The second and third areas of psychological functioning where preferences are expressed are in two mental processes, one called the perceiving process, by which one gathers or receives information, and the other called the judging process, in which one uses the information received. In the perceiving process preference is demonstrated between two ways of collecting information, by sensing (S) or by intuition (N). Those who prefer sensing start with the environment and work out

theory; whereas those who prefer intuition start with theory and look to the environment for evidence. Those who prefer sensing will instinctively look for and prefer facts as they focus on what can be seen. Those who prefer intuition prefer ideas. They look for the possibilities behind what is seen and focus on the big picture, or the meaning of what they see. Jung pointed out that people need both sensing and intuition in life, but suggested that the one that is a person's least preferred choice will be the one that lets that person down when he or she is tired or under stress.

The judging process identified by Jung is the rational decision making process. Individuals can prefer to make judgements either by thinking (T) or by feeling (F). People who prefer thinking will have a strong sense of justice; they will decide on things in an objective way as a result of logical analysis. People who prefer feeling will be more focused on human relationships, and will make judgements more subjectively, although both preferences are rational.

The final area of psychological functioning where preferences are expressed is in relation to individual attitudes to the outside world. In this area there is no new vocabulary because the attitude a person has to the outside world is a preference between judging (J) and perceiving (P). People who prefer judging like planning ahead; they make lists and structure their day in advance. Francis (2005) explains that a judging attitude to the outside world is characterised by deciding and planning, organising and scheduling, controlling and regulating (Francis, 2005, p 65). People who prefer perceiving do not make decisions as quickly as judging types, waiting as long as possible so as to gather as much information they can

before making a decision. Francis explains that a perceiving attitude to the outside world is characterised by being open-minded and able to adapt to change (Francis, 2005, p65).

These four areas constitute the eight alternatives that are the functions individuals display in expressing their psychological type, and, in particular, the central functions of sensing, intuition, thinking and feeling, which constitute the two mental processes.

Psychological type dynamics

Psychological type dynamics concerns how the functions are used by an individual. Myers and Myers (1995) are clear in their theory that each person needs all four of the central functions (sensing, intuition, thinking and feeling) to operate effectively as a human being. As a result they proposed that within these functions some preferences are developed more than others: the way in which they are developed describes the dynamics of psychological type. If the four functions were to be held in equal place, Jung suggested this would result in a person who was 'relatively undeveloped', what he called a 'primitive' (Myers and Myers, 1995).

Dominant function

Jung developed a vocabulary to describe dynamics of function within the two main psychological processes. One function, he suggested, is the dominant function, a governing force, or best process that brings unity to the rest of the functions (Myers and Myers, 1995). This dominant function 'shapes the person we become and who is recognised by others, once they really get to know us' (Francis, 2005, p 83).

Auxiliary function

Having established that there is a dominant function the question arises as to how the other functions relate. The answer is that one other function acts as an auxiliary function to the dominant function. The auxiliary function supports the dominant function and is derived from the alternative psychological process from the one in which the dominant function is located. For example, if a person's dominant function is thinking (T), this function belongs to the judging process and means that his or her auxiliary function must be one of the two functions that belong to the perceiving process (either N or S).

The auxiliary function fulfils a balancing role in two ways. First, it helps balance the dominant function with a support function from the psychological process other than the one where the dominant function operates. Second, it helps to provide a balance between the outer and inner worlds, between introversion and extraversion (Myers and Myers, 1995). The dominant function operates most naturally in the preferred world of the individual, for introverts the inner world and for extraverts the outer world. The auxiliary function therefore operates in the less preferred option and so brings a balance.

The observation by other people of this balance between dominant and auxiliary functions is worth noting, because the observations of introverts and extraverts will differ. For example, an extravert's preferred orientation is to the outer world. If an extravert's dominant function is sensing (S) then his or her auxiliary function will be either thinking or feeling. As it is most natural for them to operate their dominant function in their preferred world, in this example, the extravert will present his or

her sensing function to other people, meaning that the auxiliary function will be utilised most in the inner world. People see the extravert's dominant function even in casual conversations.

When we consider the introvert, however, the opposite is the case. For example, if an introvert's dominant function is thinking, this means that thinking operates most naturally in that person's inner world. Their outer world, where they must deal with people, is where their auxiliary function best operates (either sensing or intuition) and so people who meet introverts in casual conversation do not meet their dominant function, but the auxiliary function.

Inferior function

If, as Jung's theory suggests, functions are not all equally well developed, and there is a dominant and an auxiliary function, it is reasonable to assume that there is also a function that is not as developed as any of the others. This is what Jung proposed, and he called this function the inferior function (Francis, 2005). This raises the question as to how one knows which of the functions is the least developed. The answer is that the inferior function is the opposite function to the dominant function. For example, if a person's dominant function is thinking, then that person's inferior function is the opposite of this, namely, feeling. When under stress, either due to pressure of work or physical tiredness, the inferior function may so influence such an individual that he or she acts out of character.

Tertiary function

Finally, Jung called the remaining function the tertiary function and it is identified as

the opposite function to the auxiliary function.

Uniqueness and commonality

Psychological type addresses the tension between the uniqueness of an individual, and commonality among individuals. It is proper to accept the idea that everyone is unique, yet this idea does not rule out the observations of patterns among a group of individuals. For example, everyone has a unique fingerprint, different from anyone else, but everyone has a finger print, similar to everyone else: it is produced by the same process of growth and physical development, it is located in the same place and it can be used as a way of identifying an individual and of comparing that person with others. There is both uniqueness and commonality.

This principle applies to people who have an alcohol dependency problem. Each individual's alcohol dependency may be uniquely expressed, but each person with alcohol dependency will have common features with other people with alcohol dependency. In understanding personality type, Myers and Myers (1995) explain that,

> The theory is that much seemingly chance variation in human behaviour is not due to chance; it is in fact the logical result of a few basic, observable differences in mental functioning. (Myers and Myers, 1995, p 1)

This quotation focuses on the key elements at the foundation of this dissertation. First, there are variations of personality from individual to individual, and so there are variations in the expression of an alcohol dependency problem as a human condition. Second, there are similarities that conspire to form a pattern in the variations of personality, and, therefore, of an alcohol dependency problem through

327

that personality. These patterns are observable and are the result of a few basic differences in the way people's minds function. Third, the fields in which the characteristics of uniqueness and commonality can be observed are the two mental functioning processes within individuals. Fourth, the cognitive and mental processes that develop within individuals have a direct effect upon how that person with an alcohol dependency problem behaves.

Psychological type reliability

The sample population of individuals who had declared that they had an alcohol dependency problem completed the Francis Psychological Type Scales (FPTS) questionnaire and their responses were recorded. The internal consistency reliability of results across items within the same construct was calculated as an item rest of test correlation (r), and Cronbach's alpha coefficient was used as a statistical measure of the strength of each construct. A high alpha value means that the questions present a statistically recognisable construct and in this instance, alpha scores around .6 were considered appropriate (Kline, 1993).

Extraversion / introversion

Table 12.1 presents the internal consistency reliabilities of scales for introversion and extraversion. The percentages represent those for introversion only, as introversion and extraversion percentages together add up to 100% and will present the same alpha coefficient.

First, the percentage score for each of the ten items related to introversion represent more than half the sample population, ranging from 53% to 85%. Later in the

chapter the percentage of individuals who identified themselves as introverts and

extraverts is explored in more detail.

Table 12.1 Extraversion / Introversion

| | Agree | |
Introversion	%	r
Do you tend to be more reflective	55	.38
Are you more private	64	.57
Do you prefer a few deep friends	85	.34
Do you dislike parties	53	.39
Are you drained by too many people	60	.32
Are you happier working alone	59	.36
Do you tend to be more socially detached	59	.58
Are you more reserved	54	.55
Are you mostly an introvert	62	.56
Do you think before speaking	56	.11
Alpha		.75

Second, with the exception of one question, the item rest of test scores indicate that

there is a good relationship between the way individuals answered each question and

the way he or she answered the rest of the questions. The one exception is the

answer to the question, "Do you think before speaking," a question that recorded a

rest of test score of .11.

Third, the alpha coefficient of .75 demonstrates there is a reliable internal

consistency in the results to the questions exploring the two orientations concerned

with where energy is drawn from.

Sensing / intuition

Table 12.2 presents the internal consistency reliabilities of scales for sensing and

intuition. In this case the percentage scores for sensing are presented, as sensing and

intuition scores together add up to 100% and will present the same alpha coefficient.

Table 12.2 Sensing / Intuition

Sensing	Agree %	r
Do you tend to be more interested in facts	85	.08
Are you more practical	73	.36
Do you prefer the concrete	78	.32
Do you prefer to make	65	.14
Are you conventional	59	.35
Do you tend to be more concerned about detail	38	.13
Are you more sensible	61	.29
Are you mostly focused on present realities	49	.28
Do you prefer to keep things as they are	19	- .10
Are you down to earth	85	.26
Alpha		.50

First, the percentage score for seven of the ten items related to sensing represent more than half the sample population, ranging from 59% to 85%. Of the remaining three items one score represented just less than half the sample (49%), one just over one third (38%) and one represented only 19%. Later in the chapter the percentage of individuals who identified themselves with sensing or intuition is explored in more detail.

Second, some of the item rest of test scores indicate that there is a good relationship between the way individuals answered these questions and the way he or she answered the rest of the questions, for example, questions such as, are you practical, do you prefer the concrete and are you conventional. Some of the rest of test scores indicated there was a weaker relationship between the way individuals answered these questions and the way he or she answered the rest of the questions, for example questions such as, are you more interested in facts, do you prefer to make

and do you tend to be more concerned with detail. In one question the analysis indicated a negative item rest of test score (-.10).

Third, the alpha coefficient of .50 does not demonstrate a strong reliable internal consistency in the results to the questions exploring the two functions concerned with how people perceive information.

These results raise a question about the consistency of responses from this sample to the questions that relate to how they perceive and gather information. The inconsistencies may be related to the specific issue of alcohol dependence shared by all the respondents, and two observations may be suggested, one being more general in nature and the other being more specific.

First, a general observation may be made in remembering that the respondents are endeavouring to recover from an alcohol dependency problem, and in this light some understanding of their responses can be gained. For example, seven of the ten questions that relate to sensing sit harmoniously alongside an individual's efforts to change the direction of his or her life away from alcohol. These seven questions emphasise the pragmatism necessary for someone to make such a change, an interest in the facts, in practical actions, concrete situations, making something that is real, accepting the conventional approaches to life and being sensible and down to earth. Two of the ten questions, however, may not so easily echo an individual's efforts to make progress in sobriety, for example, a tendency to be concerned about detail (especially negative details) and to be focused on present realities (especially those that cause guilt, fear and emotional pain). Rising above such details, to look for

meaning and focusing on future possibilities rather than negative present realities, are more conducive to pastoral progress towards sobriety. In other words, a deliberate attempt to overcome an alcohol dependency problem requires individuals to adopt a more balanced demonstration of preferences in relation to the psychological functions that relate to gathering information.

Second, a more specific observation concerns the question related to keeping things as they are. A respondent, having declared a problem with alcohol and having approached a pastoral carer for help, when asked the question "do you prefer to keep things as they are?" will find it difficult to say 'yes.' Indeed, 81% of the sample responded by saying they preferred to improve things. If they prefer to keep things as they are, one might wonder why they have asked for help to change. For this reason, it is suggested that this question in particular may be deemed inappropriate in light of the nature of the common issue faced by the sample population in this research.

In view of this specific issue related to the question about keeping things as they are, it was decided to repeat the statistical analysis after deleting it from the scale. As a result, an increase in the alpha coefficient from .50 to .56 was recorded, suggesting that this sample did not respond as consistently in relation to this question as with the others in the construct. Table 12.3 presents the revised internal consistency reliabilities of scales for sensing and intuition. In this case the percentage scores for sensing are presented, as sensing and intuition scores together add up to 100% and will present the same alpha coefficient.

Table 12.3 Sensing / Intuition

Sensing	Agree %	r
Do you tend to be more interested in facts	85	.11
Are you more practical	73	.37
Do you prefer the concrete	78	.35
Do you prefer to make	65	.16
Are you conventional	59	.33
Do you tend to be more concerned about detail	38	.11
Are you more sensible	61	.32
Are you mostly focused on present realities	49	.27
Are you down to earth	85	.28
Alpha		.56

Thinking / feeling

Table 12.4 presents the internal consistency reliabilities of scales for thinking and feeling. In this case the percentage scores for feeling are presented, as thinking and feeling scores together add up to 100% and will present the same alpha coefficient.

Table 12.4 Thinking / feeling

Feeling	Agree %	r
Do you tend to be more concerned for harmony	50	.16
Are you more sympathetic	63	.39
Do you prefer feeling	54	.36
Do you tend to be gentle	63	.27
Are you affirming	55	.28
Do you tend to be more humane	55	.28
Are you more tactful	44	.11
Are you mostly trusting	59	.22
Do you seek for peace	34	.22
Are you warm hearted	69	.50
Alpha		.60

First, the percentage scores for feeling ranged from 34% to 69% and eight of the ten percentage responses represented more than half the sample. Of the remaining two

responses, under half (44%) reported they were more tactful and over one-third (34%) that they sought for peace.

Second, the item rest of test scores indicate that there is a good relationship between the way individuals answered each question and the way he or she answered the rest of the questions.

Third, the alpha coefficient of .60 is deemed high enough to demonstrate there is a reliable internal consistency in the results to the questions exploring the two judging functions which people employ to make decisions or judgements.

Judging / perceiving

Table 12.5 presents the internal consistency reliabilities of scales for judging and perceiving. In this case the percentage scores for judging are presented, as judging and perceiving scores together add up to 100% and will present the same alpha coefficient.

First, the percentage scores for judging ranged from 43% to 93%, and six of the ten responses represented more than half the sample. The remaining four responses represented just under half the sample, with scores ranging from 43% to 49%.

Second, the item rest of test scores indicate that there is a good relationship between the way individuals answered each question in this construct and the way he or she answered the rest of the questions.

Table 12.5 Judging / perceiving

Judging	Agree %	r
Routine	80	.28
Structured	49	.41
Decisions	58	.28
In control	45	.18
Orderly	43	.54
Organised	56	.53
Punctual	73	.39
Like planning	71	.42
Certainty	93	.28
Systematic	46	.45
Alpha		.72

Third, the alpha coefficient of .72 demonstrates there is a reliable internal

consistency in the results to the questions exploring the two attitudes towards the

outside world.

In summary, the alpha coefficients reported for introversion and extraversion (.75),

thinking and feeling (.60) and judging and perceiving (.72) reach a sufficient

threshold to demonstrate internal consistency reliability. In light of the nature of this

sample population with its problem with alcohol, the alpha coefficient for sensing

and intuition (.56) is considered sufficient to demonstrate a measure of internal

consistency reliability. Having demonstrated the reliability of the scales, it is

important to explore the psychological type distribution.

Psychological type distribution

Table 12.6 presents the type distribution of the FPTS with this sample population

who had all declared they had an alcohol dependency problem. It is important to

explore the findings as they are recorded in this table and, following the pattern set

out earlier in this chapter, this will involve three areas of interest; first, in relation to the dichotomous preferences; second, in relation to type dynamics; and third, in relation to complete types. Table 12.7 presents a comparison of the United Kingdom population norms to the sample population, indicating those that are statistically significant.

Type preferences

Table 12.6 includes the percentages of the sample population in relation to their dichotomous preferences. The preference between being extravert or introvert is one that reflects an individual's orientation, referring to one's source of energy and the focus of one's attention. Extraverts look to the outer world of people and things to renew their energy, whereas introverts look to their inner world of ideas. This research has demonstrated that 30% of the sample declared themselves to be extravert while 70% declared themselves to be introvert. Table 12.7 indicates that within the United Kingdom population norms, in relation to extraversion and introversion, 52% declared themselves to be extravert while 48% declared themselves to be introvert. The probability level of .001 for each of these results indicates that the differences are statistically significant. This suggests that the United Kingdom population norms are significantly more likely to be extraverts than the sample population, and, therefore, carers of this sample population are significantly more likely to encounter introverts. The preference between sensing and intuition is one that reflects an individual's perceiving process, the one by which an individual gathers information.

