Heavy alcohol consumption exerts a deleterious effect on the family (Jacob & Leonard, 1988). The extent of the negative impact produced by the alcoholic varies among family members and from family to family. These effects on the family often result in serious emotional and medical problems. Families that include at least one alcoholic consume health care services at a rate two to three times higher than families of comparable size, ages, and gender mix (Becker & Sanders, 1984; Plotnick, 1982). Even though the person suffering from alcoholism accounts for the majority of this difference in health care use, family members not addicted to alcohol are also above-average health care consumers (Holder, Blose, & Basiorowski, 1985; Holder & Hallan, 1986).

This paper examines the family therapy literature in the field of alcoholism. Additionally, literature is reviewed to explore the role of occupational therapy in treating alcoholism and in treating the family. Systems theory is presented as a means to promote understanding of the dynamics inherent in families troubled by alcoholism. An occupational therapy treatment approach is proposed that emphasizes functional performance of family members as individuals and as a family unit.

**Literature Review**

Family treatment in the field of alcoholism is a relatively new phenomenon (O'Farrell, 1986). In the late 1960s, only a few researchers and treatment professionals described alcoholism as a problem that extended beyond the individual (Haley, 1971). By the early 1970s, the alcoholic individual was viewed as a part of a family network that powerfully impacts the progression of the disease of alcoholism (O'Farrell, 1986). Family members' responses to the alcoholic's behaviors were believed to reinforce the individual's alienation and dependency resulting from alcoholism (Whitfield, 1984).

Currently, the term *co-alcoholic* signifies the nonalcoholic family members or significant others (e.g., employers, co-workers, friends) whose health and behavior influence the person suffering from alcoholism and who are also negatively affected by the same individual (Black, Bucky, & Wilder-Padilla, 1986). Children or adult co-alcoholics may display such psychiatric symptoms as anxiety, depression, insomnia, hyperactivity, aggression, anorexia nervosa, bulimia, and suicidal gestures (Whitfield, 1984). Family violence, child neglect, or chemical dependency in other family members may also result (Cermak, Hunt, Keene, & Thomas, 1989).

The occupational therapy literature on treatment of alcoholism is growing after a long hiatus in which the subject was ignored. In fact, articles on alcoholism first appeared before 1960 (Doniger, 1953; Hossack, 1952; Welsh, 1959), and the subject was not addressed again until the 1980s. More recent articles examine the contem...
porary role of occupational therapy in the treatment of alcoholism (Cassidy, 1988; Klein, 1988; Lindsay, 1983). Moyers (1988) proposed a method of occupational therapy frame of reference selection that recognizes the coping issues reflective of persons suffering from alcoholism. Five research articles on alcoholism were found that examined treatment effectiveness of a craft group (Stensrud & Lushbough, 1988) and an adolescent program (Gangle, 1987), development of leisure skill profiles (Mann & Talty, 1990), conduction of an ethnographic examination of a native American population (Lange, 1988), and analysis of performance on the Assessment of Occupational Functioning (Vik, Watts, Madigan, & Bauer, 1990).

Two articles that are described in the present paper delineate an occupational therapy intervention approach for treatment of the family affected by alcoholism (Moyers, 1991; Moyers & Barrett, 1990). Generally, however, the occupational therapy literature is just beginning to address the influence of the family on an individual’s occupational performance. For example, issues of the family are appearing in the occupational therapy literature in terms of parent-child relationships of handicapped children (Hinojosa, 1990; Hinojosa, Anderson, & Ranum, 1988; Olson, Hearney, & Soppas-Hoffman, 1989; Petersen & Wikoff, 1987) and in terms of caregiving provided for the elderly (Hasselkus, 1989, 1991).

Given the emerging emphasis on family treatment in the promotion of recovery from alcoholism and from occupational dysfunction, several questions can be posed. How can the occupational therapist become involved with alcoholism family treatment in a way that is distinct from what other professionals do? How can occupational therapists make their role in the treatment of family members affected by alcoholism more visible, better understood, or reimbursable by third-party payers?

