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## A study of family roles in Mexican/American alcoholic families

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A STUDY OF FAMILY ROLES  
IN MEXICAN/AMERICAN  
ALCOHOLIC FAMILIES

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A Special Project  
Presented to  
The Faculty of the School of Social Work  
San Jose State University

In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

by  
Deborah Carpenter-Hunt  
Mark Edward Rowe

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families

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**CHAPTER I**  
**INTRODUCTION**

The single most important event effecting both societal attitudes and treatment modalities associated with alcoholism was the declaration by the American Medical Association in 1956 that alcoholism is a disease. As a result, our society has come to accept that alcoholics are not social deviants but suffer from a medical condition over which they have little control. The disease concept also has paved the way for broader treatment approaches using the medical model. As treatment programs have proliferated due to ever increasing numbers of alcoholics seeking recovery, the far reaching effects of alcoholism in society have come to light.

Throughout the 1960's and early 1970's the focus of treatment was placed almost exclusively on the alcoholic. Programs based on either the social model or medical model focused their interventions on attempts to change the alcoholic's drinking behaviors and self perceptions. Over time, neither type of program established a significant success rate in its endeavors. The treating professionals, however, were

noticing the effects of alcoholism on family members other than the alcoholic. A new concept that suggested the focus of intervention be broadened to include treating the alcoholic's family members, as well as the alcoholic, was proposed in I'll Quit Tomorrow (Johnson, 1973). Vernon Johnson encouraged professionals to seek out the alcoholic's family members, change how they interact with the alcoholic, and this would necessarily affect a change in the alcoholic's world. It had been previously assumed that an alcoholic could not change until he had "bottomed out", as a natural process of progressive degeneration. Johnson was suggesting that changing the expected dynamics of family interaction would create a crisis sooner for the alcoholic, in essence "raising the bottom" and providing an opportunity for the alcoholic to change earlier in the disease process.

The concept of treating the family members of alcoholics spread quickly and expansively. As a result, alcohol treatment professionals gained valuable knowledge about how alcoholism affects the family and a more dynamic picture of the alcoholic's world. The correlation of alcoholism with spousal battering, child abuse, and child molestation became ever apparent.

(Ackerman, 1986; Caetano, 1985). Child abuse reporting laws, established in the late 1960's, helped bring national attention to the family problems associated with alcoholism and increased funding available to alcohol treatment programs. Expansion of services led to treatment subgrouping of the spouse or co-dependent and the children of alcoholics.

In 1979, Sharon Wegscheider, Claudia Black and Janet Woititz, all counselors from different parts of the country, came together at the Kroc Ranch in Santa Barbara, California, to discuss their work with families of alcoholics. They found common threads in their clinical practice as well as discovering they shared the common experience of having been raised in an alcoholic family system. Both of these discoveries led to their mutual decision to meet regularly to compare findings with other professionals in the alcohol abuse treatment field, to verify their common clinical and personal experiences. As subsequent conferences verified those experiences, they felt confident in bringing their findings to print.

Their writings conceptualized a theoretical model of family roles, behaviors and associated feelings common to many alcoholic families in treatment. The



non-alcoholic family members assume these roles in an effort to adapt to and survive the stress and tensions which develop as a result of living with an alcoholic (Wegscheider, 1981; Black, 1981; Woititz, 1983).

This theoretical model, later labeled "co-dependency", has become popular in the treatment and education fields. The adoption of this model in these fields speaks to its credibility; however, there are no apparent documented studies addressing the model's validity. Acceptance has been based on the useful and successful application of this model in various treatment centers throughout the country.

Further development in exploring the effects of alcoholism in relation to race and ethnicity has enjoyed a parallel growth over the past few years. However, studies of the relationship between alcoholism and the Mexican/American population have centered primarily on epidemiology (Caetano, 1987). There have been few apparent studies looking at the roles or dynamics in Mexican/American alcoholic families. There have been no studies investigating the application of the alcoholic family role theoretical model to the Mexican/American population.

As treatment professionals seek more effective ways

in helping to treat families suffering with alcoholism, their recognition of and sensitivity to ethnic and cultural differences is imperative. Taking into consideration these differences as well as similarities in the development of treatment programs will promote the greatest potential for successful intervention with minorities and their specific needs.

The theoretical model developed by Wegscheider, Black and Woititz appears to be useful to alcoholic families in our society in general. The recent proliferation of Children of Alcoholics self-help groups lends credence to this supposition. Their literature and treatment workbooks reflect the use of the previously mentioned family role model for the purposes of creating self awareness in this population, which can then lead to therapeutic affiliation and bonding with other children of alcoholics.

It is then important to further evaluate the model's application to specific ethnicities and their cultures. As the fastest growing population in the American Southwest, the Mexican/American population will be increasingly exposed to the possibilities of alcoholism affecting their families. An assessment of the application of the co-dependency family role model

to alcoholic Mexican/American families seeking treatment would provide valuable information to treating professionals. Using culturally sensitive and appropriate tools allows counselors to gain the trust and confidence of those Mexican/American clients seeking services. It is important to develop treatment programs which meet the needs of those they are intended to serve. Although there may be common denominators in the treatment approaches to alcoholism, there may be more cultural and ethnic differences needing to be addressed in an effort to provide comprehensive and effective services.

This study evaluated the application of the theoretical model of alcoholic family roles to the alcoholic Mexican/American families of the San Francisco South Bay Area who have sought services for problems relating to alcoholism in their family of origin. It assessed the identification of these family roles in Mexican/American alcoholic families, and looked for other roles evident in Mexican/American families which had not yet been previously identified.

**RESEARCH QUESTIONS:**

(1) Are the family roles in alcoholic Mexican/American families common to the theoretical model roles of Wegscheider, Black and Woititiz? (2) Do other roles exist in Mexican/American alcoholic families that are not found in that model?

**CONCEPTUAL DEFINITIONS:**

1) Alcoholism: Alcoholism is a progressive disease characterized by psychological as well as physiological dependence, a change in tolerance over time, loss of consistent control over drinking, inability to predict drinking behavior, and a greater and greater preoccupation with drinking leading to addiction. Alcoholism is a disease experienced by one or more persons, but which affects all the people in a family.

2) Family roles in alcoholic families: In response to the alcoholic's increasingly erratic behavior, decreasing ability to socially interact, decreasing ability to handle responsibilities, family members must assume roles to accommodate the disease process. The

theoretical model of co-dependency developed by Wegscheider, Black and Woititz includes roles labeled chief enabler, family hero, scapegoat, lost child and mascot.

3) Mexican/American alcoholic families: This study focused on Mexican/American families with one or both parents being alcoholic. Both parents were of Mexican or Mexican/American descent. The respondent to the interview schedule was able to speak English and may have been able to speak Spanish as well. At least one family member was seeking or had sought treatment for alcoholism or its effects. (individual, family, group, or self-help group treatment modalities).

## CHAPTER II

### LITERATURE REVIEW

Alcoholism has been recognized as a problem since biblical times. However, early forms of intervention consisted mainly of verbal admonishment or personal subjection to public ridicule, as when drunken colonists were placed in stockades. These token interventions proved to be poor deterrents and the consumption of alcohol grew during the early 1800's to the point where the per capita consumption in the United States was four times greater than it is today (Levine, 1984). During the 19th century alcoholics were considered to be lower class men of weak moral character, having been victims of the devil's work through "that Demon Rum" (Furnas, 1965). It was the "demonization" of alcohol that led to a broadened concern about alcohol consumption by the middle-class. Prior to that time temperance was primarily a concern of wives and merchants. A drunkard husband was a threat to the economic and social security of the family, while a work-force depleted by alcoholism prevented businessmen from producing, shipping or marketing goods for profit. The coupling of religious

activism with the women-driven temperance movement resulted in the establishment of self-help treatment programs which then became the forerunners of most contemporary treatment programs (Lender, 1982). It was during the times of the Washingtonians and the Sons of Temperance that the first alcohol journal was printed, "The Quarterly Journal of Inebriety" (Strug, et al., 1986).