Table 12.6 Type distribution for total sample

The Sixteen Complete Types				Dichotomous Preferences		
ISTJ	ISFJ	INFJ	INTJ	E	$n = 61$	(29.6%)
$n = 61$	$n = 47$	$n = 10$	$n = 10$	I	$n = 145$	(70.4%)
(30%)	(22.7%)	(4.8%)	(4.8%)			
				S	$n = 161$	(78.2%)
+++++	+++++	+++++	++++	N	$n = 45$	(21.8%)
+++++	+++++					
+++++	+++++					
+++++	+++++			T	$n = 95$	(46.1%)
+++++	+++			F	$n = 111$	(53.9%)
+++++						
				J	$n = 175$	(85.0%)
				P	$n = 31$	(15.0%)
ISTP	ISFP	INFP	INTP	**Pairs and Temperaments**		
$n =3$	$n = 7$	$n = 4$	$n = 3$			
(1.4%)	(3.4%)	(1.9%)	(1.4%)	IJ	$n = 128$	(62.1%)
				IP	$n = 17$	(8.3%)
+	+++	++	+	EP	$n = 14$	(6.8%)
				EJ	$n = 47$	(22.8%)
				ST	$n = 79$	(38.3%)
				SF	$n = 82$	(39.8%)
				NF	$n = 29$	(14.1%)
ESTP	ESFP	ENFP	ENTP	NT	$n = 16$	(7.8%)
$n = 1$	$n = 5$	$n = 5$	$n = 3$			
(0.5%)	(2.4%)	(2.4%)	(1.4%)	SJ	$n = 145$	(70.4%)
				SP	$n = 16$	(7.8%)
+	++	++	+	NP	$n = 15$	(7.3%)
				NJ	$n = 30$	(14.6%)
				TJ	$n = 85$	(41.3%)
				TP	$n = 10$	(4.9%)
				FP	$n = 21$	(10.2%)
ESTJ	ESFJ	ENFJ	ENTJ	FJ	$n = 90$	(43.7%)
$n = 14$	$n = 23$	$n = 10$	$n = 0$			
(6.8%)	(11.1%)	(4.8%)	(0%)	IN	$n = 27$	(13.1%)
				EN	$n = 18$	(8.7%)
+++++	+++++	+++++		IS	$n = 118$	(57.3%)
++	+++++			ES	$n = 43$	(20.9%)
	+					
				ET	$n = 18$	(8.7%)
				EF	$n = 43$	(20.9%)
				IF	$n = 69$	(33.5%)
				IT	$n = 77$	(37.4%)

_____

Jungian Types (E)			Jungian Types (I)			Dominant Types			
	n	%		n	%		n	%	*M. Williams*
E-TJ	14	6.8	I-TP	6	2.9	Dt. T	20	9.7	Alcohol
E-FJ	33	15.9	I-FP	11	5.3	Dt. F	44	21.4	dependents
ES-P	6	2.9	IS-J	108	52.4	Dt. S	114	55.3	
EN-P	8	3.9	IN-J	20	9.7	Dt. N	28	13.6	

__
$N = 207$ (NB + = 1% of N

337

Table 12.7 Comparison of sample with United Kingdom population norms

Preference	Population norms %	Sample population %	I	p<
E	52	30	0.56	.001
I	48	70	1.48	.001
S	77	78	1.02	NS
N	24	22	0.95	NS
T	46	46	1.00	NS
F	54	54	1.00	NS
J	58	85	1.45	.001
P	42	16	0.37	.001

Individuals who prefer sensing gather information by looking at the facts, by seeing the environment as it is, and from it they then work out theory. Individuals who gather information by intuition look for the possibilities behind the immediate circumstances, they look at the big picture and to it they apply theory they already hold. Table 12.6 demonstrates that 78% of the sample declared themselves to be sensing types while 22% declared themselves to be intuitive. Table 12.7 indicates that the United Kingdom population norms in relation to sensing and intuition are that 77% declared themselves to be sensing while 24% declared themselves to be intuitive. These results demonstrate that there are no statistically significant differences between this sample and the population norms.

The preference between thinking and feeling is one that reflects an individual's judging process, the one by which rational decisions are made. Individuals who prefer thinking make decisions by objective logical thought, and they will have a strong sense of what is fair or just. Individuals who make decisions by feeling are more focused on human relationships and use subjective rational processes. Table

12.6 demonstrates that 46% of the sample declared themselves to be thinking types while 54% declared themselves to be feeling types. Table 12.7 indicates that the United Kingdom population norms in relation to these preferences are that 46% declared themselves to be thinking types, while 54% declared themselves to be feeling types. These results demonstrate there are no statistically significant differences between the sample population and the population norms, indeed the percentage scores are identical.

The preference between judging and perceiving is one that reflects an individual's attitude to the outside world. Individuals who prefer judging approach the outside world either by thinking or feeling, one might say letting either their head or heart, respectively, take the lead. Individuals who prefer perceiving approach the outside world either by sensing or intuition, in either concrete or abstract terms, respectively. Table 12.6 demonstrates that 85% of the sample declared themselves to be judging types, while 15% declared themselves perceiving types. Table 12.7 indicates that the United Kingdom population norms in relation to judging and perceiving are that 58% declared themselves to be judging types, while 42% declared themselves perceiving types. The correlation score of .001 for each of these results indicates that the differences are statistically significant. This suggests that the United Kingdom population norms are significantly less likely to be judging types than the sample population, and, therefore, carers are more likely to encounter judging types.

Discussion

The sample population has demonstrated that in two of the four areas of psychological functioning it is significantly different from United Kingdom

population norms. In terms of the two mental processes identified in the FPTS there is little or no difference between this sample and United Kingdom population norms, but in terms of orientation and approach to the outside world there are significant differences. In this sample there is a predominance of introverts (70%) and of judging types (85%), which means that high percentages of the sample look to their inner world of ideas to find energy and resources for life, and that their attitude to the outer world is one that is governed by their judging process.

In trying to help people with alcohol dependence, these observations raise an important question, what benefit is there to knowing that there is a predominance of introverts and judging types? The first possible answer is that there may be no actual link between these two psychological functions and alcohol dependence, and that some other influence, so far unidentified, explains the findings observed above. Another possible answer is that there is a causal link between these psychological functions and alcohol dependence; therefore, being introverted and a judging type predisposes an individual to alcohol dependence. Alternatively, the answer may be that the observations are consequential to alcohol dependence: alcohol dependence influences individuals by making them more likely to look to their inner world, and by allowing their judging process to dominate their attitude or approach to the outside world. More research would need to be carried out to investigate the observation that there is a statistically significant link between being an introverted and a judging type with people who have alcohol dependence.

In the context of this dissertation, however, pastoral carers will do well to note that statistically they are more likely to meet people who present as being introverted and

who approach their outer world using their judging process. In practice this implies

two things. First, carers will not see the dominant personality function of their caree

during initial pastoral conversations; rather carers can expect to be presented with

the caree's auxiliary psychological function. Second, as many identify themselves

as being a judging type, for introverts this means that their thinking / feeling

preference is not their dominant function, but rather their auxiliary function. Their

dominant function lies in the other psychological function, in their perceiving

process and their preference between sensing and intuition. As there is no

statistically significant difference between this sample (78%) and the United

Kingdom population norms (77%) in relation to a sensing preference, carers may

conclude that statistically they are more likely to encounter sensing types than

intuitive types. Having a dominant sensing function means such individuals are

more naturally aware of the immediate realities of life, what is practical and what is

going on here and now (Moss, 1989).

Type dynamics

Having explored type preferences attention now turns to type dynamics. Type

dynamics refer to how the four central psychological functions of sensing, intuition,

thinking and feeling, are used by an individual. These four functions are not all

developed to the same degree; rather, one will be dominant and supported by an

auxiliary function; another will be least developed and be an inferior function, while

the remaining function is the tertiary. This is an important exploration to make

because it is the dominant function that shapes the development of the person we

become and the person recognised by those who know us (Francis, 2005). The

dominant function is like the captain of a ship, bringing unity to the other functions

(Myers and Myers, 1995). An appreciation of what a caree's dominant function might be could inform pastoral approaches to recovery thus enhancing the potential effectiveness of the care provided. Table 12.6 includes the percentage scores of each dominant function for this sample population, for sensing and intuition that belong to the perceiving process of gathering information, and for thinking and feeling that belong to the mental process of making decisions.

The highest percentage score in this sample is 55% who have sensing as their dominant function. This means that 55% of the sample is shaped by their sensing function. They gather information by looking at the environment before they construct a theory, they instinctively prefer facts and see the way things actually are, rather than construct theories of how things might be.

In the context of this dissertation, there are three implications for those whose dominant function is sensing. First, the immediate environment, the stark realities of life dependent on alcohol and how things really are can be so overwhelming for an individual it becomes difficult for him or her to find hope of change. Figuratively speaking, for people with a dominant sensing preference, alcohol dependence becomes like a pit they cannot see a way to climb out from. Second, for people with a dominant sensing preference, short term immediate improvements delay the search for longer term permanent solutions. If life is tolerable today there is little motivation to press forward with changes that are more radical and necessary for a fundamental freedom from alcohol to be experienced. Third, people with a dominant sensing preference and their tendency to be comfortable with practical matters, tend to be less comfortable in exploring deeper emotional issues that can

underpin alcohol dependence. Four, when people with dominant sensing preference are under stress, they are influenced by their inferior function which is the opposite to their dominant function. Their inferior function is intuition and this will be where they are most vulnerable; they may find they have no theory with which to handle what life as an addict now presents, they run out of ideas, they cannot see a big picture nor can they see any possibilities beyond their drinking lifestyle. A pastoral carer who has a grasp of such dynamics is better placed to offer the appropriate support and help in the move towards recovery.

Alternatively, 14% of the sample population identified intuition as their dominant function. This means that 14% of the sample is shaped by their intuition. They gather information by looking at the possibilities behind the immediate circumstances, have formed a theory and have looked for evidence in support. They focus on the possibilities behind what is seen and on the big picture.

In the context of this dissertation, there are implications for those whose dominant function is intuition. First, they may be dismissive of any negative practical realities associated with their drinking lifestyle and as a result not recognise the full import of their situation in regard to their physical health or relational security. Second, people whose dominant function is intuition do not always accept what other people may advise or suggest; Moss (1989) points out, intuitive types tend to ignore instruction manuals. As intuitive types prefer theories and ideas, the concept of sobriety may be more interesting to them than the reality. Third, when under stress intuitive types are vulnerable in their inferior function which is sensing. They

cannot grasp what to do in the immediate, how to plan a day to avoid alcohol and how to look at the practical steps to be taken to remain alcohol free.

The second highest score in this sample is 21% who have feeling as their dominant function. This means that over 21% of the sample is shaped by their feelings. They make decisions in accordance with their feelings, are more subjective and are relational by instinct.

In the context of this dissertation, there are implications for those whose dominant function is feeling. First, for people who have an alcohol problem, making decisions based on the feeling function alone is unhelpful. Drinking alcohol changes the way people experience personal and inter-personal values. Breaking free from alcohol dependence will, sooner or later, require the individual to make decisions based on criteria other than feeling. Second, people whose dominant function is feeling are relational by instinct and like to be liked. If they are alcohol dependent and aware that their drinking causes others unhappiness, their desire for harmony may instigate secrecy in drinking, denial that they have been drinking and immense guilt when drinking has passed and truth sets in. Furthermore, feeling types control their world through their beliefs and convictions, and so it is in their immediate interest to reject suggestions their drinking is harmful, relying instead on the conviction that everything is will turn out fine. For the relatives of drinkers caught in this pattern of behaviour, secrecy, denial, lies and remorse with promises to stop, become an all too familiar downward spiral of events. Third, people whose dominant function is feeling are agreeable people, and in the context of pastoral conversations centred on their drinking behaviour, a carer may find the caree agrees with everything that is

said, but stops short of taking action to change (Moss, 1989). Four, feeling types are vulnerable in their thinking function. This is seen in them not seeing things objectively, not approaching issues logically and not addressing problems systematically or in an orderly fashion.

Finally, 10% of the sample identified thinking as their dominant function. This means that 10% of the sample is shaped by their thinking. Perhaps this psychological function received the lowest percentage score because, as Moss (1989) points out, thinking types do not like to be helped and the sample population consists of those who have asked for pastoral help. Thinking types make decisions based on logical, objective reasoning, they like being systematic and look for objectivity. In the context of this dissertation, there are implications for those whose dominant function is thinking. First, thinking types can be argumentative and carers may discover in conversation that there is a solid body of reasons why their drinking is not unreasonable, and certainly not as bad as others may infer. Second, carers may also discover that thinking types interpret what they hear a carer say, and the questions they ask, in such a way that suits their perceived purposes. For example, a carer may enquire if a thinking type has obsessive thoughts about alcohol and be given the reply, "No." Further enquiry, however, may reveal that when the thinking type wants to drink, thoughts accelerate obsessively and relentlessly until a drink is taken. Third, thinking types appear to defend their drinking lifestyle with what they consider are logically watertight arguments, and they may introduce secondary issues to divert the spotlight from their drinking behaviour. Four, thinking types are vulnerable in their feeling function, which means that they may misinterpret the care others are showing for them.

This exploration of type dynamics helps a pastoral carer deepen his or her appreciation of the governing force influencing the caree they are engaged with. This appreciation not only helps the carer understand the caree more clearly, but signposts potential challenges the caree will have to face and provides pointers towards approaches to recovery the caree may find more acceptable.

Psychological type profiles

Having explored the type preferences and type dynamics of this sample population, attention now turns to the complete psychological type profiles as presented in table 12.6. A comparison was made in order to test for statistically significant differences between the complete psychological type profiles of the sample population and those of the United Kingdom population norms. Table 12.8 presents the statistical analysis of this comparison.

Table 12.8 prompts four observations drawn from this research. First, all but one of the 16 complete psychological types was represented in the sample population. The exception was the ENTJ psychological type profile that was not represented.

Second, with five of the percentage scores for complete psychological type profiles, there were statistically significant lower percentages in the sample compared to population norms. From this it is deduced that carers are statistically less likely to come across these five types in the context of alcohol dependence than if dealing with the general population. Within the sample there were significantly fewer people with specific psychological type profiles such as ISTP, ESTP, ESFP, ENFP and ENTJ. It is noteworthy that there is a predominance of extravert types, who find their energy and resource for life in the outer world of people, and a predominance

of people whose attitude to the outside world is governed by their perceiving process.

Table 12.8 Complete psychological types compared to United Kingdom population norms

Complete Type	Population norms %	Sample population %	I	$p<$
ISTJ	14	30	2.15	.001
ISFJ	13	23	1.78	.001
INFJ	2	5	2.82	.01
INTJ	1	5	3.43	.001
ISTP	6	1	0.23	.01
ISFP	6	3	0.55	NS
INFP	3	2	0.76	NS
INTP	2	1	0.59	NS
ESTP	6	1	0.08	.001
ESFP	9	2	0.28	.01
ENFP	6	2	0.38	.05
ENTP	3	1	0.55	NS
ESTJ	10	7	0.65	NS
ESFJ	13	11	0.88	NS
ENFJ	3	5	1.75	NS
ENTJ	3	0	0.00	.05

Third, with seven of the percentage scores for complete psychological type profiles, there was no statistically significant difference in the sample population compared to population norms. From this it is deduced that carers are statistically as likely to come across these seven types in the context of people with alcohol dependence as they are when dealing with the general population. Within the sample there was no significant difference in percentages of people with specific psychological type profiles such as ISFP, INFP, INTP, ENTP, ESTJ, ESFJ and ENFJ.

Fourth, with four of the percentages for complete psychological type profiles there were statistically significant higher scores in the sample population compared to

population norms. From this it is deduced that carers are statistically more likely to come across these four types in the context of people with alcohol dependence as they are when dealing with the general population. Within the sample there were significant differences in percentages of people with specific psychological type profiles such as ISTJ, ISFJ, INFJ and INTJ. Two observations are worth noting from these results; carers are *more* likely to encounter introverted judging types as IJ characteristics are shared by all four type profiles, and carers are *most* likely to encounter dominant introverted sensing types who have either auxiliary extraverted thinking or auxiliary extraverted feeling.

In the context of this dissertation it is worth noting that dominant introverted sensing types are systematic, painstaking, thorough, practical, apply themselves to detail easily and adapt well to routines (Myers and Myers, 1980). They have the potential for extreme stability; they are not impulsive but once their mind is made up, they are "hard to distract, discourage or stop" (Myers and Myers, 1980, p 102). Carers working with people who have these characteristics will be most effective if the recovery process they utilise is clear, simple, factual and detailed; a programme that is progressive, inclusive and able to be adapted into daily routines in life will appeal to this kind of person.

Psychological type and drinking motives

Following the pattern of the previous chapter, attention now turns to testing for statistically significant links between psychological type preferences and drinking motives.

Introversion / extraversion

Table 12.9 presents the research findings of a correlation of drinking motives with extraversion and introversion preferences. In the *r* column positive figures indicate introvert preferences while negative figures represent extravert preferences.