**Systems Theory**

Treatment, if it is restricted to the person suffering from alcoholism and does not include the family, is greatly reduced in its ability to produce lasting change. In separating treatment of the alcoholic from treatment of the family, we fail to consider the power of family interactions, thus rendering this approach a partial treatment at best. Development of treatment approaches that recognize the family as a system is important (Minuchin, 1970).

When alcoholism is inserted into the family system, a shift in equilibrium is created. The entire family tends to respond by creating strategies to deal with the painful stress. These strategies are designed to maintain the previous level of family equilibrium (Wegscheider & Wegscheider, 1975). Family roles become blurred or distorted, and rigid rules dictating the interaction between family members are developed.

Wegscheider (1981) described the major rules often associated with alcoholic family systems. The family functioning is guided by the belief that the individual’s use of alcohol is the most important aspect of family life. However, alcohol is not considered the cause of the family’s problems. Someone or something else is believed to perpetuate the alcoholism. The person suffering from alcoholism is therefore not held responsible. The status quo must be maintained, thus family members diligently cover up for the individual’s alcohol-related indiscretions. No one may discuss what is really happening nor share true feelings.

Wegscheider (1981) also delineated six roles typical of a family affected by alcoholism: (a) the alcoholic, (b) the chief enabler, (c) the family hero, (d) the scapegoat, (e) the lost child, and (f) the mascot. Each family role hides feelings and contributes a valuable function to the family (Wegscheider, 1981). For example, the chief enabler, often the spouse, is super-responsible and increasingly assumes the duties vacated by the alcoholic. The family hero, through efforts of achievement, brings a sense of pride to the family while simultaneously covering up the family’s fear of failure. The scapegoat’s angry, defiant behavior removes the family’s focus from alcoholism so that denial of parental alcoholism may continue. The scapegoat expresses for the entire family the anger and rage engendered by the alcoholic.

Withdrawal and isolation of the lost child brings relief to the family. The family believes that the lost child is not in need of energy from the rest of the system, thus available energy is conserved for “more important concerns.” The lost child demonstrates the family’s sense of powerlessness and helplessness. The mascot, like the lost child, also gives relief to the family, but this relief is in the form of tension release. The clowning and joking behavior masks underlying emotions of terror and hysteria.

Actually, these roles are not discrete categories. Family members assume a blend of these roles. The role combinations of a family member fluctuate as a result of changes in the system (Wegscheider, 1981). For example, if the scapegoat’s problematic behavior is resolved, possibly as the result of therapeutic intervention, another family member may be forced to take over this now vacant role. Additionally, if the alcoholic attempts abstinence, there may be strong pressure from the rest of the family system for the individual to resume drinking. Family members’ coping styles are rigid and resist change. To maintain the system’s balance or previous level of homeostasis, the family as a whole may actually sabotage individual attempts to discard dysfunctional roles. Jacob and Leonard (1988) stated that drinking has adaptive consequences for the family that can reinforce and perpetuate patterns of abusive drinking.

**Occupational Therapy Family Treatment**

Before family therapy is initiated, the number of family members and the number of families that the occupation-
al therapy program can realistically accommodate are determined. Decisions depend on the size of the families, the age ranges, and the type of services offered by the family-treatment program. The occupational therapist must determine whether the family treatment will incorporate the entire family as a unit, will address issues of specific individuals, or will focus on subcomponents of the family system, for example, the spousal relationship or sibling interaction. Decisions also have to be made regarding whether the family will be treated separately or jointly with the alcoholic. A combination of strategies is often useful.

During those times when the family is treated separately from the alcoholic, it is best that different occupational therapists, when possible, be assigned to the family and to the individual. This preserves allegiance to the primary client for each occupational therapist. Both therapists may then work together during the joint sessions.

Occupational therapists must also recognize their limitations in treating the family affected by alcoholism. Entry-level education of occupational therapists does not currently include training in family therapy. Occupational therapists may not have the skills required by family-treatment programs and are cautioned to obtain these skills before implementing the program.