Prohibition, then, was a result of diverse social segments working towards a common goal for different reasons. Women wanted a stable home and family life, the middle-class wanted a moral society, and the merchant/businessman desired higher productivity. With the passage of the Volstedt Act in 1919, the 18th Amendment to the Constitution which prohibited the use of alcohol in America, two significant changes were made in alcohol intervention. Never before had there been legislation dealing with consumption in America. Previous to the Volstedt Act, taxation of alcohol had been the focus of legislation. And secondly, prohibiting the sale of alcohol marked a change of intervention focus from the individual to the substance (Keller, 1979).

The repeal of prohibition was enacted 13 years

later on the heels of the Great Depression. It was not the general population's anger at being deprived of their legitimate source of alcohol that fueled the repeal movement, but government and big business desiring to aid economic recovery through funding of relief projects and lower business taxes from monies collected as alcoholic beverages taxes.

As alcohol legally re-entered mainstream America, advertising and media campaigns promoted drinking as a fashionable and a desirable part of everyday society (Clark, 1976). Corporate America started to subsidize the promotion of alcohol consumption at the same time as the birth of the single most popular recovery program the entire world has known was created by an alcoholic stockbroker and an alcoholic doctor. Alcoholics Anonymous (A.A.) was founded in 1935 as a voluntary self-help group of alcoholics adhering to the philosophy that alcoholism is a progressive disease, marked by the alcoholics' loss of control over their drinking, coupled with an increasing compulsion to drink. The only recognized cure is lifelong abstinence. As A.A. began to establish itself as a viable recovery program, universities and medical centers took up alcohol research projects and developed



model treatment programs. Yale University pioneered this field of study and founded the first out-patient clinic specializing in treating alcoholism, as well as introducing group therapy as a treatment method (Keller, 1981). Dr. E.M. Jellinek spearheaded medical research into the biological aspects of alcoholism as director of the Yale Center of Alcohol Studies. It was through his efforts that alcoholism was portrayed publicly as being an illness which can be eliminated by therapeutic means. As the medical and scientific fields grew increasingly involved in treating alcoholism throughout the 1940's and 1950's, clergy and temperance workers' involvement declined. By the mid-1950's, Dr. Jellinek and his followers had brought about a new definition of alcoholism and a new attitude towards alcoholics themselves. With the proclamation by the American Medical Association that alcoholism is a disease and the publishing of Jellinek's studies, in scientific terms, in his book The Disease Concept of Alcoholism, 1960, alcoholics no longer had to view themselves as degenerates with weak moral standards. They now could enjoy the status of being a patient suffering from a recognized disease that was worthy of medical treatment. This paved the way for many

"hidden" alcoholics to come forward to receive help for their illness.

Consequently, federal legislation evolved to support the research and treatment of alcoholism. The Highway Safety Act of 1966 called for reports to Congress concerning the effects of alcohol on traffic accidents. The comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 created the National Institute of Alcohol Abuse and Alcoholism (NIAAA). This new unit gave the alcoholism constituency a seemingly permanent voice in public policy and public health programs. The Uniform Alcoholism and Intoxication Act of 1971 removed many alcohol-related legal infractions from the criminal justice system, substituting medical treatment for punishment (Lender and Martin, 1982).

Alcohol treatment professionals took advantage of society's newly evolving acceptance of alcoholism as a disease and the growing availability of money for treatment. Many treatment centers opened and thrived through the 1970's and early 1980's.

Meanwhile, Alcoholics Anonymous continued to thrive and grow internationally and, in the mid-fifties, expanded the self-help concept to include the

non-drinking spouse of the alcoholic with the creation of Al-Anon. Later, in the 1960's, a branch of Al-Anon called Alateen was formed as a self-help group for teenagers with an alcoholic parent or parents. The role of Alcoholics Anonymous was to provide unqualified support for the alcoholic trying to achieve and/or maintain abstinence. Al-Anon and Alateen provided support to spouses and teenagers who were trying to cope with the difficulties of living with an alcoholic.

While the medical model of treatment included the use of professionally trained therapists, the social model self-help groups utilized recovering alcoholics or their spouses and teenaged children in the therapeutic process rather than professionals. As both forms of intervention became more prevalent, the medical model of treatment continued to be primarily focused on the alcoholic. But the self-help movement began to expand to include family members of the alcoholic. This reflected the growing national awareness of the impact of alcoholism on others in the family system. The first book specifically addressing the problems of children of alcoholics, The Forgotten Children, was written in 1969 by a Canadian social worker, Margaret Cork. During the seventies the new

awareness continued to grow. By the early eighties there was sufficient recognition of the individual nature and concerns of children of alcoholics (COAs) that formal organizations were created to address their concerns. In 1983 the National Association for Children of Alcoholics was incorporated. In the words of one of its founders, Timmen Cermak:

"Founded as a resource for children of alcoholics of all ages, and for those interested in helping children of alcoholics, NACoA is dedicated to ending the silence that has surrounded the effect of alcoholism on families." (Cermak, 1985, p.49).

At about the same time, a third branch of Al-Anon was formed, this one for adult children of alcoholics or "ACAs".

The growing awareness of alcoholism as a disease which affects the whole family was also reflected in the increased involvement of family members in the recovery processes of the medical model of treatment as well. Literally thousands of families were seen in treatment centers throughout the country, and therapists working with them began to become increasingly aware of common themes, issues and behavior patterns in alcoholic families.

Noted over and over again was the fact that pathological drinking becomes integrated into the family system and leads to predictable, compulsive behavior, both in the individual family members and in the interactions among them (Wegscheider, 1981). Wegscheider sees alcoholism as a shared disease characterized by the mutual decline of all family members in the areas of physical health, socialization, emotional health, volitional abilities, spirituality and mental health. As the alcoholic spirals down the path of self destruction, the family members try to adapt to the disease process. The problem is that there is no healthy adaptation to alcoholism, so the adaptations become pathological in themselves.

Often, the environment in this dysfunctional system often does not provide adequate opportunity for children to develop the life skills necessary to become fully functioning adults. Instead family members develop coping mechanisms to deal with the alcoholic's erratic behavior, decreasing ability to socially interact and decreasing ability to handle responsibility. (Ackerman, 1986). Despite the fact that not all children of alcoholics are affected in the same way because of the many possible intervening

variables, there appears to be a strong commonality of problems/core issues reported by therapists, counselors and researcher who work with adult children of alcoholics.