Table 12.9 Drinking motives and Introversion / Extraversion preferences

	r	*p<*
Why did you drink alcohol?		
All my friends drank socially	+.13	NS
I felt pressurised into drinking	-.01	NS
Drinking was expected of me	+.01	NS
Drinking made me feel good	+.06	NS
I was curious as to what drinking was like	+.09	NS
Drinking helped me overcome shyness	-.12	NS
I drank because I had difficulty sleeping	+.13	.05
I drank to cope with stress	-.06	NS
I drank to forget the past	+.08	NS
Drinking helped me feel better about myself	+.09	NS
Drinking helped me relate to others socially	+.02	NS
I drank because I felt rejected	+.17	.05
I drank to cope with what people did to me	-.02	NS
I drank to cope with what happened to me	+.00	NS
I drank because my mind was troubled	-.14	NS
I drank because my feelings were troubled	-.14	NS
I drank to cope with my insecurities	-.15	.05
I drank because my life was meaningless	-.03	NS

12.9 indicates there are two drinking motives that demonstrate a statistically significant link with being introvert. In chapter six above, it was recorded that 24% of the sample declared they drank because they had difficulty sleeping and 51% declared they drank because they felt rejected. It is concluded therefore, that within the group of 24% who responded positively to drinking because of difficulty sleeping, carers are more likely to encounter introverts than extraverts. Similarly, of

the 51% of the sample who responded positively to drinking because they felt rejected, carers are more likely to encounter introverts than extraverts.

Table 12.9 also indicates there is one drinking motive that demonstrates a statistically significant link with being introvert. In chapter six above, it was recorded that 82% of the sample declared they drank to cope with their insecurities, and it is concluded here that carers are more likely to encounter introverts than extraverts among this group.

Sensing / Intuition

Table 12.10 presents the research findings of a comparison between drinking motives and sensing and intuition preferences. In the *r* column positive figures indicate intuition preferences while negative figures represent sensing preferences.

Table 12.10 indicates there is one drinking motive that demonstrates a statistically significant link with being an intuitive type. In chapter six it was recorded that 26% of the sample declared they drank because they felt pressurised into drinking, and so it is concluded here that within this group carers are more likely to encounter intuitive types rather than sensing types. Why might intuitive people particularly feel pressurised into drinking? Moss (1989) explains that intuitive types take in information indirectly; information received can become blurred and taken into the unconscious; in the unconscious it is linked with other ideas and associations. In everyday life this means they tend to be good at theories and hunches. However, in a drinking environment, perhaps intuitive types perceive pressure to drink more

readily, or are more susceptible to insinuations by virtue of the way they take in

information indirectly.

Table 12.10 Drinking motives and Sensing / Intuition preferences

	r	p<
Why did you drink alcohol?		
All my friends drank socially	+.10	NS
I felt pressurised into drinking	+.15	.05
Drinking was expected of me	+.01	NS
Drinking made me feel good	+.05	NS
I was curious as to what drinking was like	+.06	NS
Drinking helped me overcome shyness	+.10	NS
I drank because I had difficulty sleeping	+.03	NS
I drank to cope with stress	+.08	NS
I drank to forget the past	+.13	NS
Drinking helped me feel better about myself	+.04	NS
Drinking helped me relate to others socially	+.03	NS
I drank because I felt rejected	+.06	NS
I drank to cope with what people did to me	+.08	NS
I drank to cope with what happened to me	+.08	NS
I drank because my mind was troubled	+.04	NS
I drank because my feelings were troubled	+.00	NS
I drank to cope with my insecurities	+.01	NS
I drank because my life was meaningless	+.04	NS

Thinking / feeling

Table 12.11 presents the research findings of a comparison between drinking

motives and thinking and feeling preferences. In the *r* column positive figures

indicate feeling preferences while negative figures represent thinking preferences.

Table 12.11 indicates there are no drinking motives that demonstrate a statistically

significant link with being either a thinking type or a feeling type. It is concluded,

therefore, that thinking types and feeling types are equally as likely to identify with

each of the drinking motives outlined in this research.

Table 12.11 Drinking motives and Thinking / Feeling preferences

	r	$p<$
Why did you drink alcohol?		
All my friends drank socially	+.08	NS
I felt pressurised into drinking	+.02	NS
Drinking was expected of me	-.01	NS
Drinking made me feel good	-.07	NS
I was curious as to what drinking was like	+.00	NS
Drinking helped me overcome shyness	-.09	NS
I drank because I had difficulty sleeping	+.01	NS
I drank to cope with stress	+.12	NS
I drank to forget the past	+.01	NS
Drinking helped me feel better about myself	-.01	NS
Drinking helped me relate to others socially	-.04	NS
I drank because I felt rejected	-.01	NS
I drank to cope with what people did to me	+.04	NS
I drank to cope with what happened to me	-.04	NS
I drank because my mind was troubled	+.06	NS
I drank because my feelings were troubled	-.04	NS
I drank to cope with my insecurities	+.05	NS
I drank because my life was meaningless	-.05	NS

Perceiving and judging

Table 12.12 presents the research findings of a comparison between drinking motives and perceiving and judging preferences. In the r column positive figures indicate judging preferences while negative figures represent perceiving preferences.

Table 12.12 indicates there is one drinking motive that demonstrates a statistically significant link with being a judging type. In chapter six it was recorded that 26% of the sample population declared they drank because they felt pressurised into drinking, and so it is concluded that among this group, carers are more likely to encounter people who are judging types than perceiving types.

Table 12.12 Drinking motives and Perceiving / Judging preferences

	r	*p<*
Why did you drink alcohol?		
All my friends drank socially	-.08	NS
I felt pressurised into drinking	+.12	.05
Drinking was expected of me	+.03	NS
Drinking made me feel good	+.07	NS
I was curious as to what drinking was like	-.11	NS
Drinking helped me overcome shyness	+.05	NS
I drank because I had difficulty sleeping	-.01	NS
I drank to cope with stress	+.01	NS
I drank to forget the past	+.00	NS
Drinking helped me feel better about myself	-.01	NS
Drinking helped me relate to others socially	-.04	NS
I drank because I felt rejected	+.10	NS
I drank to cope with what people did to me	-.02	NS
I drank to cope with what happened to me	-.01	NS
I drank because my mind was troubled	+.01	NS
I drank because my feelings were troubled	+.08	NS
I drank to cope with my insecurities	+.03	NS
I drank because my life was meaningless	-.02	NS

This reflects a similar response to one recorded earlier in relation to intuitive types. The earlier question is now repeated and elaborated to include being a judging type. Why might intuitive types and judging types, in particular, feel pressurised into drinking? Intuition is a psychological preference associated with the perceiving process; it is one way of gathering information from the outside world. As described above, intuitive types sometimes blur the information received and, in the unconscious mind, link it with other ideas and associations. Judging is a psychological preference associated with attitudes towards the outside world and with making decisions. Judging types like to be decisive and to bring closure; once they have made up their mind they resist changing or revising their decision. In the context of drinking alcohol, deciding to drink may have seemed one way of

resolving a dilemma, of bringing closure to testing social circumstances where others were drinking. A perceived pressure from other drinkers may have prompted a decision, which, once made, was not easily reversed or reviewed.

Main findings

This chapter set out to investigate psychological type and alcohol dependence and to search for links between psychological type and drinking motives. There are a number of main findings that this research has demonstrated.

First, this research has demonstrated that in two psychological processes, the perceiving process and judging process, there are no significant differences between the responses of the sample population and the United Kingdom population norms. This implies that the proportions of individuals who gather information by sensing or intuition reflect those proportions found in the wider community. Furthermore, it implies that proportions of individuals who make decisions by thinking or feeling reflect those proportions found in the wider community.

Second, this research has demonstrated that in two psychological functions there are significant differences in the responses of the sample population compared with United Kingdom population norms. For example, significantly more individuals in the sample population recorded that they identified with being introvert, and significantly more individuals indentified with being a judging type. The implication of these two observations is that pastoral carers are statistically more likely to encounter introvert judging types with people who are alcohol dependent than they would if working in the wider community.

Third, this research has demonstrated that over half the sample (55%) has a dominant sensing type. This implies a potential to be overwhelmed by the complexity and hopelessness of immediate circumstances, an inability to see a bigger picture and an instinct to focus on practicalities to the exclusion of deep emotional issues. Pastoral carers may work towards helping a caree build hope, plan for immediate and long term sobriety and express negative emotions. Furthermore, over one-fifth of the sample (21%) has a dominant feeling type. This implies a potential to make decisions based on the feeling function and an instinct to keep control through beliefs and convictions. Pastoral carers may work towards helping a caree establish other criteria upon which to base their decisions and new beliefs and convictions that will steer behaviour away from destructive addictive patterns. Together, dominant sensing and feeling types represent over three-quarters of the sample population (76%).

Finally, this research has demonstrated there is a statistically significant link between declaring an introvert preference and drinking because of difficulty in sleeping and because one had a feeling of being rejected. Furthermore, it has demonstrated there is statistically significant link between declaring an extravert preference and drinking to cope with insecurities.

Conclusion

In conclusion, attention now focuses on the underlying key question of this dissertation, 'What does a carer need to consider when he or she is asked to help a

person who has an alcohol dependency problem?' Several pastoral considerations emerge from these highlights.

First, carers are more likely to encounter introvert types. It is important, therefore, for carers to establish a meaningful relationship with a measure of trust so that the inner person of the caree will come to the fore. The psychological function initially presented will not be the dominant function, which will remain hidden.

Second, sensing types are more likely to be encountered than intuitive types and so carers must focus on dealing with immediate realities, their approach must be practical, include clear steps and follow a clear structure if possible; carers will have to try to help the caree explore deeper emotional issues and to build up, in small steps, hope for the possibilities of future recovery. Carers may consider helping intuitive types see the present reality of their circumstances without overwhelming them.

Third, carers may find it necessary to facilitate feeling types to discover that making decisions based on this function is not always helpful. This may involve agreeing upon other criteria upon which decisions might be made. Carers may also be aware that with feeling types the words of agreement they offer and the promises they make require thorough discussion, so that actions are based, not on the desire to please others, but on objective and systematic reasoning.

Fourth, carers may encounter thinking types and must be aware that people with this preference do not like being helped. In this pastoral relationship it is important for

the carer to be as objective, logical and systematic in approach as possible. Carers would do well to expect an argumentative type discussion, but to continue to work through such difficulties in order to help the caree to process their own negative emotions.

Finally, as the most likely psychological type combination a carer is likely to encounter is dominant introverted sensing types, their approach must be clear, simple, factual and detailed, and it must include a willingness to unpack vivid private reactions to events and circumstances that may fuel a harmful drinking lifestyle.

This chapter contains an exploration of psychological type theory in relation to a sample population who declared themselves as having a problem with alcohol. With reference to United Kingdom population norms, observations were made highlighting statistically significant characteristics within this population. The chapter included an investigation into links between psychological type and drinking motives. Finally, the pastoral ramifications of the psychological preferences displayed by the sample, and the psychological types that dominated the sample, were outlined. In the concluding chapter to this dissertation further thought is given to pastoral considerations in the light of all the research findings.

Chapter Thirteen

Conclusion

Chapter outline

Introduction

Phase one

Practical pastoral considerations

>   *Starting points*

>   *Fundamental truths*

>   *Religious belief*

>   *Religious conversion*

Phase two

Practical pastoral considerations

>   *Early onset*

>   *Drinking patterns*

>   *Craving*

>   *Secrecy and denial*

>   *Drinking motives*

>   *Drinking consequences*

Phase three

Practical pastoral considerations

>   *Parental alcohol abuse*

>   *Personality dimensions*

>   *Psychological type*

Conclusion

Introduction

The purpose of the research was to gather and evaluate information that related to

people who had an alcohol dependency problem and who approached the Stauros

Foundation for pastoral support in their recovery. The information gathered was

intended to better inform carers within Stauros about the people who request

pastoral support, thus raising awareness of possible complexities that may

accompany alcohol dependence within those individuals. The evaluation was designed to explore how pastoral care should be informed or influenced by such information. To this end the key question, "what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?" threads its way throughout the dissertation.

The dissertation progressed through three phases. Phase one explored alcohol dependency in theoretical terms and aimed at highlighting preliminary issues pastoral carers do well to bear in mind. Phase two explored the drinking behaviour, motives and consequences of those within the sample population. Phase three explored individual drinkers' family background and personality.

Phase One

In the first phase, chapter one addressed preliminary questions aimed at what can be understood about alcohol dependency in relation to who is responsible for its development and for recovery. Chapter two addressed questions aimed at discovering the general profile of people who approached Stauros for help. Chapters three and four addressed questions aimed at clarifying what role, if any, religious belief and conversion played in the process of recovering from alcohol dependency.

It is important carers are clear in their own minds about the question of responsibility. The individual with an alcohol problem must face his or her responsibility, not only in relation to their motives to change, but also in relation to past decisions and behaviour as their alcohol dependence developed. This introduces the moral vocabulary of words such as guilt and shame to pastoral

conversations. The individual must face his or her responsibility in relation to present choices and decision making processes, even in the face of compulsion and obsession. Finally, the carer must face his or her responsibility to approach issues related to religious faith with sensitivity, encouraging those carees for whom it is an important element of recovery, while respecting the right of others to set it aside if they so desire.

The general profile of people who requested support from Stauros can be summarised by stating that they were more likely to be male than female. In general, people who requested help had been drinking for between eight to twelve years, and were between 30 years of age and 50 years of age. They were more likely to be in a marriage/partnership than not, and were more likely to belong to a church than not. Generally, they had been brought up in church but had left around 13 years of age. They were more likely to be semi-skilled, skilled or semi-professional in employment status.

Religious belief, for some individuals, may help motivate them to make a change to their lifestyle, proving to be a source of hope that may previously have been wanting. Religious belief also provides a philosophical framework and a vocabulary which may facilitate resolving circumstances, experiences and processes individuals may wrestle with on a daily basis. Religious conversion, for some individuals, provides an "other worldly" answer to life's struggles, a spiritual element from outside personal circumstances which can reach in and bring something positive, something that was previously unknown. Religious conversion provides a framework for an understanding of inner battles, and a language to facilitate

personal and lifestyle change.

Practical pastoral considerations

To begin with, pastoral carers need to consider how they can provide a safe context for carees to unburden themselves, without being distracted from their purpose of helping them to recover from alcohol dependency. This provision is the beginning of a pastoral relationship between carer and caree, a relationship that facilitates understanding one of another. There are, however, other practical considerations raised in phase one in relation to appropriate and effective pastoral care.

Starting points

These preliminary questions demonstrated the need for carers to be aware of different starting points for pastoral conversations, starting points which may be initiated from three perspectives. First, conversations may be initiated by carees from a circumstantial perspective, where information provided relates to external factors that have contributed to the development of alcohol dependency, to elements that have made the caree vulnerable to alcohol dependency. From this perspective there is the tendency to seek for explanations that provide answers that are acceptable, reasonable and leave the personal integrity of the caree intact. These explanations focus on alcohol dependency as a problem that cannot be solved.

Second, pastoral conversations may be initiated from a perspective representing a much more personal view. In this instance a conversation may be dominated by expressions of personal failure, where the client presents him or herself either in terms of being a victim, or using moral vocabulary such as guilt, shame and remorse.

These explanations focus on alcohol dependency as creating powerlessness that cannot be overcome.

Third, pastoral conversations may be initiated from a perspective representing the characteristics of the condition. Compulsions, triggers and cognitive processes are explorations of how drinking behaviour resists change. These explanations focus on alcohol dependency as a process that cannot be combated.

Carers need to be aware of the significance of these three starting points, or they may conclude that problems clients share cannot be solved, that the powerlessness clients feel cannot be challenged and that the processes clients wrestle with cannot be overcome.

Furthermore, carers might consider what conclusions a client may wish them to draw, based on which of these perspectives the caree has adopted. For example, a caree may wish a carer to excuse him or her, based on the circumstantial factors that made him or her vulnerable to alcohol dependency. A caree may wish a carer to mollycoddle him or her, based on the open professions of failure, guilt, shame and remorse. A caree may wish a carer to defend him or her, based on the diagnosis of the cognitive and emotional processes that have been identified.

Fundamental truths

Preliminary questions also demonstrated the need for carers to be aware of the nature of alcohol dependency as a condition, and the nature of pastoral care as a means to recovery. First, in relation to the nature of alcohol dependency, carers

need to consider their bedrock beliefs about the condition. Such beliefs incorporate fundamental truths such as "drinking can stop", "there is an alternative lifestyle that is alcohol-free" and "life without alcohol is possible." Pastoral carers need to consider how they can evoke these truths in the minds of those for whom they care.

Religious belief

Carers must consider what role, if any, religious belief may play in the recovery process. If a caree has a religious belief, and wishes to incorporate faith into a pastoral recovery model, carers need to consider how that may be accomplished. For example, religious belief, understood in this dissertation as based in Biblical literature, may contribute to leading clients to conclude they need to change their lifestyle. Religious belief, through Biblical literature, however, is not only a catalyst for change; it also offers hope that change is possible. It balances the expediency of turning away from alcohol dependency, and the lifestyle it dominates, with the hope that such action is possible. Furthermore, religious belief not only provides a framework within which an understanding of life's problems and purposes may be arranged, it provides a vocabulary that facilitates self-awareness of the inner struggles of the mind.