Family members cannot relinquish their maladaptive roles unless more adaptive behaviors are learned. In fact, the individual’s long-term sobriety may be partially dependent on the family’s replacement of maladaptive roles with more open, nondefensive, and authentic ways of interacting within the system. For the occupational therapist to facilitate progressive changes in the family’s role behaviors, three treatment levels are proposed as a critical factor in guiding treatment (Moyers, 1991; Moyers & Barrett, 1990). Treatment targeted for each level produces general outcomes (Moyers, 1991; Moyers & Barrett, 1990). Upon completion of Treatment Level 1, the family relinquishes maladaptive role behaviors. The family develops improved coping mechanisms at Treatment Level 2, thereby weakening the family’s reliance on maladaptive roles. Emotional development or growth occurs at Treatment Level 3 as the family obtains insight that confronts any remaining use of maladaptive role behaviors (see Table 1).

**Treatment Level 1**

The occupational therapy treatment goals for the family at Treatment Level 1 involve reducing stress, augmenting ability to provide external control for the alcoholic, and changing negative attitudes held toward that individual. Each of these treatment strategies is described below (see also Table 1).

The first emphasis of family-oriented occupational therapy is stress reduction, thus allowing the family to participate actively in treatment. The family is taught in occupational therapy to covertly reframe problems in a way that denotes expectation for problem resolution. For example, family members may believe that their situation is hopeless, thus they make no attempt to solve problems. Through treatment, the family learns, as a result of successfully reducing the stress in their lives, that positive changes can occur in response to their own efforts.

Family members reduce anxiety by implementing relaxation techniques learned in occupational therapy. A household daily routine is planned in occupational therapy as a method to control the chaos often characteristic of families affected by alcoholism. Other stress reduction activities experienced in occupational therapy include instituting a balanced diet, engaging in exercise, and selecting meaningful leisure activities.

To obtain sobriety, the alcoholic must accept external control from others, especially from the family, during the initial phase of treatment (Wallace, 1985). Loss of control over drinking indicates that the person is unable to achieve abstinence without assistance. Providing external control does not indicate that the family needs to control the alcoholic’s behavior. Attempts to control the person’s alcoholic behaviors (e.g., by hiding the car keys so that the person does not drive when drunk) are typical of enabling, which is defined as the inadvertent support of drinking behaviors through the removal of responsibility (Whitfield, 1984).

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Occupational Therapy Interventions and Outcomes According to Treatment Level</th>
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<tr>
<td><strong>Level</strong></td>
<td><strong>Family Role Changes</strong></td>
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<tr>
<td>1</td>
<td>Relinquish maladaptive role behaviors</td>
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<td>Gain emotional development or growth</td>
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helping themselves. Therefore, family members at Treatment Level 1 learn in occupational therapy to stop enabling the drunken behavior and to let the person suffer the effects of drinking (e.g., getting fired or sleeping wherever becoming stuporous). Examples of maladaptive family actions that are targeted for intervention by the occupational therapist include emptying liquor bottles, putting the person to bed when drunk, bailing the drunken family member out of jail, or calling work to make excuses when the family member is hung over.

Apart from the treatment program for the alcoholic, an occupational therapy program is conducted to help the family replace enabling behaviors with healthy methods of responding to the person’s drinking. These sessions focus on identification, practice, and implementation of skills necessary for family provision of external control. The family learns to communicate expectations for responsible behavior.

The therapist initiates external control skill training by supplying family members with information regarding maladaptive roles (e.g., mascot, enabler, lost child). The family then identifies in occupational therapy, through group processing and projective techniques (e.g., drawing, working with clay, writing poetry) the maladaptive roles that each has assumed. For example, a child asked to draw the family engaging in an activity may inadvertently sketch the self away from the others, using light lines that denote the invisible characteristics of the lost child. In discussing the drawing with the occupational therapist and the other family members, the child is helped to express feelings of isolation, fear, and loneliness. The rest of the family becomes acutely aware of the need to help this child develop skills that enhance interaction with others.