Children raised in "healthy" homes where there is open communication, consistency of lifestyle, and flexible, fair and verbalized rules are presented with opportunities to adopt a variety of roles depending on the situation. These children learn how to be responsible, how to organize, how to set realistic goals, how to play and to have fun. They learn sensitivity to the feelings of others and willingness to help others. These children develop a sense of autonomy as well as a sense of belonging to a group. (Black, 1981). In contrast, children growing up in alcoholic homes seldom learn the combinations of roles which are needed to build healthy personalities. "Instead, they become locked into roles based on their perception of what they need to do to 'survive' and to bring some stability to their lives" (Black, 1981, p.14). Wegscheider describes five family roles members adopt to keep the family working as it deteriorates along with the disease process. The "chief enabler" is often the spouse, and the one who

makes excuses and covers up for the alcoholic's embarrassing and irresponsible behavior. This person will sometimes lie for the alcoholic and often takes on more family responsibilities as the alcoholic becomes less responsible. Sometimes the chief enabler spends a lot of energy trying to control the alcoholic's drinking. This can cause friction in the home. The first born often takes on the role of the "hero". The hero is very responsible, hard working and organized. This person often excels at school, can be a star athlete and always does what's right, bringing honor to the family. The hero often acts as surrogate parent for younger siblings. Middle siblings often take on the "scapegoat" or "lost child" roles. The scapegoat attracts negative attention by frequently getting into trouble at home, at school, or with the law. This family member may begin to use drugs and alcohol at an early age, drop out of school or become pregnant as a teen. The "lost child" role allows this family member to cope by withdrawing and living in his or her own world. This person may spend many hours alone, perhaps watching TV, listening to music or doing creative projects. The lost child may be overweight, and as a young child, may have had imaginary friends.

The youngest child frequently becomes the family "mascot" and provides relief and humor by being funny and charming during stressful times. This child is likeable, immature and may be considered the "family pet." (Wegscheider, 1981)

These roles are rigid in nature, but may be shared or exchanged over time by different family members. As the family becomes literally "sick" in tandem with the alcoholic, so too do they need therapeutic intervention to alleviate their distorted sense of self and family.

Children of alcoholics often suffer from low self esteem and an underlying depression. This is a result of having sacrificed personality development and personal identity needs in order to provide more structure and stability to the family by assuming a rigid survival role (Woititz, 1983). Woititz proposes that if the family members do not get help, their disease process will carry over into adulthood and even into the following generation.

Adult children of alcoholics function out of a distorted perception of reality, which results in problems in the areas of self-worth, responsibility, relationships and communications. One of the keys to successful readaptation to life is education. Woititz



believes that children of alcoholics lack the necessary information and training ideally provided in the family of origin to live a healthy life. But, once provided the necessary information about themselves, the dynamics of alcoholic families, and given the opportunity to integrate this into a more normal perception of life, the adult child of an alcoholic family often can lead a successful, happy life.

Another serious problem area for children of alcoholics lies in their own increased risk for alcoholism. The estimated 28 to 34 million children and adult children from alcoholic families in America today have been statistically shown to be at a high risk of either becoming alcoholics themselves or a marrying an alcoholic (Black, 1981). Without intervention, an estimated 40 to 60 percent of children of alcoholic parents become alcoholic themselves (Ackerman, 1979).

Claudia Black states that three family rules exist and are strictly adhered to for emotional and physical survival in alcoholic families. The family learns not to talk, not to trust and not to feel. Coupled with observing the abnormal behavioral responses by the alcoholic to life's situations and emotions, it should

not be surprising that a large proportion of family members learn to drink alcohol in order to deal with life's offerings (Cermak,1985).

There have been few studies or articles to date which look at alcoholism in Mexican/American families. The most extensive research has been done here in Northern California in the area of epidemiology. The foremost researcher in epidemiological studies involving the Mexican/American population is Dr. Raul Caetano of the Alcohol Research Group in Berkeley, California. His research focuses on drinking patterns, frequency and attitudes. Caetano acknowledges that clinical research indicates that alcoholism in Mexican/American families causes problems in the family proportional to the amount of drinking by the alcoholic. Outside of clinical findings, field research indicates that family problems related to excessive alcohol intake are not commonly reported (Caetano, 1987). This may be related to the denial process associated with alcoholism or because alcoholism still carries a social stigma.

Acculturation affects the drinking patterns of Mexican/Americans. Based on an acculturation scale he devised (Caetano, 1986a.), Caetano found that first

generation (U.S.-born with at least one parent born abroad) Hispanic males had the lowest rate of abstinence and the highest rate of frequent high-maximum drinkers in comparison to foreign born or second generation or greater groups. Mexican/American groups had lower abstinence rates and more frequent high maximum drinking rates than Puerto Rican and Cuban/American men.

Acculturation affects opinions and attitudes of both men and women. Mexican/American men and women ranked high in acculturation were found to have more liberal opinions about alcohol use by people in different age and sex groups than do men and women who score low in acculturation (Caetano, 1986b). And Mexican/American women who ranked high in acculturation have more liberal attitudes toward alcohol consumption than other Mexican/Americans (Caetano and Medina-Mora, 1986).

Other research conducted by Jean Gilbert of University of California Los Angeles has shown similar findings. In regards to Mexican/American women, Gilbert suggests that acculturation increases women's participation in drinking activities. This has the effect of increasing their own amount of drinking

behavior while reducing the amount of drinking by the men who are present on those occasions. Gilbert found that the rate of alcohol abstinence declined in progressing generations while the rate of the frequency of daily drinking increased (Gilbert, 1985b). Caetano and Gilberts' research indicates the importance of acculturation in understanding drinking patterns of Mexican/Americans.

Also culturally significant is the understanding of traditional family roles. Family roles may be affected by the traditional and clearly defined sex roles of the Mexican/American cultures and/or by level of acculturation (Oliver-Diaz and Figueroa, 1986). The male is the father, hunter, protector, and to him belongs the last word. The female role is that of mother, provider and life giver. There has developed an entire code of ethics, social expectations and responsibilities based on the division of duties. Acculturation, necessarily tied to the family's needs for economic survival and mobility, is likely to be a source of problems intergenerationally as the family's traditional identity, bonds and roles are tested and changed by language, cultural assimilation and better educational opportunities. Oliver-Diaz and Figueroa

caution against overlooking sex roles, level of acculturation, and a client's personal and community systems when providing services for the Mexican/American client.

Caetano suggests the traditional roles of husband being the provider and wife being the nurturer contribute to continued drinking practices of the Mexican/American male. As a good provider the male feels justified in participating in traditional patterns of drinking with his friends after a hard day's work. Women, concerned with the security of their children, are likely to tolerate their husbands' drinking as long as he provides adequately and does his heavy drinking outside the home (Caetano, 1987).

Also culturally specific to the Mexican/American male is the "Machismo" role. The role of machismo was evaluated by Panitz, et al., (1983), in terms of being a contributing factor to the Mexican/American male becoming alcoholic. Widespread acceptance of the machismo ethos and its determining role in the structure, dynamics and value systems of the traditional Mexican/American family seems to encourage alcohol abuse by men. Exhibiting machismo-like traits will most likely elicit negative responses from the

dominant culture and its institutions, resulting in dysphoric states for which the time-honored remedy of the Mexican/American culture is alcohol. Thus, careful consideration should be given to clear definitions of the machismo role, should it be exposed as an identified Mexican/American alcoholic family role.