If a client has no religious belief, and no inclination to incorporate religious belief into pastoral conversations, carers must find another construct that provides a catalyst for change, hope of recovery, a way of understanding life's problems and purposes and vocabulary that facilitate self-awareness of the inner struggles of the mind. A construct that provides these characteristics is not uncommon in helping people with an alcohol dependency problem.

Religious conversion

Carers must consider what role religious conversion plays in helping someone recover from an alcohol dependency problem. For those who declare having a religious belief, conversion has a religious expression. Its holistic character incorporates a spiritual awakening, often expressed using Biblical language and/or imagery: an awakening that is associated with a crisis in life, but that has ramifications for thinking, feeling, making decisions and behaving. This, it might be said, is a religious experience explained in biblical terms.

For those who have no religious belief, conversion incorporates a response to a crisis that involves seeking an alternative lifestyle by setting clear goals and making the necessary adjustments to accomplish the goals. Life is turned around by clarifying how life is now, how life ought to be and what plans need to be implemented in order to achieve the desired outcome. This, it might be said, is a psychological experience explained in logical terms.

Whether religious or non-religious conversion is preferred, finding others with a similar outlook, will prove helpful. Others can provide an example of sobriety and provide a group with whom a caree may find support and encouragement. Either way, an external reality, for some religious for others logical, is nurtured in a social context. Carers need to respect the personal perspective of a caree so as to follow the route most appropriate for that individual. These are the preliminary questions that carers do well to settle in their minds before engaging with individual carees: these questions help carers know their perspective before exploring the alcohol dependency problems of others.

Phase Two

In the second phase, drinking behaviour was explored by investigating drinking history, practice and motives. This phase also considered the primary and secondary consequences of drinking behaviour. Chapter five addressed the dual elements of drinking history and drinking practice; chapter six addressed the issue of drinking motives; and chapters seven and eight addressed the issues of the primary and secondary consequences of drinking behaviour, respectively. In this phase alcohol dependency becomes the focus of attention, exploring not only how it is individually expressed, but how it impacts an individual and his or her family.

Practical pastoral considerations

There are a number of practical pastoral considerations carers may need to consider, gathered from the information in chapter five.

Early onset

Early onset of drinking alerts a carer to consider life experiences of the client now coming for help. For example, parental drinking, family unhappiness, community pressures or traumatic experiences (or a combination of all of these) may have contributed to the early onset of a drinking lifestyle. The pastoral questions that arise from these considerations include: whether there are unresolved issues remaining in the psyche, and how cognitive processes have been effected by early onset of drinking behaviour? Unresolved issues and unhelpful cognitive processes combine to create the environment in which alcohol dependency is sustained.

Drinking patterns

Drinking patterns present the carer with the practical problem of how clients occupy their time after drinking has ceased. For example, if drinking has been a weekly or a daily practice, and if such practice has been established over several years, clients may find they need help in addressing the question of how to occupy the time previously spent in drinking behaviour. There will inevitably be a transition period between the ending of one lifestyle and the establishment of another, a period that will be best negotiated by careful planning and with determined perseverance. In certain instances, residential care for some clients may prove helpful in breaking the pattern of a drinking lifestyle, although the return home after a period of respite also needs to consider the practical implications.

Craving

Perhaps of all the pastoral considerations that may be addressed, this one factor is central to helping a person break free from an alcohol dependency problem. Pastoral carers may explore craving in four areas. There may be physical expressions of withdrawal that constitute craving, elements that medical care may help alleviate; there may be emotional factors, such as anger, rejection, stress or fear, that play their part in intensifying craving; there may be cognitive processes that are biased towards drinking and oblivious to consequences; and there may be decision-making procedures that short circuit truth and reason. Unravelling the tangle of threads from these four areas allows carers to help carees address the perception that drinking is inevitable.

Secrecy and denial

Three quarters of the sample declared they kept their drinking secret. This practice may indicate a client is drinking, while pretending to close family and friends that he or she is managing not to drink. Alternatively it could mean that a client is admitting he or she is drinking, but pretending that the amount of alcohol being consumed is much less than it is. Carers need to consider how they will respond and if, or when, a caree is being duplicitous. Carers must bear in mind that they may be deceived by carees, and that they may know they are being deceived. How to challenge or confront a caree in their duplicity, whilst maintaining a pastoral relationship, remains one of the challenges of helping people with an alcohol dependency problem.

Drinking motives

Regarding the motives that lie behind drinking behaviour, pastoral carers may consider exploring the social relationships of carees. High percentages (79% or more) declared that they drank to overcome shyness and/or to help them relate to others socially; clients under 40 years of age were more likely to drink because they felt pressurised into drinking. Social interaction and social skills are factors to consider including in a pastoral approach to recovery.

Pastoral carers may find that one of the central motives behind drinking behaviour is the desire to change negative emotions. For example, many in the sample declared they drank to feel good, because their feelings were troubled or to feel better, with over three-quarters declaring that they drank because their mind was troubled; this was especially true for females and those under 40 years of age. Carers may

consider the emotional background to drinking behaviour to some effect, and

helping carees not to make decisions based on negative emotions plays a significant

part in pastoral care of people with alcohol dependency.

Pastoral carers may consider the difficulties clients find in either dealing with past

events and memories, or coping with current stresses and insecurities. For example,

past events may include a feeling of having been rejected, or a memory of what

someone did, both more likely to be the experience of female clients. Current

stresses and insecurities may represent deeper feelings of unworthiness or

inadequacies that may prove important in a pastoral approach to recovery from

alcohol dependency.

Drinking consequences

Pastoral carers may be alerted to the consequences of harmful drinking and the

immediate needs of withdrawal. In both instances pastoral care must include

professional medical help that will include medication to help with withdrawal

symptoms, and/or hospitalisation to care for clients experiencing hallucinations, or

delirium tremens. These issues are especially true for male clients. Other clients,

especially those over 40 years of age, may perceive their needs as being able to talk

to someone further about their drinking, how to stay sober and how to solve their

alcohol dependency problem.

Finally, carees may need to address relationship issues that have been directly linked

to their drinking lifestyle: relational consequences of a drinking lifestyle may leave

carees with a variety of issues with which to contend. For example, carees may feel

guilty and remorseful at the unhappiness their drinking lifestyle has caused; or they may feel isolated if they are no longer in a relationship, or are no longer in communication with children, siblings or parents. Facing the realities of broken relationships is important. Carees may have to field a negative backlash from relatives who have been hurt by a drinking lifestyle, and/or manage family relationships with relatives for whom alcohol continues to play a role in weekly or daily routines.

Phase Three

In the third phase attention turned to the psychosocial well-being of the sample population. This involved an exploration of the family background (chapter nine), parental relationships (chapter ten), personality dimensions (chapter eleven) and psychological types (chapter twelve) of the sample population. This phase represents a departure from the previous two phases, both of which focused, in one way or another, on alcohol dependency and its consequences. The purpose of this phase is to gain as deep an understanding of individuals as possible, an understanding that begins by exploring drinking motives, in association with their mothers and fathers who abused alcohol; an understanding that progresses by exploring their relationships with their parents, and concludes with an exploration of matters related to personality.

Practical pastoral considerations

Parental alcohol abuse

Pastoral carers may explore whether or not mothers and fathers of carees abused alcohol, and from the responses be alerted to possible pastoral considerations. First,

for example, carees whose fathers abused alcohol are more likely to declare motives for drinking that include having experienced physical and emotional abuse. Carees might find that talking about their physical and emotional abuse a helpful exercise, one that defuses intense negative emotions against their parents, emotions that can include anger, and guilt about being angry with parents; emotions such as love and hate that sit concurrently side-by-side.

Carees whose mothers abused alcohol are more likely to declare motives for drinking that are responses to having a victim perception of the past. For example, respondents who declared their mothers to have abused alcohol declared that they were motivated to drink by a desire to forget the past, because of what people did and what happened to them. In these responses carees identify with being a victim of one kind or another. Subsequently, respondents in this category are more likely to be motivated to drink because it makes them feel better about themselves, because they have fears and phobias, and because they experienced emotional abuse.

Carers need to consider the implications of negative relationships between carees and their mothers, a relationship that is particularly relevant in regard to female clients. For example, in general carees declared that they perceived their maternal carers to have been judgemental, critical and restricting: more specifically, when they identified that their maternal carer abused alcohol, they were unsupportive, ungiving, damning and unforgiving. These are strongly worded negative perceptions of maternal figures, and carers need to consider what contribution these sentiments make, first to the desire for alcohol, and second to a general feeling of worthlessness.

Carers need to consider the implications of negative relationships between clients and their fathers. In general clients declared that their paternal figures were also judgemental, critical and restricting: more specifically, when they identified that their paternal figure abused alcohol, they were, among other things, never there, hating and rejecting. Again, these are strongly worded negative perceptions, and carers need to consider the impact these have on the emotional stability and welfare of the carees who come to them for help.

Personality dimensions

An exploration of personality dimensions highlighted a number of important issues for pastoral carers to consider. For example, extraverts are more likely to drink out of curiosity and in a social context. Carers could, to some advantage, focus attention on the social environment in which extraverts feel most comfortable. Extraverts make decisions based on immediate experiences and require an opportunity to consider this process in light of the longer term consequences of such actions.

Introverts drink to overcome shyness and are likely to experience feelings of social inadequacy. They are also likely to drink because of feelings of rejection. Here are important elements for pastoral carers to consider when endeavouring to help introverted individuals recover from alcohol dependency.

Neurotics drink for both general and specific purposes. They drink as a way of coping with general life situations they find difficult, but more specifically to forget the past, because of something someone did or something that happened, and because they had troubled thoughts and feelings. Pastoral carers may feel it

necessary to explore what past events cause such unhappiness and why thoughts and feelings are troubled.

Psychological type

An exploration of psychological type highlighted a number of important issues for pastoral carers to consider. For example, statistically carers are more likely to encounter introverted types than extraverted types, and also more likely to encounter judging types than perceiving types. Neither of these results reflects United Kingdom population norms, although in keeping with United Kingdom norms, carers are more likely to encounter dominant sensing types.

The most likely psychological type combination a carer is likely to encounter is dominant introverted sensing types, and this has obvious implications for pastoral conversations related to alcohol dependency. For example, a carer's approach must help the caree to find a recovery process that is clear, simple, factual and detailed. This approach would probably be reflected in one that incorporates factual and educational information alongside detailed planning to accomplish achievable goals.

Conclusion

This dissertation began by drawing attention to three elements incorporated within the title. It declared an interest in the uniqueness of individuals, in searching for patterns related to life experiences and drinking behaviour and in helping people who have an alcohol dependency problem. These three interests are incorporated into the phases outlined above.

The key question, "what does a carer need to consider when he or she is asked to help a person who has an alcohol dependency problem?" introduces a practical pastoral dimension to the discussions by anticipating and raising issues relevant to the discussions. However, in the context of the Stauros Foundation, these practical considerations, first, need to be anchored in what is recognised as good practice in pastoral care using counselling skills; second, they need to be formatted into a structure that is orderly: and third, they need to be communicable to others interested in learning how to help people with alcohol dependency problems in the context of Christian pastoral care.

REFERENCES

Abaied, J.L. and Rudolph, K.D. (2010), Contributions of maternal adult attachment to socialisation of coping, *Journal of Social and Personal Relationships,* 27, pp 637 - 657

Acuda, W. and Alexander, B. (1998), Individual characteristics and drinking patterns, in M**.** Grant and J. Litvak (eds) *Drinking Patterns and Their Consequences,* pp 43 – 62, Washington DC, Taylor and Francis

Ainsworth, M.D.S. and Bowlby, J. (1991), An ethological approach to personality development, *American Psychologist,* 46, 4, pp 333-341

Alcohol Statistics Scotland (2007), available online on the national website: http://www.alcoholinformation.isdscotland.org/

Alcoholics Anonymous (1979), *Twelve Steps and Twelve Traditions,* Aylesbury, England, Hazell Watson and Viney Ltd.

Alcohol Concern (2010), www.alcoholandfamilies.org.uk

Alcohol Harm Reduction Strategy for England (2004), Strategy Unit www.strategy.gov.uk

Allen, J.P., Fertig, J.B. and Mattson, M.E. (1994), Personality-based subtypes of chemically dependent patients, in T.F. Babor, V. Hesselbrock, R.E. Meyer and W. Shoemaker (eds), *Types of Alcoholics: Evidence from Clinical, Experimental and Genetic Research,* volume 708, pp 7 – 22, New York, Annals of the New York Academy of Sciences

Allen, J.P., Moore, C., Kupermine, G. and Bell, K. (1998), Attachment and psychosocial functioning, *Child Development,* 69, pp 1406 – 1419

Allsopp, J.F. (1986), Personality as a determinant of beer and cider consumption among young men, *Personality and Individual Differences,* 7, 3, pp 341 – 347

Anderson, S.L. and Teicher, M.H. (2009), Desperately driven and no brakes: developmental stress exposure and subsequent risk of substance abuse, *Neuroscience and Biobehavioral Reviews,* 33, pp 516 – 524

Argyle, M. (2000), *Psychology and Religion: an Introduction,* London, England, Routledge

Babor, T.F. (1994), Method and theory in the classification of person with alcohol dependency, in T.F. Babor, V. Hesselbrook, R.E. Meyer and W. Shoemaker (eds),

Types of Alcoholics: Evidence from Clinical, Experimental, and Genetic Research, pp 1- 6, New York, Annals of the New York Academy of Sciences, 708

Banger, M., Philipp, M., Herth, T., Hebenstreit, M. and Aldenhoff, J. (1992), development of a rating scale for quantitative measurement of alcohol withdrawal syndrome, *European Archives of Psychiatry and Clinical Neuroscience,* 241, pp 241 – 246

Barber, J.G. (2002), *Social Work With Addictions*, England, Palgrave MacMillan

Barnes, G.E. (1983), Clinical and personality characteristics, in B. Kissen and H. Begleiter (Eds), *The Pathogenesis of Alcoholism: Psychosocial Factors (volume 6),* pp 113 – 196,New York, Plenum Press

Barnes, G.M. (1990), Impact of the family on adolescent drinking patterns, in R.L. Collins, K.E. Leonard and J.S. Searles (eds), *Alcohol and the Family*, pp 137 – 161, London, The Guilford Press

Barnow, S., Ulrich, I., Grabe, H-J., Freyberger, H.J. and Spitzer, C. (2007), The influence of parental drinking behaviour and antisocial personality disorder on adolescent behavioural problems: results of the Greifswalder family study, *Alcohol and Alcoholism,* 42, 6, pp 623 – 628

Barrett, C.K. (1979), *A Commentary on the First Epistle to the Corinthians,* London, England, Adam and Charles Black

Barth, D.F., (2010), Frozen in time: idealisation and parent-blaming in the therapeutic process, *Clinical Social Work Journal,* 38, pp 331 – 340

Batson, C.D., Schoenrade, P. and Ventis, W.L. (1993), *Religion and the Individual: a Social Psychological Perspective,* New York, Oxford University Press

Behrendt, S., Wittchen, H-U., Höfler, M., Lieb, R., Chooi Ping Low, N., Rehm, J. and Beesdo, K. (2008), Risk and speed of transition to first alcohol dependence symptoms in adolescents: a 10-year longitudinal community study in Germany, *Addiction,* 103, pp1638 – 1647

Beit-Hallahmi, B. and Argyle, M. (1997), *The Psychology of Religious Behaviour, Belief and Experience,* London, England, Routledge

Benet, V. and Waller, N.G. (1995), The Big Seven Factor model of personality description: evidence for its cross-cultural generality in a Spanish sample, *Journal of Personality and Social Psychology,* 69, 4, pp 701 – 718

Bennett, L.A. and Wolin, S.J. (1990), Family culture and alcohol transmission, in R.L. Collins, K.E. Leonard and J.S. Searles (eds), *Alcohol and the family,* pp 194 – 219, London, The Guilford Press

Berreman, G.D. (1956), Drinking patterns of the Aleuts, *Quarterly Journal of Studies on Alcohol,* 17, pp 503 – 514

Beseler, C.L., Aharonovich, E., Keyes, K.M. and Hasin, D.S. (2008), Adult transition from at risk drinking to alcohol dependence: the relationship of family history and drinking motives, *Alcoholism: Clinical and Experimental Research,* 32, 4, pp 607 – 616

Bijttebier, P., Goethals, E. and Ansoms, S. (2006), Parental drinking as a risk factors for children's maladjustment: the mediating role of family environment, *Psychology of Addictive Behaviours,* 20, 2 pp 126 – 130

Birditt, K.S., Rott, L.M. and Fingerman, K.L. (2009), "If you can't say something nice, don't say anything at all": coping with interpersonal tensions in the parent-child relationship during adulthood, *Journal of Family Psychology,* 23, 6, pp769 – 778