During the process of occupational therapy, the therapist determines skills that each family member requires in order to relinquish the maladaptive roles. For example, a family member may state the desire to learn how to avoid arguments with the actively drinking person, a skill needed by the chief enabler and the scapegoat. The therapist and family delineate the components of the argument-avoidance skill (e.g., firmly stating that the problem will be discussed at a time when the person is sober and then walking away from the drunken person). The therapist models each skill component. Through role-play, family members practice the skill components and receive feedback from each other and from other families. Barriers to skill use are identified and problem solving is implemented to remove barriers when possible.

At Treatment Level 1, the family also expresses the years of anger generated by the alcoholic’s disregard for the family’s pain. Unless these hostile feelings are explored, the family has difficulty abandoning old, maladaptive roles that perpetuated drinking. Family game playing, for example, “Kick Me” and “Uproar” (Steiner, 1971), is often facilitated when unresolved anger is expressed passively-aggressively or aggressively to the alcoholic.

In the game of “Kick Me,” the family verbally kicks the alcoholic during an argument. The alcoholic uses self-pity as a justification for continued drinking. The game of “Uproar” refers to the family arguments prompted by the alcoholic, who goads the family into becoming upset and wanting to fight. The resulting angry trip to the bar can thus be blamed on the “unreasonable” family members.

To avoid future game playing, the occupational therapist uses projective techniques that stimulate identification of anger and release of this emotion within the safe company of other family members or other families who also experience similar feelings. The family is then taught, through role-playing and practice during family activities, to assertively express these feelings to the alcoholic in a manner that avoids blaming, is congruent with the situation, and is timed to correspond with the person’s periods of sobriety (Satir, Stachowiak, & Taschman, 1983).

### Treatment Level 2

Separate groups or conjoint sessions with the alcoholic and his or her family may be indicated during Treatment Level 2. The family goals for this level emphasize problem solving and the implementation of effective coping strategies. Problem solving is differentiated from that of Treatment Level 1 in that typical family issues are dealt with during Treatment Level 2. Problem solving is not restricted to the crises revolving around alcoholism, which was characteristic of the first treatment level. Both the family and the alcoholic are learning to invoke a variety of healthy coping techniques in response to routine problems (see Table 1).

The family and the alcoholic benefit from occupational therapy sessions focusing on assertiveness, stress management, cognitive-behavioral strategies, physical activity, or biofeedback. Planning for family weekend outings, designed as a means of spending time together and as a method of stress reduction, is an example of a joint occupational therapy session. The family is relearning in occupational therapy how to play and have fun together now that family members can risk being genuine in each other’s company. In terms of separate groups, the alcoholic’s wife, for example, may want to develop assertive skills in order to respond to her husband’s dominating tendencies that are no longer subdued by drinking.

At the completion of Treatment Level 2, the family and the alcoholic independently use their newly learned coping skills. To ensure that transfer of coping skills from the treatment environment to the home results, the occupational therapist gives the alcoholic individual and the family increasing responsibility in selecting, planning, and implementing their treatment goals.

The family unit may decide, for example, that parent-
ing issues require emphasis in treatment. Parental training provided in occupational therapy assists the spouses in developing a united front. As a result, the parents help the children relinquish premature responsibilities assumed in response to the parents’ past preoccupation with drinking (Fox, 1972). Setting rules regarding curfews, limiting chores to more reasonable routines typical of the children’s ages, and carefully responding to the children’s resentment over lost control are examples of parental supervision skills learned in occupational therapy. Additionally, the treatment for the children involves the promotion roles more consistent with their ages (e.g., playing, studying, dating).

Also contributing to the independence of the family is the practicing of new family skills outside of occupational therapy groups according to specific homework assignments. For example, the daughter, who previously functioned as the family scapegoat, may contract with the occupational therapist to ask her father, who is recovering from alcoholism, to go to the movies with her as a means of improving the father-daughter relationship. In this way, family members gain experience in using problem-solving and coping skills in a variety of real-life circumstances. In addition, the individual suffering from alcoholism and the family are required to develop discharge plans in occupational therapy that structure coping alternatives (e.g., family meetings, family outings, leisure activities, shared family meals) into a daily schedule to be followed at home.