Lacking in the literature is a theoretical explanation of the affect of alcoholism on the children of Mexican/American families. The work of Caetano and Gilbert implies that children are taught tolerance of male alcohol consumption, or even expectation, because of the male roles of provider and machismo. Only Ackerman makes specific mention of children in his literature about treating families suffering the effects of alcoholism. He reports that "children of acculturation" have all the problems of children of alcoholics; children of acculturation being those children adapting to the dominant culture through school and the community while attempting to balance their new experiences, which may be in conflict, with the values and expectations their parents bring with them from their mother country. In addition, these children often suffer from role reversal, assuming a parenting role as a result of a greater degree of

competency in the dominant culture. This is primarily due to attending U.S. schools, where English language development and socialization takes place. As these children acculturate more rapidly than their parents, they tend to develop ambivalent feelings about the parents they love but whose language, dress, and lifestyle embarrass them (Ackerman, 1986). Forced to take the leadership role in dealings with the dominant culture, too often including treatment services, these children accept responsibility beyond their years. These traits of leadership and responsibility are primary to the theoretical model role of the family hero. Ackerman warns treating therapists to be aware of the complexities of trying to assist children of acculturation from alcoholic families. Carrying a double burden is extremely stressful on these children.

Although all the authors who speak to treatment issues state the treatment of choice for alcoholism in Mexican/American families is family therapy, no one outside of Ackerman has discussed the children. Caetano, Gilbert and Panitz all mention family problems as a type of alcohol related problem in these families, which in essence is defined as marital conflict. None of them, however, discuss children specifically and the

recommendation of family therapy as the treatment of choice receives no more than single sentence mention.



## **CHAPTER III**

### **METHODOLOGY**

#### **RESEARCH DESIGN:**

The design of this project was a cross cultural, comparative study in which the current concepts of the theoretical model of co-dependent family roles in alcoholic families developed by Black, Wegscheider and Woitiz were applied to Mexican/American families of alcoholics. The purpose of the project was to obtain preliminary information about the accuracy of this theoretical model when applied to Mexican/American alcoholic families.

#### **SAMPLE AND SAMPLING PROCEDURES:**

The theoretical population for this study consisted of all Mexican/American families of alcoholics in the United States. However, the unit of study was an individual member of a Mexican/American alcoholic family.

The sampling frame consisted of all Mexican/American alcoholic families in the San Francisco-South Bay area of which one member was in one

of the organizations through which this study was advertised. The actual sample was composed of a volunteer sample of 20 individuals from the San Jose geographical area obtained from family members who agreed to participate in the study. The participants were English speaking members of Mexican/American alcoholic families who were at least 18 years of age. Participants were solicited from Alcoholics Anonymous, Al-Anon and Adult Children of Alcoholics (ACA) groups in Santa Clara and San Mateo Counties during January, February and March 1989. Fliers were distributed on the San Jose State University campus to departments other than the School of Social Work, inviting participation of those who grew up in Mexican/American alcoholic families.

Fellow students at the SJSU School of Social Work were not solicited in order to avoid invasion of privacy. Respondents were contacted by phone to set up an interview at their convenience. Interviews with participants solicited via announcements during the business portion of AA, Al-Anon, and ACA meetings were scheduled after the meetings at the volunteers' convenience.

## **INSTRUMENTATION**

Data was collected by phone interview. This was a modification of the researchers' original intent to collect data by direct interviewing, and was necessitated by the difficulties encountered in trying to find a mutually convenient, private and accessible location for both parties of the interview. Interviewees were chosen by their previously expressed willingness to participate. The collection of data took place January through March 1989. Researchers estimate that the length of the interview ranged between 30 and 45 minutes.

The interview technique, rather than written questionnaires, was selected because of the need to use open-ended questions and to explore interviewee responses. Because of the sensitivity of the subject of family alcoholism, the personal interview may have elicited a higher response rate than a written questionnaire.

The interview schedule included descriptive material and questions about co-dependent family roles, as well as questions dealing with demographic information, level of acculturation, birth order and

sex of children in the family of origin, perceived extent and effects of family alcoholism, and awareness of one or more family members having sought services for problems relating to alcoholism in the family of origin. The interview schedule is displayed in Appendix D.

Demographic information was obtained in questions 1-8, and covered age, sex, number of children and birth order in family of origin, educational, occupational and marital status. Level of acculturation was addressed in questions 9-17 using an adaptation of Acculturation Rating Scale for Mexican Americans designed by Cuellar, Harris, and Jasso in 1980. Included were questions on country of birth of respondent, respondent's parents and grandparents, number of years in U.S., age when immigrated if not born in U.S., languages spoken and read and fluency therein, radio and T.V. programming in terms of language preference, and amount of contact with Mexico.

Extent and effects of family alcoholism were explored in questions 18-23 and 50-53. Included were identification of alcoholic parent(s) and other alcoholic members of household, identification of family members who have or are now seeking help for

problems related to parental alcoholism, and extent of current alcohol use and alcohol related problems of participant and siblings.

Questions 24-44 probed for the existence of the five family roles included in the theoretical model of co-dependency in alcoholic families developed by Black, Wegscheider and Woititz. These are chief enabler, hero, scapegoat, lost child and mascot. The five roles were described in the interview schedule as follows:

Family Role #1: This person is the one the alcoholic depends on the most to make excuses for the alcoholic related behavior, and to hide or fix the alcoholic's mistakes. This person sometimes will lie for the alcoholic and often takes on more family responsibilities as the alcoholic becomes less responsible. This person almost always puts other peoples' needs first.

Family Role #2: This person is very responsible, hard working and organized. This person often excels at school, can be a star athlete, does what is right and is usually quite serious. This person brings pride and honor to the family.

Family Role #3: This person often breaks rules or gets into trouble. He or she often does poorly at school, and may drop out or get pregnant in their mid-teens. This person may begin to use drugs and alcohol at an early age. This person uses negative behavior to get attention from the family.

Family Role #4: This person is quiet, independent, and stays out of everyone's way. He or she spends a lot of time alone, watching TV, listening to music or doing creative projects. This person may be overweight, and, as a young child, may have had imaginary friends.

Family Role #5: This person provides relief and humor by being funny and charming during stressful times. This person is usually active and can be hyperactive. He or she jokes around a lot and likes to be the center of attention. This person is very likeable and may be considered the "family pet".

Questions 45-49 probe for the existence of any other family roles, descriptive information about these roles, and related facts regarding birth order/family position, gender, and current life conditions of the person who took this role.

#### **PROCEDURES:**

Participants were solicited via announcements during the business portion of AA, Al-Anon, and ACA meetings. The interviewers introduced the study in the following way:

Hello, my name is Mark/Debbie and I am a social work student conducting research on alcoholism in Mexican/American families. Specifically, I am investigating the effects of growing up with an alcoholic parent or parents. The information learned in this study could be helpful in developing better treatment plans for members of these families. If you grew up in a Mexican/American home where alcohol was recognized as a problem and would like to volunteer for an interview lasting 30-45 minutes, please see me after this meeting. The interview will be scheduled at your convenience and all information will be treated as confidential and used for

research purpose only. Anyone who is interested in participating, please see me after this meeting or call me at (415) 851-8125 or (408) 286-8388. The telephone numbers again are (415) 851-8125 or (408) 286-8388. Thank you.

Prior to the meeting, written permission to solicit research volunteers was obtained from the presiding officer. (See Appendix A). Participation also was solicited by the distribution of fliers at the above meetings or on the SJSU campus to departments other than the School of Social Work. (See Appendix B: Flier.)

A total of twenty subjects volunteered to participate. All participants were 18 years of age or older and had the ability to provide informed consent. Interviews took place over the phone and were scheduled at a time convenient for the volunteer. Before the interview, volunteers were sent two copies of the consent form and a stamped pre-addressed return envelope. They were asked to read, sign and return one copy of the consent form to the interviewer prior to the actual interview and to keep one copy for their files. (See Appendix C: Consent Form.)