Blatz, W.E. (1966), *Human Security: Some Reflections,* Toronto: Canada, University of Toronto Press

Bowlby, J. (1969), *Attachment and Loss, Volume 1,* United Kingdom, Pimlico

Breslow, R.A. and Graubard, B.I. (2008), Prospective study of alcohol consumption in the United States: quantity, frequency and cause-specific mortality, *Alcoholism: Clinical and Experimental Research,* 32, 3, pp 513 – 521

Brickman, P., Rabinowitz, V.C., Karuza, J. Jr., Ajzen, D., Cohn, E. and Kidder, L. (1982), Models of helping and coping, *American Psychologist,* 37, pp 368 – 384

Bromley, D.G. and Shupe, A.D. (1979), "Just a few years seem like a lifetime": a role theory approach to participation in religious movements, in L. Kriesberg (ed), *Research in Social Movements, Conflicts and Change,* vol. 2, Greenich, CT: JAI Press, pp159 – 185

Brown, S. (1988), *Treating Adult Children of Person with Alcohol Dependency,* New York, Wiley

Bunzel, R. (1940), The role of alcoholism in two central American cultures, *Psychiatry,* 3, pp 361 – 387

Burstein, M., Stanger, C., Kamon, J. and Dumenci, L. (2006), Parent psychopathology, child internalising problems in substance – abusing families, *Psychology of Addictive Behaviour,* 20, 2 pp 97 – 106

Caplan, G. (1980), An approach to preventive intervention in child psychiatry, *Canadian Journal of Psychiatry,* 25, pp 671 – 682

Caplan, M., Weissberg, R.P., Grober, J.S., Sivo, P.J., Grady, K. and Jacoby, C. (1992), Social competence promotion with inner-city and suburban young adolescents: effects on social adjustment and harmful drinking, *Journal of Consulting and Clinical Psychology,* 60, pp 56 – 63

Capone, C. and Wood, D. (2008), Density of familial alcoholism and its effects on alcohol use and problems in college students, *Alcoholism: Clinical and Experimental Research,* 32, 8, pp 1451 – 1458

Cartledge, M. J. (2003), *Practical Theology,* United Kingdom, Paternoster Press

Cattell, R.B. (1943), The description of personality: basic traits resolved into clusters, *Journal of Abnormal Social Psychology,* 38, pp 476 – 506

Cattell, R.B., Eber, H.W. and Tatsuoka, M.M. (1970), *Handbook of the Sixteen Personality Factor Questionnaire,* Champaign, Il, Personality Ability Testing

Chamorro-Premuzic, T. and Furnham, A. (2005), *Personality and Intellectual Competence,* New Jersey, Lawrence Erlbaum Associates

Chassin, L., Pillow, D.R., Curran, P.J., Molina, B.S.G. and Barrera, M. (1993), Relation of parental alcoholism to early adolescent substance use: a test of three mediating mechanisms, *Journal of Abnormal Psychology,* 102, 1, pp 3 – 19

Chassin, L., Rogosch, F. and Barrera, M. (1991), Substance use and symptomatology among adolescent children of person with alcohol dependency, *Journal of Abnormal Psychology,* 100, 4, pp449 – 463

Clarke, A. (1967), *Adam Clarke's Commentary, One-Volume Edition*, Kansas City, Missouri, Beacon Hill Press

Clarke, L., Beeghley, L. and Cochrane, J.K. (1990), Religiosity, social class and alcohol use, *Sociological Perspectives,* 33, 2, pp 201 – 218

Clinebell, H. (1998), *Understanding and Counselling Persons With Alcohol, Drug and Behavioural Addictions*, Nashville, TN, Abingdon Press

Cloninger, C.R. (1987), Neurogenetic adaptive mechanisms in alcoholism, *Science,* 236, pp 410-416

Cole, R.A. (1984), *Galatians,* Leicester, England, Inter-Varsity Press

Collins, R.L. and Bradizza, C.M. (2001), Social and cognitive learning processes, in N. Heather, T.J. Peters and T. Stockwell (eds) *International Handbook of Alcohol Dependence and Problems*, pp 317 – 337, England, J. Wiley and Sons Ltd.

Cook, C.C.H. (2006), *Alcohol, Addiction and Christian Ethics,* Cambridge, England, Cambridge University Press

Cook, C.C.H. (2008), Alcohol and other addictions, in B. Geary and J. Bryan (eds) *Abuse, Addiction and Difficult Behaviour,* pp 83 – 111, England, Kevin Mayhew Ltd.

Cooper, M.L. (1994), Motivations for alcohol use among adolescents: development and validation of a four factor model, *Psychological Assessment,* 6, pp 117 – 128

Copper, M.L., Russell, M., Skinner, J.B. and Windle, M. (1992), Development and validation of a three-dimensional measure of drinking motives, *Psychological Assessment,* 4, 2, pp 123 – 132

Cooper, M.L., Frone, M.R., Russell, M. and Mudar, P. (1995), Drinking to regulate positive and negative emotions: a motivational model of alcohol use, *Journal of Personality and Social Psychology,* 69, 5, pp 990-1005

Cornelius, J.R., Jarrett, P.J., Thase, M.E., Fabrega Jr., H., Haas, G.L., Jones-Barlock, A., Mezzich, J.E. and Ulrich, R.F. (1995), Gender effects on the clinical presentation of person with alcohol dependency at a psychiatric hospital, *Comprehensive Psychiatry,* 36, 6, pp 435 – 440

Corte, C. and Zucker, R.A. (2008), Self-concept disturbances: cognitive vulnerability for early drinking and early drunkenness in adolescents at high risk for alcohol problems, *Addictive Behaviours,* 33, pp 1282 – 1290

Costa, P.T. Jr. and McCrae, R.R. (1985), *The NEO Personality Inventory manual.* Odessa, FL, Psychological Assessment Resources

Costa, P.T. Jr. and McCrae, R.R. (1989), Personality continuity and the changes in adult life, in M. Storandt and G.R. Vanden Bos (eds), *The Adult Years: Continuity and Change,* pp 45 – 77, Washington DC, American Psychological Association

Costa, P.T. Jr. and McCrae, R.R. (1992), *Revised NEO Personality Inventory (NEO-*

PI-R) and NEO Five Factor Inventory (NEO-FFI) professional manual, Odessa, FL, Psychological Assessment Resources

Costa, P.T. Jr. and McCrae, R.R. (1997), Stability and change in personality assessment: the Revised NEO Personality Inventory in the year 2000, *Journal of Personality Assessment*, 68, pp 86 – 94

Cox, W.M. and Klinger, E. (1988), A motivational model of alcohol use, *Journal of Abnormal Psychology,* 97, 2, pp 168-180

Cox, W.M., Yeates, G.N., Gilligan, P.A.T. and Hosier, S.G. (2000), Individual differences, in N. Heather, T.J. Peters and T. Stockwell (eds), International Handbook of *Alcohol Dependence and Problems,* pp 357 – 374, New York, John Wiley and Sons Ltd.

Craigie, P.C. (1976), *The Book of Deuteronomy,* The New International Commentary on the Bible, Grand Rapids, Michigan, William B. Eerdmans Publishing Company

Cranford, J.A., Eisenberg, D. and Serras, A.M. (2009), Substance use behaviours, mental health problems, and use of mental health services in probability sample of college students, *Addictive Behaviours,* 34, pp 134 – 145

Crum, R.M., Storr, C.L., Ialongo, N. and Anthony, J.C. (2008), Is depressed mood in childhood associated with an increased risk for initiation of alcohol use in early adolescence?, *Addictive Behaviours,* 33, pp24 – 40

Cyders, M.A., Flory, K., Rainer, S. and Smith, G.T., (2009), The role of personality dispositions to risky behaviour in predicting first-year college drinking, *Addiction,* 104, pp 193 – 202

Danielson, C.K., Amstadter, A.B., Dangelmaier, R.E., Resnick, H.S., Saunders, B.E. and Kilpatrick, D.G. (2009), Trauma-related risk factors for substance abuse among male versus female young adults, *Addictive Behaviours,* 34, pp 395-399

Darynani, H.E., Santolaria, F.J., Reimers, E.G., Jorge, J.A., Lopez, N.B., Hernandez, F.M., Reira, A.M. and Rodriguez, E.R. (1994), Person with alcohol dependency withdrawal syndrome and seizures, *Alcohol and Addiction,* 29, 3, pp 323 – 328

Davids, P.H. (1990), *The First Epistle of Peter,* The New International Commentary on the Bible, Grand Rapids, Michigan, William B. Eerdmans Publishing Company

Davis, D.L. (1962), Normal drinking in recovered alcohol addicts, *Quarterly Journal of Studies on Alcohol,* 23, pp 93 – 104

Dawson, D.A. (1994), Are men or women more likely to stop drinking because of alcohol problems?, *Drug and Alcohol Dependence,* 36, pp 57 – 64

Dawson, D.A., Grant, B.F. and Ruan, W.J. (2005), The association between stress and drinking: modifying effects of gender and vulnerability, *Alcohol and Alcoholism,* 40, 5, pp 453 – 460

De Menzi, M. C.R. (2010), Gender and cultural attachment and links with children's self-competence, depression and loneliness in middle and late childhood, *Early Child Development and Care,* 180, 1, pp 193 – 209

De Silva, P. and Eysenck, S.B.G. (1987), Personality and addictiveness in anorexic and bulimic patients, *Personality and Individual Differences,* 8, 5, pp 749 - 751

De Visser, R.O. and Smith, J.A. (2007), Young men's ambivalence towards alcohol, *Social Science and Medicine,* 64, pp 350 – 362

Diamond, D. and Doane, J.A. (1994), Disturbed attachment and negative affective style, *British Journal of Psychiatry,* 164, pp 770 – 781

Digman, J.M. (1990), Personality structure: emergence of the five factor model, *Annual Reviews Psychology,* 41, pp 417 – 440

Digman, J.M. and Takemoto-Chock, N.K. (1981), Factors in the natural language of personality: re-analysis, comparison and interpretation of six major studies, *Multivariate Behavioural Research,* 16, pp 149 – 170

Donavan, D. M. (1988), Assessment of addictive behaviours, implications of an emerging biopsychosocial model, in D. M. Donovan and G.A. Marlatt (eds) *Assessment and Addictive Behaviours,* pp 3 – 48,New York, Guilford

Driessen, M., Lange, W., Junghanns, K. and Wetterling, T. (2005), Proposal of comprehensive clinical typology of alcohol withdrawal – a cluster analysis approach, *Alcohol and Alcoholism,* 40, 4, pp 308 – 313

Drobes, D.J., Saladin, M.E. and Tiffany, S.T. (2001), Classical conditioning mechanisms in alcohol dependence, in N. Heather, T.J. Peters and T. Stockwell (eds), *International Handbook of Alcohol Addiction and Problems,* pp 281-297, Chichester, John Wiley & Sons, Ltd.

Dunn, J. (1986), *God is for the Person with Alcohol Dependency,* Chicago, Moody Press

Ebstein, R.P., Benjamin, J. and Belmaker, R.H. (2000), Genetics of personality dimensions, *Current Opinion in Psychiatry,* 13, 6, pp 617 – 622

Edwards, G. and Gross, M. (1976), Alcohol dependence: provisional description of a clinical syndrome, *British Medical Journal*, 1, pp 1058 – 1061

Edwards, G., Gross, M.M., Keller, M., Moser, J. and Room, R. (eds) (1977), *Alcohol-related Disabilities*, WHO offset publication, 32, Geneva, WHO

Edwards, G., Marshall, E.J. and Cook, C.C.H. (2003), *The Treatment of Drinking Problems: a Guide for Helping Professions,* England, Cambridge University Press

Elkins, I.J., King, S.M., McGue, M., Iacono, W.G. (2006), Personality traits and the development of nicotine, alcohol, and illicit drug disorders: Prospective links from adolescence to young adulthood, *Journal of Abnormal Psychology*,115, pp 26 – 39

Ellison, C.G., Barrett, J.B. and Moulton, B.E. (2008), Gender, marital status and alcohol behaviour: the neglected role of religion, *Journal for the Scientific Study of Religion,* 47, 4, pp 660 – 677

Epstein, E.E. (2001), Classification of alcohol-related problems and dependence, in N. Heather, T.J. Peters and T. Stockwell (eds) *International Handbook of Alcohol Dependence and Problems*, pp 47 – 70, England, J. Wiley and Sons Ltd.

Estelle, M. (1990), Id, in R.J. Hunter (ed) *Dictionary of Pastoral care and Counselling,* Nashville, TN, Abingdon Press

Eysenck, H.J. and Eysenck, S.B.G. (1975), *Manual of the Eysenck Personality Questionnaire (adult and junior),* London, Hodder and Stoughton

Eysenck, H.J. and Eysenck, S.B.G. (1991), *Manual of Eysenck Personality Scales (EPS Adult),* London, Hodder and Stoughton

Eysenck, H.J. (1992), The definition and measurement of psychoticism, *Personality and Individual Differences,*13, 7, pp 757 – 785

Eysenck, H.J. (1998), *Dimensions of Personality,* London, Transaction Publishers

Eysenck, H.J. (1995), Trait theories of personality, in S.E. Hampson and A.M. Colman (eds) *Individual Differences and Personality,* pp 40 – 58, London, Longman.

Eysenck, H.J. (1997), Addiction, personality and motivation, *Human Psychopharmacology,* 12, pp 79 – 87

Eysenck, S.B.G., Eysenck, H.J. and Barrett, P. (1985), A revised version of the psychoticism scale, *Personality and Individual Differences,* 6, 1, pp 21 – 29

Eysenck, S.B.G., Nias, D.K.B. and Eysenck, H.J. (1971), Interpretation of children's Lie Scale scores, *British Journal of Educational Psychology,* 41, pp 23 – 31

Fadardi, J.S. and Cox, W.M. (2008), Alcohol-attentional bias and motivational structures as independent predictors of social drinkers' alcohol consumption, *Drug and Alcohol Dependence,* 97, pp 247 – 256

Fals-Stewart, W., Leonard, K.E. and Birchler, G.R. (2005), The occurrence of male-to-female intimate partner violence on days of men's drinking: the moderating effect of antisocial personality disorder, *Journal of Consulting and Clinical Psychology,* 73, 2, pp 239 – 248

Feldman, J. and Eysenck, S.B.G. (1986), Addictive personality traits and bulimic patients, *Personality and Individual Differences,* 7, 6, pp 923 - 926

Fernandez, A.C., Begley, E.A. and Marlatt, G.A. (2006), Family and peer interventions for adults: past approaches and future directions, *Psychology of Addictive Behaviour,* 20, 2, pp 207 – 213

Field, A., (2003), *Discovering Statistics using SPSS for Windows,* England, SAGE Publications

Field, M. And Cox, W.M. (2008), Attentional bias in addictive behaviours: a review of its development, causes and consequences, *Drug and Alcohol Dependence,* 97, 1-2, pp 1 – 20

Fingarette, H. (1989), *Heavy Drinking: the Myth of Alcoholism as a Disease*, London, University of California Press

Finney, J., Smith, D., Skeeters, D. and Auvenshine, C. (1971), MMPI alcoholism scales, factor structure and content analysis, *Quarterly Journal of Studies on Alcohol*, 32, pp 1055 – 1060

Fischer, S. and Smith, G.T. (2008), Binge eating, problem drinking and pathological gambling: linking behaviour to shared traits and social learning, *Personality and Individual Differences,* 44, pp 789 – 800

Fiske, D.W. (1949), Consistency of the factorial structures of personality ratings from different sources, *Journal of Abnormal Social Psychology,* 44, pp 329 – 344

Francis, L.J., Fulljames, P. and Kay, W.K. (1992) The functioning of the EPQ Lie scale among religious subjects in England, *Journal of Psychology and Christianity,* 11, 3, pp 255 – 261

Francis, L.J. (1996), The relationship between Eysenck's personality factors and attitudes towards substance use among 13 -15 year-olds, *Personality and Individual Differences,* 21, 5, pp 633 – 640

Francis, L.J. (2005), *Faith and Psychology*, London, Darton, Longman and Todd

Francis, L.J., Brown, L.B. and Philipchalk, R. (1992), The development of an abbreviated form of the Revised Eysenck Personality Questionnaire (EPQR-A): its use among students in England, Canada, the USA and Australia, *Personality and Individual Differences,* 13, pp 443 – 449

Francis, L.J., Lewis, C.A. and Ziebertz, H. (2006) The short-form revised Eysenck personality questionnaire (EPQ-S): a German edition, *Social Behaviour and Personality,* 34, 2, pp 197 – 204

Fung, R.Y.K. (1998), *The Epistle to the Galatians,* The New International Commentary on the Bible, Grand Rapids, Michigan, William B. Eerdmans Publishing Company