**Treatment Level 3**

The goals of Treatment Level 3, accomplished in either joint or separate family sessions, involve promotion of insight and emotional development (see Table 1). These two goals are important in combating the restricted personality development that resulted from long-term interaction in a dysfunctional family system (Sedgwick, 1981).

In fact, the family learns that the individual’s cessation of drinking could produce serious emotional upheaval (McCabe, 1978). Changes in life-style and family roles, even when they are an improvement over previous circumstances, are experienced as losses by the family (Swift & Williams, 1975). The emotional development of each family member causes a reorganization of the family system. When the family learns to focus on other important issues and problems, the alcoholic is removed from the center of attention. As a result, there is no longer someone upon whom to blame problems. Although destructive, the old methods of responding to the drunken behavior were familiar and provided emotional security for the family.

The primary focus of the occupational therapy sessions is confrontation of the family’s continued reliance on maladaptive roles. Occupational therapy sessions incorporate projective techniques and group processing methods that explore the family’s need to maintain the alcoholic’s addiction. For example, during a collage activity designed to examine the wife’s payoff in promoting her husband’s drunken behavior, the wife discovers her persistent need to be in charge.

Insight alone rarely results in changes in behavior (Mosey, 1986). Self-discoveries of family members are directed by the occupational therapist into problem solving and implementation of coping strategies learned previously. To illustrate this, the wife from the previous example might use problem solving to resolve her control issues, such as assuming leadership in a group outside of the family and developing a plan with her husband to share family leadership. Thus, identified maladaptive role behaviors are changed into more satisfying styles of interacting (e.g., the wife’s no longer having to struggle with her husband for family power).

The occupational therapist then designs contexts in which maladaptive role behaviors were in the past typically elicited, for example, the wife’s control issues surfacing when discussing family finances with her husband. The family experiences success in coping by instituting healthy role behaviors during situations that in the past produced maladaptive role behaviors, (e.g., the wife shares decision making with her husband when paying the bills). Mosey (1986) refers to this process as “working through” (pp. 397–398). As a result, learning accumulated from the other two treatment levels is generalized to a variety of situations.

In addition to insight development and the working-through process, goals for a future free of enabling behaviors are delineated in occupational therapy by each family member according to his or her respective interests and values. Occupational therapy facilitates family exploration of supporting values for healthy role development through values clarification, interests through interest surveys or the experiencing of potential interests, and skills through practice in carefully selected environments. For example, the eldest child (the family hero) may decide to refocus the past unrelenting pursuit of achievement by reorganizing time to include more leisure activities and fewer work-related activities. In doing so, this child needs to resolve the values conflict between engaging in leisure and viewing relaxation as wasting time. Interesting leisure activities that accommodate abilities while simultaneously avoiding the reinforcement of past overachievement patterns require identification.

**Summary**

This article discussed the family’s maladaptive roles (i.e., chief enabler, hero, mascot, lost child, and scapegoat), assumed in response to alcoholism, that influence desired family treatment outcomes. Occupational therapy treatment methods for the family were organized according to three hierarchical treatment levels.
Treatment Level 1 focuses on relinquishment of maladaptive family roles through stress reduction, external control training, and resolution of judgmental attitudes held toward the alcoholic. Problem solving and coping skill training are emphasized during Treatment Level 2 in order to further weaken reliance on the family’s maladaptive roles. At Treatment Level 3, the therapist facilitates growth by stimulating insight into the issues of family enabling, thus effectively confronting the remaining reliance on the family maladaptive role behaviors. Acting on insight and planning are appropriate treatment challenges at this level.

Ideas regarding the separation of treatment of the alcoholic from treatment of the family; organization of treatment around the family unit, individual family members, or family subcomponents; and determination of the number of family members and total numbers of families capably addressed by the occupational therapy program were discussed. Occupational therapy treatment of the alcoholic will likely be enhanced through the development of family treatment approaches. According to Whitfield (1984, p. 20), “once recovery in the family occurs, the alcoholic from treatment of the family; organization of control training, and resolution of judgmental attitudes held toward the alcoholic. Problem solving and coping...”

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