In order to maintain confidentiality, participants' names were not recorded, and a code number was used for identification. First names of other family members

were coded in terms of family relationship (mother, father, brother, sister, etc.) and birth order, and were recorded in that form during the interview.

Consent forms will be stored separately and maintained for the required seven year period.

The first part of the interview procedure consisted of direct questioning. (See Interview Schedule, questions 1-23.) In the second section, (questions 24-44) the interviewer read aloud a description of the characteristics of each of the five known family roles of non-alcoholic members of alcoholic families without naming the role. After each description, interviewees were asked to identify family members who fit this description and to answer questions related to this person or persons. The final part of the interview consisted of six direct questions about alcohol consumption by the respondents and their siblings.

When all sections of the interview schedule were completed, researchers offered as a service to the interviewees a copy of the Michigan Alcohol Screening Test (M.A.S.T.) and a scoring key. The purpose for making available this self-administered test was to give the participants the opportunity to assess their current level of drinking. Scoring categories are



"probably not alcoholic," "potential alcoholic," "definitely alcoholic," and "chronic alcoholic." Additionally, an Alcoholics Anonymous (A.A.), referral telephone number was listed on the scoring sheet for the participants' information. The researchers think that this was a valuable service because children of alcoholics are known to be at high risk of becoming alcoholics themselves.

#### **LIMITATIONS:**

It is unclear how results can be generalized because of the necessity to take a convenience sample. Also the possibility exists that the interviewees' responses may have been affected by the fact that both interviewers were Anglo. It is hoped that the interviewers' awareness of this possibility plus their training in transcultural social work minimized this potential problem. Also interviewers did reveal their status as adult children of alcoholics in order to establish a better connection with the interviewee. Finally, there is the possibility that some interviewees may not have given correct information due to the sensitivity of the material.

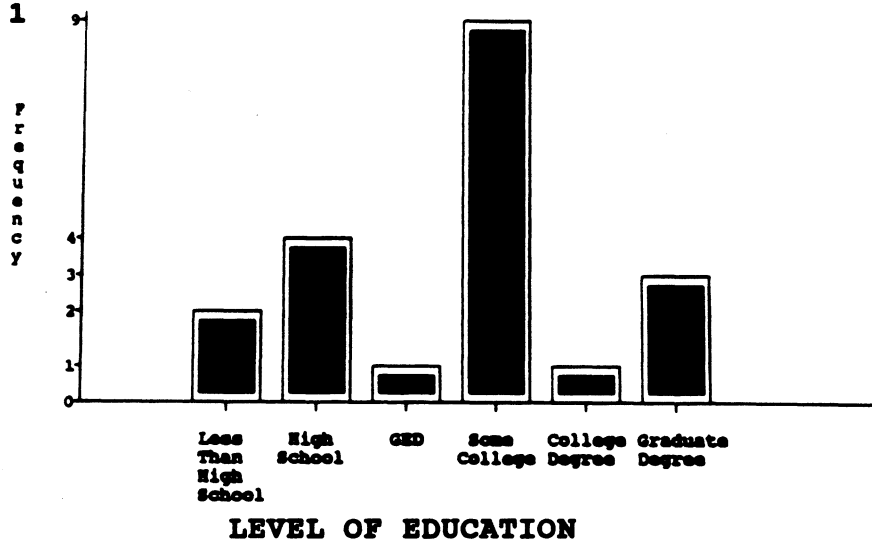
## CHAPTER IV

### FINDINGS AND ANALYSIS

#### DEMOGRAPHIC CHARACTERISTICS

The researchers conducted twenty interviews between December 1988 and February 1989 with adult children of Mexican/American families who grew up with one or both parents being alcoholic. The twelve female and eight male respondents ranged from 29 to 62 years of age, with a mean age of 39.8 years. As can be seen in Figure 1 below, 13 of the respondents had some college education and 18 of 20 had at least a high school education.

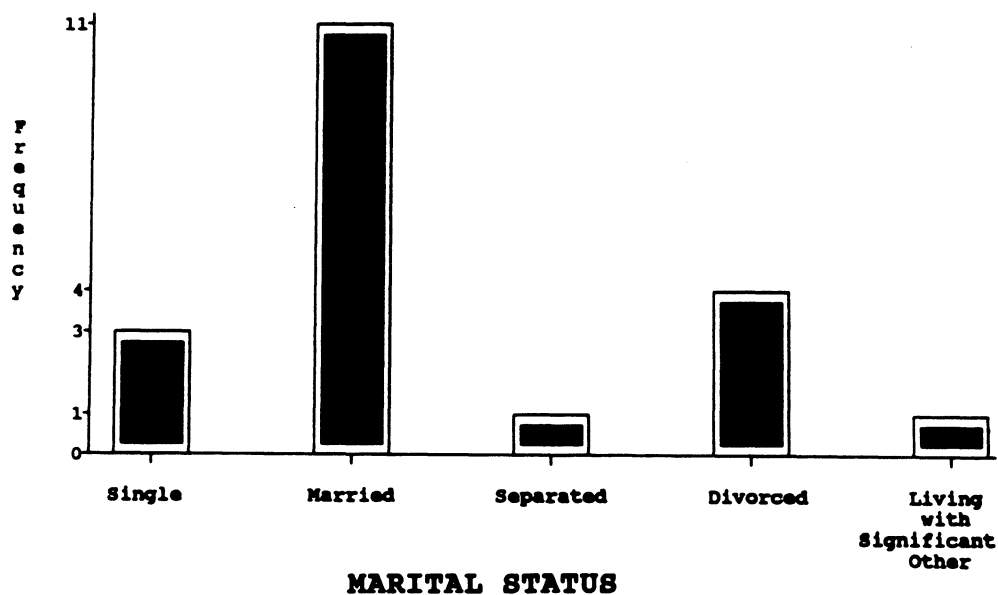
FIGURE 1



Occupations: The occupations of the interviewees varied widely. Among their various occupations were hospital administrator social worker, high school guidance counselor, secretary, dental assistant, realtor, construction worker, janitor, others. Eighty percent of the sample, or 16 of the 20 respondents had occupations at the paraprofessional or professional levels. All were employed at the time of their interview.

Marital status: As indicated in Figure 2 below, a majority of the interviewees were married or in a long term relationship with a significant other and one fourth were either divorced or separated.

**FIGURE 2**



Birth order: The respondents were questioned about the number of siblings in their families and the birth order of each child in the family. Birth order is significant in this investigation due to the correlation between birth order and specific family roles in the theoretical model. The theoretical model suggests the likelihood of first born or only children taking on the hero role, the last born taking on the mascot role, and the middle children assuming either the scapegoat or lost child roles. In the 20 families of the interviewees, there were a total of 92 siblings; 48 male children and 44 female children. This represents an average of 4.6 children per family. The birth order of the respondents is analyzed in correlation with their identified family role in the figure below.

FIGURE 3

	<b>FIRST BORN</b>	<b>MIDDLE SIBLINGS</b>	<b>LAST BORN</b>
<b>CHIEF ENABLER</b>	0	2	0
<b>HERO</b>	7	0	2
<b>SCAPEGOAT</b>	0	2	0
<b>LOST CHILD</b>	0	1	0
<b>MASCOT</b>	1	2	3
<b>CULTURALLY BASED ROLE</b>	0	0	0

**RESPONDENT'S BIRTH ORDER**

Of the respondents in this study, seven of eight first born assumed the hero role and three of five last born assumed the mascot role, as might be expected from the theoretical model. Middle children occupied the scapegoat or lost child roles in three of seven occasions, less supportive of the theoretical framework.