Furnham, A. and Heaven, P. (1999), *Personality and Social Behaviour,* London, Arnold

Furnham, A. and Cheng, H. (2000), Perceived parental behaviour, self-esteem and happiness, *Social Psychiatry,* 35, pp 463 – 470

George, M.R.W., Cummings, E.M. and Davies, P.T. (2010), Positive aspects of fathering and mothering, and children's attachment in kindergarten, *Early Child Development and Care,* 180, 1, pp 107 – 119

George, W. (1989), Marlatt and Gordon's relapse prevention model: a cognitive behavioural approach to understanding and preventing relapse, *Journal of American Medical Association*, 226, pp 125 – 152

Gillespie, N.A., Zhu, G., Evans, D.M., Medland, S.E., Wright, M.J. and Martin, N.G. (2008), A genome-wide scan for Eysenckian personality dimensions in adolescent twin sibships: psychoticism, extraversion, neuroticism and lie, *Journal of Personality,* 76, pp 1415 – 1445

Gmel, G., Gaume, J., Faouzi, M., Kulling, J-P and Daeppen, J-B. (2008)**,** Who drinks most of the total alcohol in young men – risky single occasion drinking as normative behaviour, *Alcohol and Alcoholism,* 43, 6, pp 692 – 697

Goffman, E. (1959), *The Presentation of Self in Everyday Life,* New York, Doubleday

Goldberg, L.R. (1981), Language and individual differences: the search for universals in personality lexicons, in L. Wheeler (ed), *Review of Personality and Social Psychology,* pp 141 – 165, Beverly Hills, CA, Sage

Goldberg, L.R. (1990), An alternative 'description of personality': The five factor structure, *Journal of Personality and Social Psychology,* 59, pp 1216 – 1229

Gomberg, E.S.L. and Lisansky, J.M. (1984), Antecedents of alcohol problems in women, in S.C. Wilsnack and L.J. Beckman (eds) *Alcohol Problems in Women,* New York, Guildford

Gooren, H. (2007), Reassessing conventional approaches to conversion: toward a new synthesis, *Journal for Scientific Study of Religion,* 46, 3, pp 337 – 353

Gossop, M.R. and Eysenck, S.B.G. (1980), a further investigation into the personality of drug addicts in treatment, *British Journal of Addiction,* 75, pp 305 – 311

Goudriaan, A.E., Grekin, E.R. and Sher, K.J. (2007), Decision making and binge drinking, *Alcoholism: Clinical and Experimental Research,* 31, 6, pp 928 – 938

Graham, J.R. (1990), *MMPI-2 Assessing Personality and Psychopathology,* New York, Oxford University Press

Grant, B.F. and Dawson, D.A. (1997), Age at onset of alcohol use and its association with DSM-IV harmful drinking and dependence, *Journal of Substance Abuse,* 9, pp 103 – 110

Greil, A.L. (1977), Previous Dispositions and Conversion to Prescriptives of Social and Religious Movements, *Sociological analysis,* 38, 2, pp 115-125

Griffin, K.W., Scheier, L.M., Botvin, G.J. and Diaz, T. (2001), Protective role of personal competence skills in adolescent substance use: psychological well-being as a mediating factor, *Psychology of Addictive Behaviours,* 15, 3, pp 194 – 203

Grossarth-Maticek, R., Eysenck, H.J. and Boyle, G.J. (1995), Alcohol consumption and health: synergistic interaction with personality, *Psychological Reports,* 77, pp 675 – 687

Grucza, R.A., Norberg, K., Bucholz, K.K. and Bierut, L.J. (2008), Correspondence between secular changes in alcohol dependence and age at onset among women in the United States, *Alcoholism: Clinical and Experimental Research,* 32, 8, pp 1493 –

1501

Gusfield, (1967), Moral passage: the symbolic process in public designations of deviance, *Social Problems,* 15, pp 175 – 188

Hall, W., Degenhardt, L. and Teesson, M. (2009), Understanding comorbidity between substance use, anxiety and affective disorders: broadening the research base, *Addictive Behaviours,* 34, pp 526 – 530

Ham, L.S. and Hope, D.A. (2003), Alcohol and anxiety: subtle and obvious attributes of abuse in adults with social anxiety disorder and panic disorder, *Depression and Anxiety,* 18, pp 128 – 139

Ham, L.S., Bonin, M. and Hope, D.A. (2007), The role of drinking motives in social anxiety and alcohol use, *Journal of Anxiety Disorders,* 21, pp 991 – 1003

Hampson, S.E. (1995), The construction of personality, in S.E. Hampson and A.M. Colman (eds) *Individual Differences and Personality,* pp 20 – 39, London, Longman

Hathaway, S.R. and McKinley, J.C. (1951), *MMPI Manual,* New York, New York Psychological Corporation

Hatton, J., Burton, A., Nash, H., Munn, E., Burgoyne, L. and Sheron, N. (2009), Drinking patterns, dependency and life-time drinking history in alcohol-related liver disease, *Addiction,* 104, pp 587 – 592

Hazen, N.L., McFarland, L., Jacobvitz, D. and Boyd-Soisson, E. (2010), Father's frightening behaviours and sensitivity with infants: relations with father's attachment representations, father-infant attachment and children's later outcomes, *Early Child Development and Care,* 180, 1, pp 51 – 69

Heath, D.B. (1962), Drinking patterns of the Bolivian Camba, in D.J. Pitman and C.R. Snyder (eds), *Society, Culture and Drinking Patterns*, London, John Wiley and Sons

Heath, A.C., Bucholz, K.K., Madden, P.A.F., Dinwiddie, S.H., Slutske, W.S., Bierut, L.J., Statham, D.J., Duune, M.P., Whitfield, J.B. and Martin, N.G. (1997), Genetic and environmental contributions to alcohol dependence risk in a national twin sample: consistency of findings in women and men, *Psychological Medicine,* 27, pp 1381 – 1396

Heather, N, and Robertson, I. (2001), *Problem Drinking*, Oxford, Oxford University Press

Hierich, M. (1977), Change of Heart: a test of some widely held theories about religious conversion, *American journal of sociology,* 83(3), pp 653-680

Hirsh, S.K., and Kise, J.A.G. (2000), *Looking At Type and Spirituality,* Gainesville, FL, CAPT

Holloway, R. (2000), *Godless Morality,* Edinburgh, Scotland, Canongate

International Classification of Diseases (2006), Mental and behavioural disorders due to psychoactive substance use, *ICD-10,* icd10online

Jaeger, E., Hahn, N.B. and Weinraub, M. (2000), Attachment in adult daughters of person with alcohol dependency fathers, *Addiction,* 95, 2, pp 267 – 276

James, W. (1985), *The Varieties of Religious Experience,* London, England, Penguin

Jang, K.L., Vernon, P.A. and Livesley, W.J. (2000), Personality disorder traits, family environment, and alcohol misuse: a multivariate behavioural genetic analysis, *Addiction,* 95, 6, pp 873 – 888

Janowsky, D.S. (1999), Introduction to personality-biological interactions in alcoholism: the Markku Linnoila memorial symposium, *Alcohol and Alcoholism,* 34, 3, pp 357 – 358

Jellinek, E.M., (1946), Phases in the drinking histories of person with alcohol dependency, *Quarterly Journal of Studies on Alcohol,* 7, pp 1 – 88

Jellinek, E.M., (1952), Phases of alcohol addiction, *Quarterly Journal of Studies on Alcohol,* 13, pp 673 – 684

Jellinek, E.M., (1960a), Alcoholism: a genus and some of its species, *Canadian Medical Association Journal,* 83, pp 1341 – 1345

Jellinek, E.M. (1960b), *The Disease Concept of Alcoholism*, New Haven, CT Hillhouse

Jellinek, E.M. (1962), Phases of alcohol addiction, in D.J. Pitman and C.R. Snyder (eds.) *Society, Culture and Drinking Patterns,* London, John Wiley and Sons

Johnson, J.L. and Rolf, J.E. (1990), When children change: research perspectives on children of person with alcohol dependency, in L.R. Collins, K.E. Leonard and J.S. Searles (eds), *Alcohol and the Family: Research and Clinical Perspectives,* pp 162 – 193, London, Guildford Press.

Johnson-Greene, D., Adams, K.M., Gilman, S. and Junck, L. (2002), Relationship between neuropsychological and emotional functioning in severe chronic alcoholism, *The Clinical Neuropsychologist,* 16, 3, pp 300 – 309

Johnston, L.D., O'Malley, P.M. and Bachman, J.G. (1989), Drug use, drinking and smoking: National survey results from High School, College and young adult populations, *National Institute of Drug Abuse, DHSS Publication number n(ADM) 89-1638,* Washington DC, Superintendent of Documents, US Government Printing Office.

Jung, C.G., (1990), *Psychological Types,* A revision by R.F.C. Hull of the translation by H.G. Baynes, Princeton, New Jersey, Princeton University Press

Kay W.K. and Francis L.J. (1985), The seamless robe: interdisciplinary enquiry in religious education, *British Journal of Religious Education,* 7, 2, pages 64 – 67

Keating, C. J., (2004), *Who We Are Is How We Pray: matching personality and spirituality,* Mystic, CT, Twenty-Third Publications

Keller, P.S., El-Sheikh, M., Keiley, M. and Liao, P-J. (2009), Longitudinal relations between marital aggression and alcohol problems, *Psychology of Addictive Behaviour,* 23, 1, pp 2 – 13

Kestilä, L., Martelin, T., Rahkonen, O., Joutsenniemi, K., Pirkola, S., Poikolainen, K. and Koskinen, S. (2008), Childhood and current determinants of heavy drinking in early adulthood, *Alcohol and Alcoholism,* 43, 4, pp 460 – 469

Kidner, D. (1974), *Genesis,* Tyndale Old Testament Commentaries, London, England, Inter-Varsity Press

Kline, P. (1993), *The Handbook of Psychological Testing*, London, Routledge

Knight, R.G. (2001), Neurological consequences of alcohol use, in N. Heather, T.J. Peters and T. Stockwell, (eds), *International Handbook of Alcohol Addiction and Problems,* pp 129 – 148, England, John Wiley and Sons Ltd.

Köhnke, M.D. (2008), Approach to the genetics of alcoholism: a review based on pathophysiology, *Biochemical Pharmacology,* 75 (1) pp 160 – 177

Krivanek, J.A. (1982), *Drug Problems, People Problems: Causes, Treatment and Prevention,* Sydney, Allen and Unwin

Kuendig, H. and Kuntsche, E. (2006), Family bonding And adolescent alcohol use: moderating effect of living with excessive drinking parents, *Alcohol and Alcoholism,* 41, 4, pp 464 – 471

Kumar, P.J. and Clark, M.L. (1990), *Clinical Medicine,* London, Bailliere Tindall

Kuntsche, E. and Gmel, G. (2006), Changes in adolescents' reasons for drinking in Switzerland and associations with alcohol use from 1994 to 2002, *Journal of Adolescent Health,* 39, pp 705 – 711

Kuo, P.H., Aggen, S.H., Prescott, C.A., Kendler and Neale, M.C. (2008), Using a factor mixture modelling approach in alcohol dependence in a general population, *Drug and Alcohol Dependence,* 98 (1-2) pp 105 – 114

Lavikainen, H.M., Lintonen, T. and Kosunen, E. (2009), Sexual behaviour and drinking style among teenagers: a population-based study in Finland, *Health Promotion International,* 24, 2, pp108 – 119

Lee, N. and Rawson, R. (2008), A systematic review of cognitive and behavioural therapies for methamphetamine dependence, *Drug and Alcohol Review,* 27 (3), pp 309 – 317

Leonard, K.E. (1990), Summary: family processes and alcoholism, in R.L. Collins, K.E. Leonard and J.S. Searles (eds), *Alcohol and the Family,* pp 272 – 281, London, The Guilford Press

Leonard, K.E. (1990), Marital functioning among episodic and steady person with alcohol dependency, in L.R. Collins, K.E. Leonard and J.S. Searles (eds), *Alcohol and the Family,* pp 220 – 243, London, Guildford Press

Levine, H.G. (1978), The discovery of addiction: changing conceptions of habitual drunkenness in America, *Journal of Studies on Alcohol*, (39) pp 143 – 174

Livingstone, M. and Room, R., (2009), Variations in age and sex in alcohol-related problematic behaviour per drinking volume and heavier drinking occasion, *Drug and Alcohol Dependence,* 3, pp169 – 175

Locke, T.F. and Newcomb, M.D. (2001), Alcohol involvement and dysphoria: a longitudinal examination of gender differences from late adolescence to adulthood, *Psychology of Addictive Behaviours,* 15, 3, pp 227 – 236

Lofland, J. and Stark, R. (1965), Becoming a world saver: a theory of conversion to a deviant perspective, *American sociological review,* 30(6), pp 862 – 875

Long, T.E. and Hadden, J.K. (1983), Religious conversion and process of socialization: integrating the brainwashing and drift models, *Journal for the Scientific Study of Religion,* 22, 1, pp1-14

Loukas, A., Krull, J.L., Chassin, L. and Carle, A.C. (2000), The relation of personality to harmful drinking/dependence in a high risk sample, *Journal of Personality,* 68, 6, pp 1153 – 1175

Mac Andrew, C. (1981), What the MAC scale tells us about men alcoholics, *Journal of Studies on Alcohol,* 42, pp 604 – 625

Mac Andrew, C. (1986), Similarities in the self-depiction of female alcoholics and psychiatric outpatients: Examination of Eysenck's dimension of emotionality in women, *Journal of Studies on Alcohol,* 47, pp 478 - 484

McFadyen, A. (2000), *Bound to Sin: Abuse, Holocaust and the Christian Doctrine of Sin,* Cambridge, Cambridge University Press

Malony, H.N. (1998), The psychology of religious conversion, lecture delivered at International Coalition for Religious Freedom conference, Japan, www.religiousfreedom.com

Maltby, J., Day, L. and Macaskill, A. (2010), *Personality, Individual Differences and Intelligence,* London, Prentice Hall

Mandelbaum, D.G. (1965), Alcohol and culture, *Current Anthropology,* 6, 3, pp 281 – 293

Martin, D. (1997), *Reflections on Sociology and Theology,* Oxford, Clarendon Press.

Martinic, M. (1998), The implications for measurement and research, in M. Grant and J. Litvak (eds) *Drinking Patterns and Their Consequences,* pp 221 – 241, Washington DC, Taylor and Francis.

Mason, W.A., Kosterman, R., Haggerty, K.P., Hawkins, J.D., Redmond, C., Spoth, R.L. and Shin, C. (2009), Gender moderation and social development mediation of the effect of family-focused substance use preventive intervention on young adult alcohol use, *Addictive Behaviours,* 34, pp 599 – 605

May, G. G. (1991), *Addiction and Grace: Love and Spirituality in the Healing of Addictions,* New York, Harper Collins

Mayfield, R.D., Harris, R.A. and Schuckit, M.A. (2008), Genetic factors influencing alcohol dependence, *British Journal of Pharmacology,* 154, 2, pp 275 – 287

Measham, F. (2008), The turning tides of intoxication: young people's drinking in Britain in the 2000s, *Health Education,* 108, 3, pp 207 – 222

Mello, N. and Mendelson, J. (1978), Behavioural pharmacology of alcohol, heroin and marijuana use, in J. Fishman (ed) *The Basis of Addiction,* pp 133-155, Berlin, Dahlem Konferenzen

Mennella, J.A. and Forestell, C.A. (2008), Children's hedonic responses to the odours of person with alcohol dependency beverages: a window of emotions, *Alcohol,* 42, pp 249 – 260

Mercadante, L.A. (1996), *Victims and Sinners: Spiritual Roots of Addiction and Recovery,* Louisville, KY, Westminster John Knox Press

Mezquita, L., Stewart, S.H. and Ruipérez, M.Ά. (2010), Big five personality domains predict internal drinking motives in young adults, *Personality and Individual Differences,* 49, pp 240 – 245

Michaelis, W. and Eysenck, H.J. (1971) The determination of personality inventory factors and interconnections by changes in real life motivation, *Journal of General Psychology,* 118, pp 223 – 234

Michiels, D., Grietens, H., Onghena, P. and Kuppens, S. (2010), Perceptions of maternal and paternal attachment security in middle childhood: links with positive parental affection and psychosocial adjustment, *Early Child Development and Care,* 180, 1, pp 211 – 225

Miller, H.R. and Streiner, D.L. (1990), Using the Millon Clinical Multiaxial Inventory's Scale B and the Mac Andrew Alcoholism Scale to identify alcoholics with concurrent psychiatric diagnoses, *Journal of Personality Assessment,* 54, pp 736 – 746

Möller-Leimkühler, A.M., Schwarz, R., Burtscheidt, W. and Gaebel, W. (2002), Alcohol dependence and gender role orientation, *European Psychiatry,* 17, pp 1 – 8

Morey, L.C., Roberts, W.R. and Penk, W. (1987), MMPI person with alcohol dependency subtypes: replicability and validity of the 2-8-7-4 subtype, *Journal of Abnormal Psychology,* 96, pp 164 – 166

Moss, S. (1989), *Jungian Typology, Melbourne* Australia, Collins Dove

Mounce, W.D. (2000), *The Pastoral Epistles,* Nashville, TN, Nelson

Mullahy, J. and Sindelar, J. (1996), Employment, unemployment and problem drinking, *Journal of Health Economics,* 15, pp 409 – 434

Muris, P. and Maas, A. (2004), Strengths and difficulties as correlates of attachment style in institutional and non-institutionalised children with below average intellectual abilities, *Child Psychiatry and Human Development,* 34, 4, pp 317 – 328

Myers, I.B. (1962), *The Myers-Briggs Type Indicator*, Palo Alto, CA, CPP Inc.