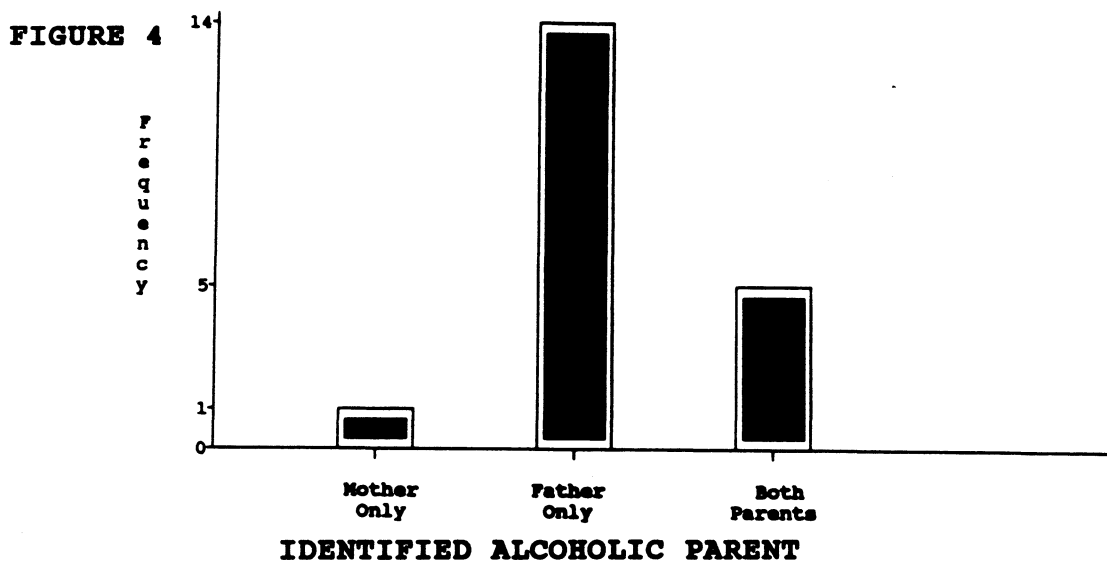
Acculturation: An abbreviated acculturation assessment developed by Cuellar, Harris and Jasso in 1980 was used in the study to determine the level of acculturation of the interviewees and their families. All but three interviewees were born in the United States. And all the interviewees had lived in this country for 15 years or more. Eighteen were bilingual but English was the primary language used in 16 homes. Most reported an ability to read Spanish, but to widely varying degrees of proficiency. All could read English and only one reported less than fluent proficiency. Five of the interviewees utilized bilingual media coverage. Sixteen interviewees related that they only visited Mexico occasionally. This data suggests that the respondents in this study are highly acculturated.

The interviewees' parents were born in the United States 25 of 40 times, while the grandparents were born

in Mexico 59 of 80 times. This would indicate that the respondents were primarily second generation Mexican/Americans.

The results of this study, therefore, must be evaluated with the understanding that respondents may only represent other highly-acculturated, second generation Mexican/American families in which alcoholism is recognized as a family problem.

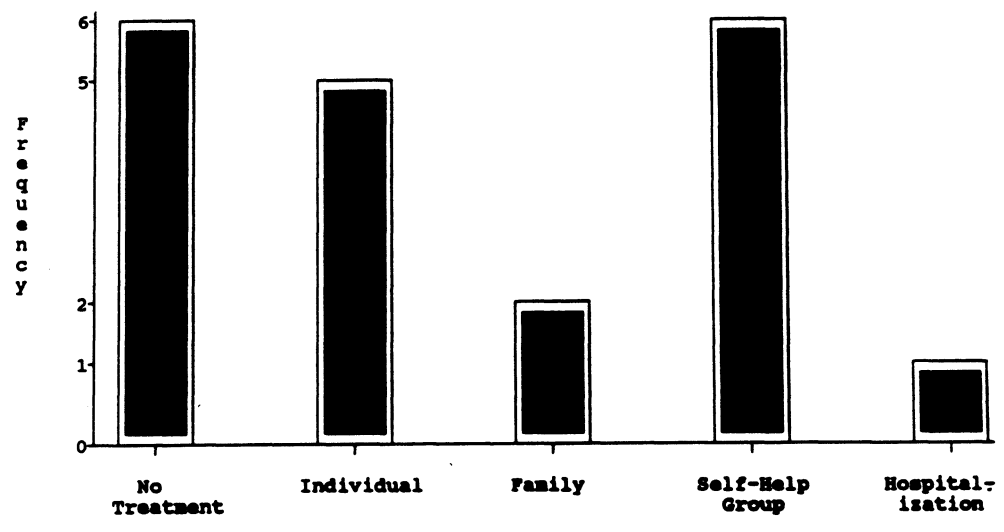
Family alcohol history: The interviewees were asked to provide a history of drinking in their families of origin based on recollections of their childhood and adolescence. When asked to identify the alcoholic parent in their family, 70% of the sample cited the father, while mothers were identified in six of the families as indicated in Figure 4 below.



In 11 families the other parent was also noted to drink. There were three families in which other family members were considered to be heavy drinkers. In one case the heavy drinker was a grandparent and in the other two cases, an older sibling.

Also significant in this section was the identification of alcoholism as a family problem as evidenced by the fact that treatment was sought by the alcoholic, codependents, or both. This familial recognition was necessary for the validity of the study as the theoretical family roles were developed through clinical work with families who had sought treatment for alcohol related problems. The respondents in this study had to give affirmation that some family member had sought treatment related to alcoholism in the family. Only five of the 25 identified alcoholics in this sample received treatment for their disease, while 14 of the respondents, or 70 percent, sought treatment for themselves. The treatment modalities most often utilized by the respondents were individual or group treatment, including in self-help groups such as Al-Anon or Adult Children of Alcoholics.

**FIGURE 5**



**PERSONAL TREATMENT MODALITIES**

In five of the families, another family member, other than the identified alcoholic(s) or interviewees sought treatment, primarily through individual treatment.

**RESEARCH QUESTION #1:** Are the family roles in alcoholic Mexican/American families common to the

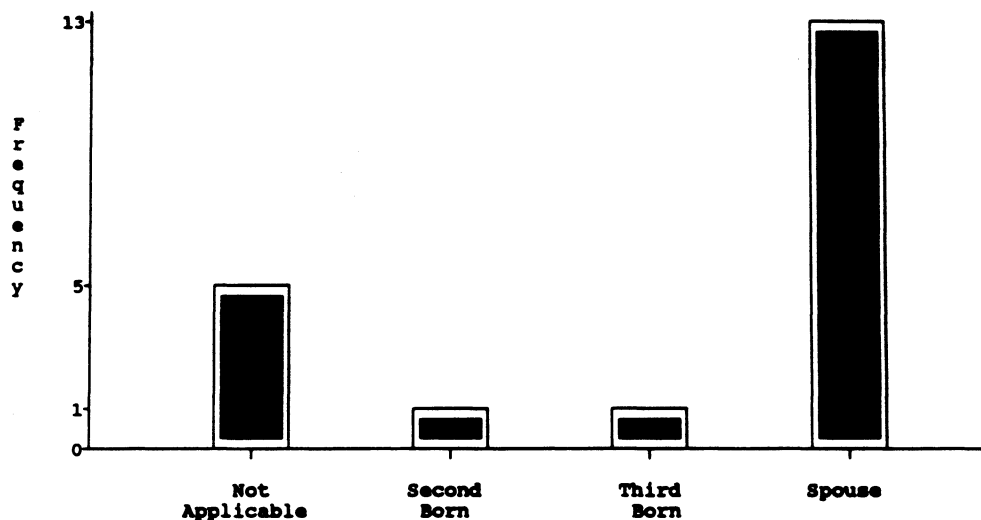


theoretical model roles of Wegscheider, Black and Woititz?

The respondents were asked to identify the existence of a given family role in their own family based on a general description of behaviors and attitudes reflective of that role without the perjorative labels, chief enabler, hero, scapegoat, lost child, or mascot. They were asked to identify which family member most closely resembled that description. The theoretical model cautions that the roles could be changed with other family members or shared at times. The key variable to this piece of the study, however, is birth order or family position.

Chief enabler: There were 15 families with a member identified as taking on the chief enabler role. Of those assuming this role, 13 were female and two were male. As would be expected from the theoretical model, 13 of those assuming this role were the spouses of the alcoholic. In this study all of the spouses identified as chief enablers were female, while the other family members taking that role were one second born and one third born male sibling. The chief enabler role was found to be common to 75% of the families in this study.

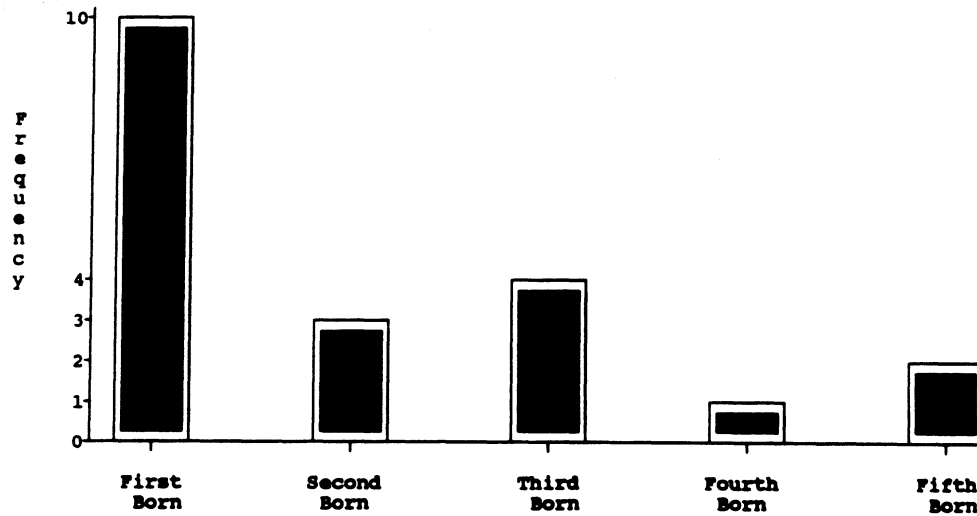
FIGURE 6



#### BIRTH ORDER OF CHIEF ENABLER

Family hero: The hero was identified as being present in each family, the only role enjoying that distinction. Of those assuming the hero role, 14 were female and six were male. The family hero was first born 10 times, second born three times, third born four times, fourth born once, and fifth born twice. The high percentage of first born heroes is consistent with the theoretical model expectations. The hero role was found to be common to 100% of the families in this study.

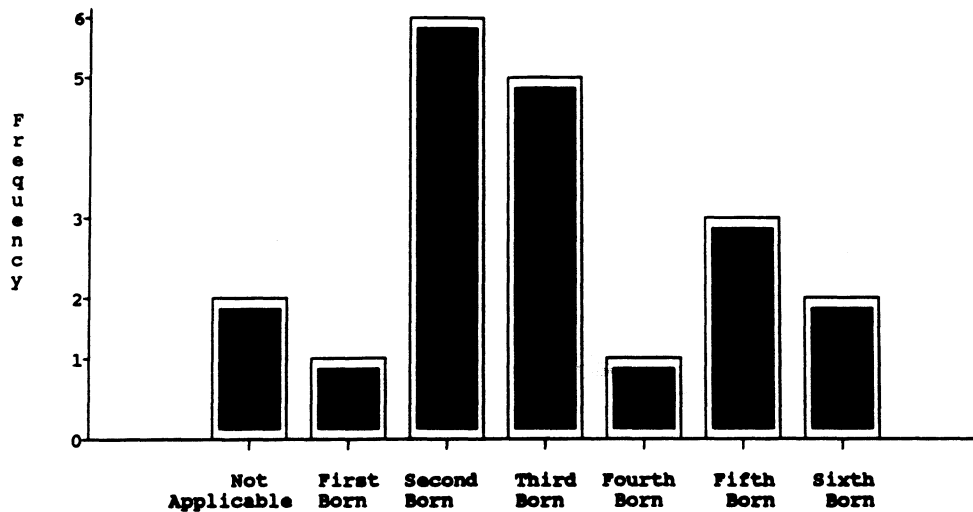
FIGURE 7



#### BIRTH ORDER OF HERO ROLE

Scapegoat: There were 18 families in which someone took on the scapegoat role. Significantly, 14 of the 18 scapegoats were males. Scapegoats occupied the second and third born slots six and five times respectively, the fifth spot three times, the sixth spot two times, and the first and fourth spot once each.

FIGURE 8



#### BIRTH ORDER OF SCAPEGOAT

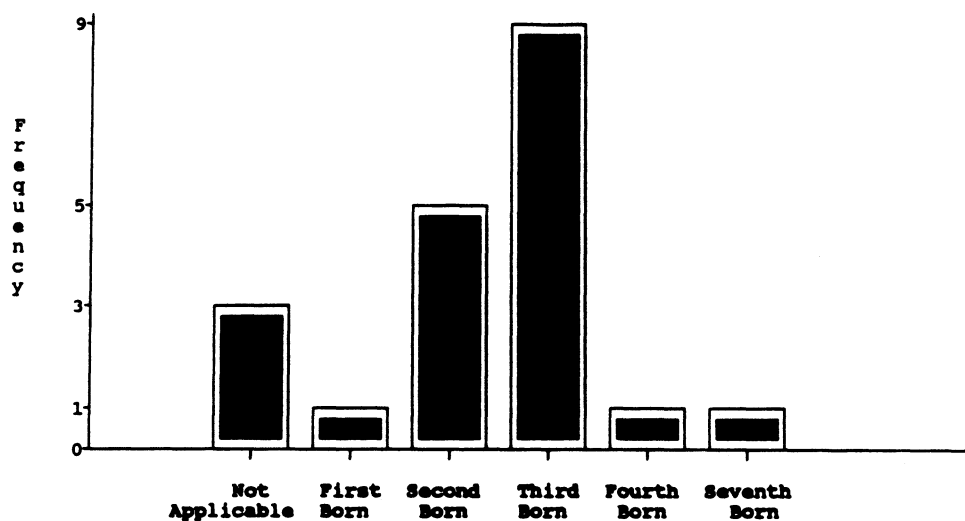
The theoretical model would expect a high ratio of second born or occasionally third born to assume this role. In this study, these two positions contained 55% of the total scapegoat role family members. The scapegoat role was found to be common to 90% of the families in this study.

Lost child: The alcoholic family role of lost child was identified in 17 of the study families; eight were female and nine were male. The lost child most

often was third born, occupying that birth order position nine times, followed by the second born slot with five members and one lost child each in the first, fourth and seventh positions.