Myers I.B. and Myers, P.B. (1995), *Gifts Differing,* Palo Alto, CA, Davies-Black Publishing

National Statistics (2002), *Drinking: Adults' Behaviour and Knowledge in 2002,* London, Office of National Statistics, www.statistics.gov.uk/lib

Newland, L.A. and Coyl, D.D. (2010), Fathers' role as attachment figures: an interview with Sir Richard Bowlby, *Early Child Development and Care,* 180, 1, pp 25 – 32

Norman, W.T. (1963), Toward an adequate taxonomy of personality attributes: replicated factor structure in peer nomination personality ratings, *Journal of Abnormal Social Psychology,* 66, pp 574 - 583

Ogden, M.E., Dundas, M. and Bhat, A.V. (1989), Personality differences among alcohol misusers in community treatment, *Personality and Individual Differences,* 10, 2, pp 265 – 267

Overbeek, G., Vollebergh, W., Meeus, W., de Graaf, R. and Engels, R.C.M.E. (2004), Young adults' recollections of parental bonds, *Social Psychiatry,* 39, pp 703 – 710

Parker, G., Roussos, J., Hadzi-Pavlovic, D., Mitchel, P., Wilhelm, K. and Austin, M-P (1997), The development of a refined measure of dysfunctional parenting and assessment of its relevance in patients with affective disorders, *Psychological Medicine,* 27, pp 1193 – 1203

Parks, G.A., Marlatt, G.A. and Anderson, B.K. (2001), Cognitive-behavioural alcohol treatment, in N. Heather, T.J. Peters and T. Stockwell (eds) *International Handbook of Alcohol Dependence and Problems*, pp 557 – 573, England, J. Wiley and Sons Ltd.

Parker, J.N. and Parker, P.M. (2004), *Alcohol Withdrawal,* San Diego, CA; ICON Group International, Inc

Parsons, T. (1955a), The American family: its relation to personality and to the social structure, in T. Parsons and R.F. Bales (eds), pp 3 – 34,*Family Socialisation and Interaction Process,* New York, The Free Press

Parsons, T. (1955b), Family structure and the socialisation of the child, in T. Parsons and R.F. Bales (eds), pp 35 – 132, *Family Socialisation and Interaction Process,* New York, The Free Press

Paulhus, D.L. and Reid, D.B. (1991) Enhancement and denial in socially desirable responding, *Journal of Personality and Social Psychology,* 60, pp 307 - 317

Peabody, D. and Goldberg, L.R. (1989), Some determinants of factor representations of trait adjectives, *Journal of Personality and Social Psychology,*

Pearle, R. (1926), *Alcohol and Longevity,* New York, Knopf

Pearson, P.R. and Francis, L.J. (1989) The dual nature of the Eysenckian Lie scales: are religious adolescents more truthful? *Personality and Individual Differences,* 10, pp 1041 – 1048

Peele, S. (1990), Personality and alcohol addiction: establishing the link, in D.A. Ward (ed), *Alcoholism: Introduction to Theory and Treatment,* pp 147 – 156, Dubuque, IA, Kendal-Hunt

Pita, D.D. (2004), *Addictions Counselling,* New York, Crossroad Publishing Company

Prior, D. (1985), *The Message of 1 Corinthians,* The Bible Speaks Today, Leicester, England, Inter-Varsity Press

Proschaska, J.O. and DiClemente, C.C. (1986), Towards a comprehensive model of change, in W.R. Miller and N. Heather (eds), *Treating Addictive Behaviours: Processes of Change*, pp 3 – 27, New York, Plenum Press

Rambo, L.R. (1990), Conversion, in R.J. Hunter (ed) *Dictionary of Pastoral Care and Counselling,* Nashville, TN, Abingdon Press

Rankin, H., Stockwell, T. and Hodgson, R. (1982), Personality and alcohol dependence, *Personality and Individual Differences,* 3, pp 145 – 151

Richardson, J.T. (1978), *Conversion Careers: In and Out of the New Religions,* Beverly Hills, CA, SAGE

Richardson, J.T. and Stewart, M. (1978), Conversion Process Models and the Jesus Movement, in J.T. Richardson (ed) *Conversion Careers: In and Out of the New Religions,* pp 24 – 42, Beverly Hills, CA, SAGE

Room, R. (2001) Governing images in public discourse about problematic drinking, in N. Heather, T.J. Peters and T. Stockwell (eds) *International Handbook of Alcohol Dependence and Problems*, pp 33 – 45, London, J. Wiley and Sons Ltd.

Rosenthal, T.L., Edwards, N.B., Ackerman, B.J., Knott, D.H. and Rosenthal, R.H. (1990), Substance abuse patterns reveal contrasting personal traits, *Journal of Substance Abuse,* 2, pp 255 – 263

Schumm, J.A., O'Farrell, T.J., Murphy, C.M. and Fals-Stewart, W. (2009), Partner violence before and after couple-based alcoholism treatment for female person with alcohol dependency patients, *Journal of Consulting and Clinical Psychology,* 77, 6, pp 1136 – 1146

Sher, K.J. and Trull, T.J. (1994), Personality and disinhibitory psychopathology: alcoholism and antisocial personality disorder, *Journal of Abnormal Psychology,* 103, 1, pp 92 – 102

Shin, H.S., Edwards, E.M. and Heeren, T. (2009), Child abuse and neglect: relations to adolescent binge drinking in the national longitudinal study of Adolescent Health study, *Addictive Behaviours,* 34, pp 277 – 280

Single, E. and Leino, V.E. (1998), The levels, patterns and consequences of drinking, in M. Grant and J. Litvak (eds) *Drinking Patterns and Their Consequences,* pp 7 – 24, Washington DC, Taylor and Francis

Skinner, B.F. (1938), *The Behaviour of Organisms*, MS, New York, Appleton

Smith, L. (1989), Substance abuse, *Nursing Standard,* 43, 3, pp 24 – 26

Snow, D.A. and Machalek, R. (1983), The convert as a social type, in Collins R. (ed) *Sociological Theory,* pp 259 – 289, San Francisco, CA, Jossey-Bass

Snow, D.A. and Machalek, R. (1984), The sociology of sonversion, *Annual Review of Sociology,* 10, pp 167 – 190

Sobell, M.B. and Sobell, L.C. (1993), *Problem Drinkers: Guided Self Change Treatment*, London, Guilford Press

Stein, L.A.R., Graham, J.R., Ben-Porath, Y.S. and McNulty, J.L. (1999), Using the MMPI-2 to detect substance abuse in an outpatient mental health setting, *Psychological Assessment,* 11, 1, pp 94 - 100

Stott, J. (1994), *The Message of Romans,* The Bible Speaks Today, Leicester, England, Inter-Varsity Press

Stranges, S., Notaro, J., Freudenheim, J.L., Calogero, R.M., Muti, P., Farinaro, E., Russell, M., Nochajski, T.H. and Trevisan, M. (2006), Alcohol drinking pattern and subjective health in a population-based study, *Addiction,* 101, pp 1265 – 1276

Straus, R.A. (1979), Religious conversion as a personal and collective accomplishment, *Sociological Analysis,* 40, 2, pp 158 – 165

Swinson, R.P. and Eaves, D., (1978), *Alcoholism and Addiction,* Plymouth, McDonald and Evans

Tait, L., Birchwood, M. and Trower, P. (2004) Adapting to the challenge of psychosis: personal resilience and the use of sealing-over (avoidant) coping strategies, *The British Journal of Psychiatry,* 185, pp 410 – 415

Taylor, A., Toner, P., Templeton, L. and Velleman, R. (2002), Alcohol problems and the family: challenges and opportunity, *Alcoholics: Newsletter from the Medical Council on Alcohol,* 21, 6

Tellegen, A. and Waller, N.G. (1987), Re-examining basic dimensions of natural language trait descriptors. Paper presented at the 95th Annual Convention of the American Psychological Association, New York, NY

Terza, J.V. (2002), Harmful drinking and employment: a second look, *Journal of Applied Econometrics,* 17, 4, pp 393-404

The Twelve Steps, (1970), *The Twelve Steps and Twelve Traditions,* London, Alcoholics Anonymous Publishing Company

Theakston, J.A., Stewart, S.H., Dawson, M.Y., Knowlden-Loewen, A.B. and Lehman, D.R. (2004), Big-five personality domains predict drinking motives, *Personality and Individual Differences,* 37, pp 971 – 984

Tildesley, E.A. and Andrews, J.A. (2008), The development of children's intentions to use alcohol: direct and indirect effects of parent alcohol use and parenting behaviours, *Psychology of Addictive Behaviours,* 22, 3, pp 326 – 339

Timko, C., Moos, B.S. and Moos, R.H. (2009), Gender differences in 16-year trends in assault and police related problems due to drinking, *Addictive Behaviours,* 34, pp 744 – 750

Tippett, A.R. (1977), Conversion as a dynamic process in Christian mission, *Missiology,* 5, pp 203-221

Trochim, W. M. K. (2006), *Research Methods Knowledge Base,* www.socialresearchmethods.net/kb/index

Tsiaousi, E.T., Hatzitolios, A.I., Trygonis, S.K. and Savopoulis, (2008), Malnutrition in end stage liver disease: recommendations and nutritional support, *Journal of Gastroenterology and Hepatology,* 23, 4, pp 527 – 533

Turton, D.W. and Francis, L.J. (2006), The relationship between parental images and ministerial job satisfaction among Anglican clergymen in England, *Research in the Social Scientific Study of Religion,* 17, pp 105 – 122

Ullman, C. (1982), Cognitive and emotional antecedents of religious conversion, *Journal of Personality and Social Psychology,* 43, pp 183 – 193

Van der Ven, J.A. (1993), *Practical Theology: An Empirical Approach,* Kampen, Kok Pharos.

Vorst, H. Van der, Engels, R.C.M.E., Meeus, W., Deković, M. and Vermulst, A. (2006), Parental attachment, parental control and early development of alcohol use: a longitudinal study, *Psychology of Addictive Behaviours,* 20, 2, pp 107 – 116

Waller, T. and Rumball, D. (2004), *Treating Drinkers and Drug Users in the Community,* Oxford, Blackwell Science Ltd.

Wanner, B., Vitaro, F., Carbonneau, R. and Trembly, R.E. (2009), Cross-lagged links among gambling, substance use and delinquency from mid-adolescence to young adulthood: additive and moderating effects of common risk factors, *Psychology of Addictive Behaviour,* 23, 1, pp 91 – 104

Watkins, L.E., O'Farrell, T.J., Suvak, M.K., Murphy, C.M. and Taft, C.T. (2009), Parenting satisfaction among fathers with alcoholism, *Addictive Behaviours,* 34, pp 610 – 612

Weizmann-Henelius, G., Putkonen, H., Naukkarinen, H. and Eronen, M. (2009), Intoxication and violent women, *Archives of Women's Mental Health,* 12, pp 15 – 25

White, W.L. (2000), Addiction as a disease: birth of a concept, *Counsellor*, 1, 1, pp 46-51, 73

Wilcock, M. (1979), *The Message of Luke,* The Bible speaks today, Leicester, England, Inter-Varsity Press

Wikler, A. (1965), Conditioning factors in opiate addiction and relapse, in D.M. Wilner and G.G. Kassebaum (eds), *Narcotics*, New York, McGraw-Hill

Williams, R. (2008), The pervading influence of alcohol liver disease and hepatology, *Alcohol and Alcoholism,* 43, 4, pp 393 – 397

Wilson, W. (1950), 'Person with alcohol Alcoholics Anonymous' from a panel discussion on 'Chronic alcoholism as a Medical Problem,' *New York State Journal of Medicine,* July 15

Wong, C.F., Kipke, M.D. and Weiss, G. (2008), Risk factors for adult use, frequent use and binge drinking among young men who have sex with men, *Addictive Behaviours,* 33, pp 1012 – 1020

Young, R., Sweeting, H. and West, P. (2008), A longitudinal study of alcohol use and antisocial behaviour in young people, *Alcohol and Alcoholism,* 43, 2, pp 204 – 214

Zelenski, J.M. and Larsen, R.J. (1999), Susceptibility to affect: a comparison of three personality taxonomies, *Journal of Personality,* 65, 5, pp 761 – 791

Ziyadeh, N.J., Prokop, L.A., Fisher, L.B., Rosario, M., Field, A.E., Camargo Jr., C.A. and Austin, S.B. (2007), Sexual orientation, gender, and alcohol use in a cohort study of U.S. adolescent girls and boys, *Drug and Alcohol Dependence,* 87, pp119 – 130

Zuckerman, M., Kuhlman, D.M., Joireman, J., Teta, P. and Kraft, M. (1993), A comparison of three structural models for personality: the Big Three, the Big Five and the Alternative Five, *Journal of Personality and Social Psychology,* 65, 4, pp 757 – 768

Pastoral Care and People Addicted to Alcohol

The research is being carried out on behalf of the Stauros Foundation. It is addressed to people who believe they have, or have had, an alcohol problem and who are associated with Stauros. Each contribution is important in helping Stauros establish a clearer picture of the pastoral needs of the people who request help and support. The information provided is confidential and will be used to help develop the pastoral provision of the agency for future associates.

Please respond to each question as honestly as possible. There are no right or wrong answers to these questions, but we are interested in you and your views. Please do not discuss what a question might mean with the person administering the questionnaire, and do not pause for too long over any one question. You do not have to write your name on the booklet or in any other way identify yourself.

Stauros Foundation

Please help by completing the questionnaire and returning it to:

Mr. M. Williams

142 Finvoy Road

Ballymoney

Co. Antrim

BT53 7JL

Northern Ireland

Date: / /

What is your sex?

Male	1	
Female	2	

How old are you?

Under 20	1	
20-29	2	
20-39	3	
40-49	4	
50-59	5	
60-69	6	
70 and over	7	

In your family are you ...

An only child	1	
The oldest child	2	
The youngest child	3	
A middle child	4	

Were you adopted or fostered as a child?

No	1	
Yes	2	

Were your parents separated or divorced?

No	1	
Yes	2	

In your personal life have you had to deal
with any of the following difficulties?
(Tick all that apply)

An emotional trauma	1	
A prison sentence	1	
Life threatening illness	1	
Mental health problem	1	
Death of a relative	1	
Death of a close friend	1	
Single	1	

398

What is your marital status?

Married	2	
Cohabiting	3	
Widowed	4	
Separated	5	
Divorced	6	
Remarried	7	

Have you any children?

No	1	
Yes	2	

How would describe your employment status?

In full time paid work	1	
In part time paid work	2	
A housewife / house husband / carer	3	
Unwaged able to work	4	
Unwaged unable to work	5	
Student	6	
Retired	7	

In your present or most recent employment how would you regard yourself?

Unskilled manual	1	
Semiskilled manual	2	
Skilled manual	3	
Non-manual	4	
Semi-skilled	5	
Professional	6	

How would you describe your social background?

Upper class	1	
Upper middle class	2	
Middle class	3	
Lower middle class	4	
Working class	5	

Did you attend a place of worship at least six times per year at any of these ages (apart from weddings, baptisms and funerals)?
Tick as many age groups as apply

5 to 7 years old	1	
8 to 10 years old	1	
11 to 13 years old	1	
14 to 16 years old	1	
17 to 19 years old	1	

How often do you attend a place of worship now (apart from weddings, baptisms or funerals)?

Never	1	
At least once per year	2	
At least six times per year	3	
At least once per month	4	
Nearly every week	5	

How often do you pray now?

Never	1	
At least once per year	2	
At least once per month	3	
At least once per week	4	
Nearly every day	5	

How often do you read the Bible now?

Never	1	
At least once per year	2	
At least once per month	3	
At least once per week	4	
Nearly every day	5	

Have you ever had something you would describe as a religious experience?

No	1	
Possibly but I'm not sure	2	
Probably but I'm not sure	3	
Yes, definitely	4	

Which Christian or religious denomination do you belong to?

None	1	
Roman Catholic	2	
Protestant	3	
Other (please specify)	4	

Respond to each question by putting a circle around the 'Yes' or 'No'. Work quickly and do not think too long about the meaning of the questions.

Does your mood often go up and down? .... Yes No

Are you a talkative person? .... Yes No

Would being in debt worry you? .... Yes No

Are you rather lively? .... Yes No

Were you ever greedy by helping yourself to more than
your share of something? .... Yes No

Would you take illegal drugs which may have a strange
or dangerous effect on you? .... Yes No

Have you ever blamed someone for something you knew
was really your fault? .... Yes No

Do you enjoy co-operating with others?

Do you often feel 'fed up'? .... Yes No

Have you ever taken anything (even a pin or a button)
that belonged to someone else? .... Yes No

Would you call yourself a nervous person? .... Yes No

Do you think marriage is old fashioned and should be done away with? .... Yes No

Can you easily get some life into a dull party? .... Yes No

Are you a worrier? .... Yes No

Do you tend to keep in the background on social occasions? .... Yes No

Do you try not to be rude to people? .... Yes No

Have you ever cheated at a game? .... Yes No

Do you suffer from nerves? .... Yes No

Have you ever taken advantage of someone? .... Yes No

Are you mostly quiet when you are with other people? .... Yes No

Do you often feel lonely? .... Yes No

Would you like other people to be afraid of you? .... Yes No

Do other people think of you as being very lively? .... Yes No

Do you always practice what you preach? .... Yes No

The following list contains pairs of characteristics. For each pair tick (√) one box next to the characteristic which is closer to the real you, even if you feel both characteristics apply to you. Tick the characteristic that reflects the real you, even if other people see you differently. Please complete all the questions.

Do you tend to be more...

Active ☐ or ☐ Reflective

Do you tend to be more...

Interested in facts ☐ or ☐ interested in theories

Dop you tend to be more...

Concerned for harmony ☐ or ☐ Concerned for justice

Do you tend to be more...

Happy with routine ☐ or ☐ Unhappy with routine

Are you more...

Private ☐ or ☐ Sociable

Are you more...

Inspirational ☐ or ☐ Practical

Are you more...

Analytical ☐ or ☐ Sympathetic

Are you more...

Structure ☐ or ☐ Open-ended

Do you prefer...

Having many friends ☐ or ☐ A few deep friends

Do you prefer...

The concrete ☐ or ☐ The abstract

Do you prefer...

Feeling ☐ or ☐ Thinking

Do you prefer...

To act on impulse ☐ or ☐ To act on decisions

Do you...

Dislike parties ☐ or ☐ Like parties

Do you...

Prefer to design ☐ or ☐ Prefer to make

Do you...

Tend to be firm ☐ or ☐ Tend to gentle

Do you...

Like to be in control ☐ or ☐ Like to be adaptable

Are you...

Energised by others ☐ or ☐ Drained by too many people

Are you...

Conventional ☐ or ☐ Inventive

Are you...

Critical ☐ or ☐ Affirming

Are you...

Happier working alone ☐ or ☐ Happier working in a group

Do you tend to be more...

Socially detached ☐ or ☐ Socially involved

Do you tend to be more...

Concerned for meaning ☐ or ☐ Concerned about detail

Do you tend to be more...

Logical ☐ or ☐ Humane

Do you tend to be more...

Orderly ☐ or ☐ Easygoing

Are you more...

Talkative ☐ or ☐ Reserved

Are you more...

Sensible ☐ or ☐ Imaginative

Are you more...

Tactful ☐ or ☐ Truthful

Are you more...

Spontaneous ☐ or ☐ Organised

Are you mostly...

An introvert ☐ or ☐ An extravert

Are you mostly focused on...

Present realities ☐ or ☐ Future possibilities

Are you mostly...

Trusting ☐ or ☐ Sceptical

Are you mostly...

Leisurely ☐ or ☐ Punctual

Do you...

Speak before thinking ☐ or ☐ Think before speaking

Do you prefer to...

Improve things ☐ or ☐ Keep things as they are

Do you...

Seek for truth ☐ or ☐ Seek for peace

Do you...

Dislike detailed planning ☐ or ☐ Like detailed planning

Are you...

Happier with uncertain ☐ or ☐ Happier with certainty

Are you...

Up in the air ☐ or ☐ Down to earth

Are you...

Warm hearted ☐ or ☐ Fair minded

Are you...

Systematic ☐ or ☐ Casual

Did alcohol have a positive influence on your home and family during any of these ages? *Tick more than one box if necessary.*

5 to 7 years old	1	
8 to 10 years old	1	
11 to 13 years old	1	
14 to 16 years old	1	
17 years old or over	1	

Did alcohol have a negative influence on your home and family during any of these ages? *Tick more than one box if necessary.*

5 to 7 years old	1	
8 to 10 years old	1	
11 to 13 years old	1	
14 to 16 years old	1	
17 years old or over	1	

Was alcohol abuse a feature of the lives of members of your family?
Tick more than one box if necessary

Grandfather (s)	1	
Grandmother (s)	1	
Father / step father	1	
Mother / step mother	1	
Brother (s)	1	
Sister (s)	1	
Significant other	1	

How long have you been associated with the Stauros Foundation?

Recently a new contact	1	
Less than one year	2	
1 to 2 years	3	
2 to 4 years	4	
4 to 6 years	5	
6 to 8 years	6	
8 to 10 years	7	
10 to 15 years	8	
15 to 20 years	9	

Please circle ONE number on each line
3 means very much
2 means quite a lot
1 means a little
0 means not at all
If your mother was *very much a* lenient person answer like this
Lenient   3   2   1   0   1   2   3 Strict

How would you describe your mother / maternal carer?

Alcohol abuser	3	2	1	0	1	2	3 Non-drinker
Lenient	3	2	1	0	1	2	3 Strict
Distant	3	2	1	0	1	2	3 Close
Involved	3	2	1	0	1	2	3 Uninvolved
Uncaring	3	2	1	0	1	2	3 Caring
Sensitive	3	2	1	0	1	2	3 Insensitive
Unsupportive	3	2	1	0	1	2	3 Supportive
Always there	3	2	1	0	1	2	3 Never there
Judgement	3	2	1	0	1	2	3 Non-judgemental
Unselfish	3	2	1	0	1	2	3 Selfish
Hating	3	2	1	0	1	2	3 Loving
Non-critical	3	2	1	0	1	2	3 Critical
Rejecting	3	2	1	0	1	2	3 Accepting
Giving	3	2	1	0	1	2	3 Ungiving
Damning	3	2	1	0	1	2	3 Saving
Not demanding	3	2	1	0	1	2	3 Demanding
Restricting	3	2	1	0	1	2	3 Freeing
Approving	3	2	1	0	1	2	3 Disapproving
Unforgiving	3	2	1	0	1	2	3 Forgiving

How would you describe your father / paternal carer?

Alcohol abuser	3	2	1	0	1	2	3 Non-drinker
Lenient	3	2	1	0	1	2	3 Strict
Distant	3	2	1	0	1	2	3 Close
Involved	3	2	1	0	1	2	3 Uninvolved
Uncaring	3	2	1	0	1	2	3 Caring
Sensitive	3	2	1	0	1	2	3 Insensitive
Unsupportive	3	2	1	0	1	2	3 Supportive
Always there	3	2	1	0	1	2	3 Never there
Judgement	3	2	1	0	1	2	3 Non-judgemental
Unselfish	3	2	1	0	1	2	3 Selfish
Hating	3	2	1	0	1	2	3 Loving
Non-critical	3	2	1	0	1	2	3 Critical
Rejecting	3	2	1	0	1	2	3 Accepting
Giving	3	2	1	0	1	2	3 Ungiving
Damning	3	2	1	0	1	2	3 Saving
Not demanding	3	2	1	0	1	2	3 Demanding
Restricting	3	2	1	0	1	2	3 Freeing
Approving	3	2	1	0	1	2	3 Disapproving
Unforgiving	3	2	1	0	1	2	3 Forgiving

At what age did you have your first
alcoholic drink?

Before the age of 12 years	1	
12 to 14 years old	2	
15 to 17 years old	3	
Over 17 years	4	

When you first started drinking, how often did
you drink?

Special occasions	1	
Once or twice per month	2	
Once or twice per week	3	
Every day	4	

How often were you drinking when you thought
you might have a problem?

Special occasions	1	
Once or twice per month	2	
Once or twice per week	3	
Every day	4	

How long was it before you thought you might
have a problem with alcohol?

The first time I drank	1	
After some weeks	2	
After some months	3	
After some years	4	

Who first suggested you might have a problem
with alcohol?

A relative	1	
A friend	2	
A drinking companion	3	
Your own realisation	4	
Other (please specify)	5	

How long is it since you had your last drink?

More than one week	1	
More than one month	2	
More than six months	3	
More than one year	4	
More than three years	5	

Why did you drink alcohol?

All my friends drank socially.. AS A NC D DS

I felt pressurised into drinking.. AS A NC D DS

Drinking was expected of me.. AS A NC D DS

Drinking made me feel good... AS A NC D DS

I was curious as to what drinking was like.................................... AS A NC D DS

Drinking helped me overcome shyness... AS A NC D DS

I drank because I had difficulty sleeping....................................... AS A NC D DS

I drank to cope with stress.. AS A NC D DS

I drank to forget the past.. AS A NC D DS

Drinking helped me feel better about myself................................. AS A NC D DS

Drinking helped me relate to others socially................................. AS A NC D DS

I drank because i felt rejected.. AS A NC D DS

I drank to cope with the memories of what people did to me........ AS A NC D DS

I drank to cope with the memories of what happened to me.......... AS A NC D DS

I drank because my mind was troubled.. AS A NC D DS

I drank because my feelings were troubled................................... AS A NC D DS

I drank to cope with me insecurities.. AS A NC D DS

I drank because my life was meaningless...................................... AS A NC D DS

How would you describe elements of your drinking problem?

I craved alcohol... AS A NC D DS

I drank to avoid withdrawal symptoms... AS A NC D DS

I preferred to drink alone.. AS A NC D DS

I had to conceal how much I drank... AS A NC D DS

I felt remorse after drinking... AS A NC D DS

I was a binge drinker.. AS A NC D DS

My drinking was out of control... AS A NC D DS

> PART FOUR asks for information about the effects alcohol has had upon you and your family. Respond to each statement by putting a circle around the 'Yes' or 'No'

How has your drinking affected your physical, emotional and mental well being?

I have lost hours, even days, due to alcohol amnesia................................. Yes   No

I have had to attend my GP for problems caused directly or

 indirectly by alcohol abuse .... Yes   No

I have been prescribed medication for conditions directly or indirectly related

to alcohol abuse .... Yes   No

I have been hospitalised as a direct or indirect result of alcohol abuse ...... Yes   No

I have attended a medical facility for detoxification .... Yes   No

I have had the shakes and sweats withdrawing from alcohol .... Yes   No

I have had nightmares and horrors caused by alcohol abuse .... Yes   No

My sleep pattern is disrupted due to alcohol abuse .... Yes   No

I have hallucinated – seen objects change, seen and heard things that are not

real – because of alcohol abuse .... Yes   No

I have had 'grand mal' type fits or seizures withdrawing from alcohol ...... Yes   No

I have experienced irrational fear as a result of alcohol abuse.................... Yes   No

I used to feel good about myself, but alcohol abuse has robbed me of that ...Yes   No

I have experienced extreme mood swings withdrawing from alcohol .... Yes   No

I have become irritable withdrawing from alcohol .... Yes   No

I have had the delirium tremens (being in another world, feeling disorientated

and lost) withdrawing from alcohol .... Yes   No

How has your drinking affected your work?

People at work have joked about my drinking .... Yes   No

I have had to take time off work because of my drinking .... Yes   No

My drinking has robbed me of ambition at work .... Yes   No

My drinking has deprived me of concentration at work .... Yes   No

My drinking has got me into trouble at work .... Yes   No

How has your drinking affected your home and family life?

My drinking has made my family life unhappy .... Yes   No

My drinking has spoilt my relationship with my children .... Yes   No

My drinking has made my family believe I no longer cared about them ....   Yes   No

My drinking has had a negative effect on my relationship with my partner...Yes   No

My drinking has contributed to the breakup of a former

marriage/partnership .... Yes   No

My drinking has caused me to feel guilty about my behaviour towards

my family .... Yes   No

My drinking caused my family embarrassment .... Yes   No

My drinking caused my family financial difficulties .... Yes   No

How has your drinking affected your social behaviour?

I have been arrested for an alcohol related offence .... Yes   No

I have been convicted of a crime directly or indirectly related to

alcohol abuse .... Yes   No

I have served a prison sentence for alcohol related offences .... Yes   No

I have been ashamed of my drunken behaviour in public .... Yes   No

How would you describe alcohol addiction?

A disease	1	
A learned behaviour	2	
A sin	3	
Other (please specify)	4	

┌───┐
│ PART FIVE asks for information about belief in God and pastoral support │
└───┘

Please circle ONE number on each line

3 means very much
2 means quite a lot
1 means a little
0 means not at all

If you believe **very much** that God exists answer like this
God exists   3   2   1   0   1   2   3 God does not exist

How would you assess your belief in God?

God exists	3	2	1	0	1	2	3	God does not exist
God can help me	3	2	1	0	1	2	3	God cannot help me
God can guide me	3	2	1	0	1	2	3	Guide cannot guide me
God loves me	3	2	1	0	1	2	3	God doesn't love me
God is angry with me	3	2	1	0	1	2	3	God is not angry with me
God understands me	3	2	1	0	1	2	3	God does not understand me
God can give me hope	3	2	1	0	1	2	3	God cannot give me hope
God can be trusted	3	2	1	0	1	2	3	God cannot be trusted
God is relevant to life	3	2	1	0	1	2	3	God is not relevant to life
God can forgive	3	2	1	0	1	2	3	God cannot forgive
God can heal								God cannot heal
emotional hurt	3	2	1	0	1	2	3	emotional hurt

How would you describe God?

Damning	3	2	1	0	1	2	3	Saving
Rejecting	3	2	1	0	1	2	3	Accepting
Demanding	3	2	1	0	1	2	3	Not demanding
Loving	3	2	1	0	1	2	3	Hating
Freeing	3	2	1	0	1	2	3	Restricting
Unforgiving	3	2	1	0	1	2	3	Forgiving
Approving	3	2	1	0	1	2	3	Disapproving
Strict	3	2	1	0	1	2	3	Lenient

In what areas do you feel you need pastoral support?

> **Please read each sentence carefully and think 'Do I agree with it?'**
>
> I you Agree Strongly put a ring around .... AS A NC D DS
> If you Agree put a ring around .... AS A NC D DS
> If you are Not Certain a ring around .... AS A NC D DS
> If you Disagree put a ring around .... AS A NC D DS
> If you Disagree Strongly put a ring around .... AS A NC D DS

I need pastoral support in ...

Helping me solve my alcohol addiction problem........................... AS A NC D DS

Talking to someone about my addiction.. AS A NC D DS

Losing the desire for alcohol.. AS A NC D DS

Getting help to go through withdrawal... AS A NC D DS

Getting sober... AS A NC D DS

Staying sober... AS A NC D DS

Helping me discover who I really am.. AS A NC D DS

Helping me accept what and who I am.. AS A NC D DS

Getting me a job... AS A NC D DS

Restoring my relationships.. AS A NC D DS

How I can live the Christian life.. AS A NC D DS

Being prayed for... AS A NC D DS

Being prayed with... AS A NC D DS

Experiencing God in a meaningful way.. AS A NC D DS

Developing character that pleases God.. AS A NC D DS

Bringing my life into line with God's purposes............................ AS A NC D DS

Accepting what I have done... AS A NC D DS

I also need pastoral support with...

Addiction to illegal substances other than alcohol........................ AS A NC D DS

Gambling... AS A NC D DS

Compulsive behaviour related to pornography.............................. AS A NC D DS

Masturbation... AS A NC D DS

Questions of sexual orientation... AS A NC D DS

Eating disorder.. AS A NC D DS

Self harm... AS A NC D DS

Suicidal tendencies.. AS A NC D DS

Psychological disorders... AS A NC D DS

Mental illness.. AS A NC D DS

Physical abuse as a child... AS A NC D DS

Physical abuse as an adult... AS A NC D DS

Emotional abuse as a child.. AS A NC D DS

Emotional abuse as an adult.. AS A NC D DS

Perpetrator of violence.. AS A NC D DS

Victim of violence... AS A NC D DS

Perpetrator of sexual misconduct.. AS A NC D DS

Victim of sexual misconduct... AS A NC D DS

Fears and phobias.. AS A NC D DS

Medically prescribed drugs... AS A NC D DS

Have you any helpful comments to make about this questionnaire?

Thank you for your cooperation and help in completing this questionnaire.