Again, consistent with expectations of the theoretical model, the lost child occupied the third or second birth order position 70% of the time. The lost child role was found to be common to 85% of the families.

**FIGURE 9**

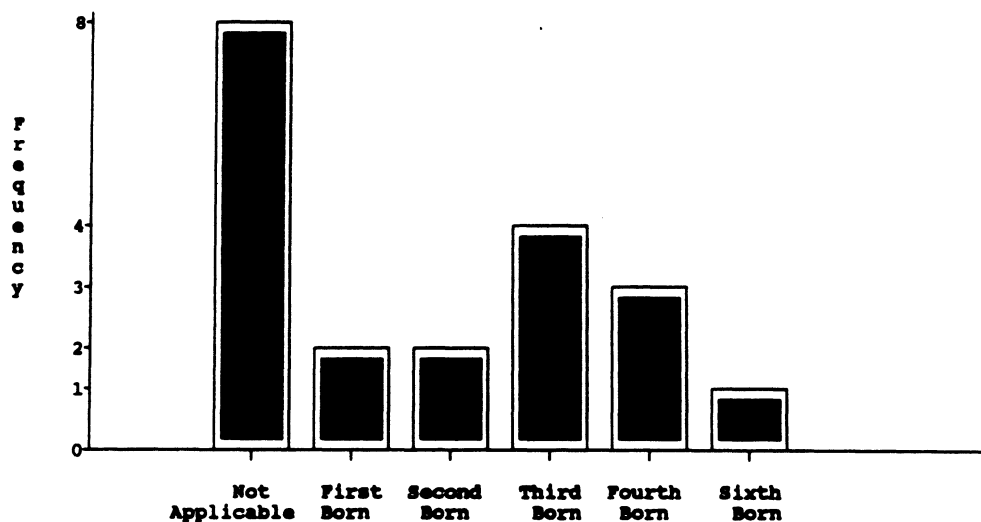


#### BIRTH ORDER OF LOST CHILD

Mascot: The role of family mascot was present in 13 of the respondents' families, six being female and

seven being male. The mascot role occurred four times in the third born slot and three times in the fourth born slot.

**FIGURE 10**



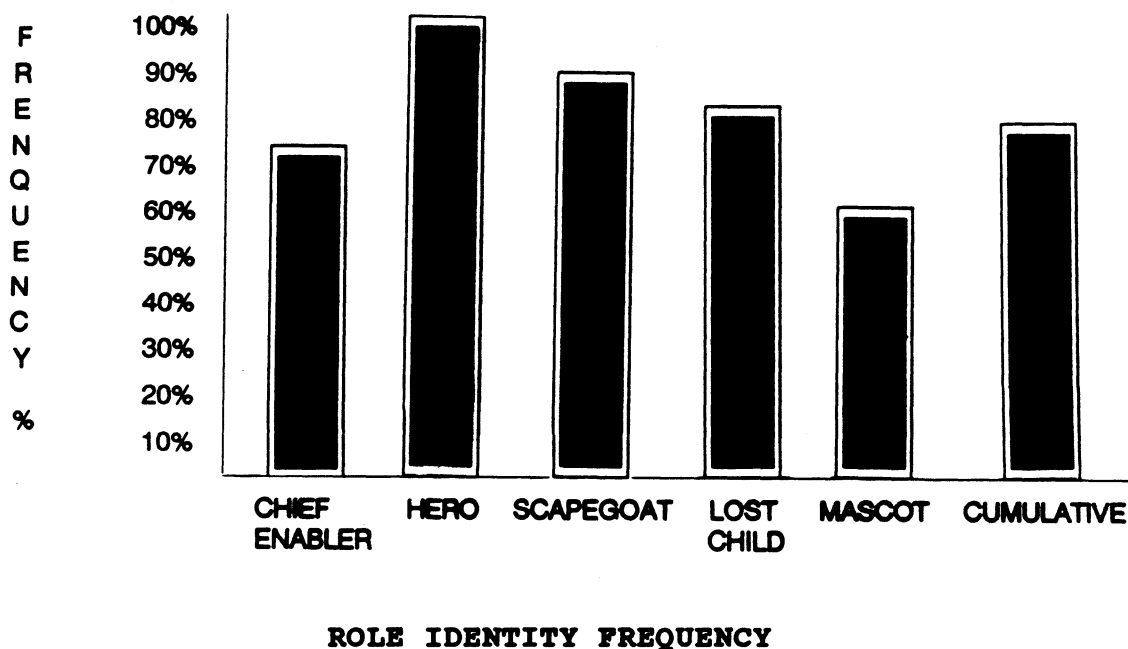
**BIRTH ORDER OF MASCOT ROLE**

The mascot role would be expected to appear most often in the fourth or the last born positions. In this study only three were fourth born and two others were last born. In total, five of the 12 identified mascots occupied positions consistent with the model. The mascot role was found to be present in only 60% of the families. The lower identification percentage of this role may be a result of the fact that seven families had less than four children. Half of the

families which did not identify a mascot had less than four children in the family.

In summary, this study contained a high rate of identification with the roles of the theoretical model. Four of the five roles achieved an identification frequency of 75% or better, and for reasons noted above, the mascot role may actually more closely approximate the others. As is, however, the cumulative identification frequency is 82% for all five roles.

**FIGURE 11**



**RESEARCH QUESTION #2:** Do other roles exist in Mexican/American alcoholic families that are not found

in the theoretical model?

A total of 20 family members were not identified with the five alcoholic family roles of the theoretical model during the initial process. The respondents were asked to describe the family members left out in terms their behaviors and attitudes. With further review, twelve of those not previously associated with the theoretical roles were found to match these roles. There remained eight family members whose personal qualities appeared different from the theoretical roles in some significant way. They were then further assessed to determine the existence of any culturally associated roles. Six interviewees identified one non-conforming role and one interviewee identified two non-conforming roles. Of these roles, three were filled by females and five by males.

There were four different roles identified within the field of eight. On two occasions the person was described as being virtually absent from the family. Unlike the lost child who is present but unnoticed, this person was rarely at the home; was absent altogether. "Macho", the Spanish word for male, but with many different meanings, was used to describe a male Mexican/American role. In this study five members



were described as being macho. However, in three of the cases they were described in positive terms of being dignified, respected and looked up to. In the other two descriptions, they were ascribed negative characteristics of being condescending, bullying and without concern for others. The positive macho role may be similar to the hero role in having a positive image, but different in having high personal regard by other family members. A hero is honored for their achievements and not necessarily for the type of person they are.

The final role identified occurred just once. The family member was the alcoholic parent's mother, who was living with the family. The practice of having grandparents live with their offspring is common in Mexican/American families. She was described as being the "arrimada", which means a person who is feeling unwanted, burdensome and taking on martyr-like attitudes. In the theoretical framework of this study, this person would most resemble the chief enabler role because she promoted her alcoholic son in his provider role.

Of the four differing roles discussed, the three roles of "positive macho", "negative macho" and

"arrimada" are most likely to be roles related to other highly acculturated, second generation Mexican/American alcoholic families. Therefore, it appears that other roles, or cultural variations of the theoretical roles, exist in these families that differ from the theoretical model, or are cultural variations of the existing roles.

#### **ADULT CHILDREN DRINKING DATA**

The respondents were asked about the historical and current drinking behaviors of their siblings and themselves to conclude the interview schedule. Fourteen interviewees reported at least one brother currently known to be drinking, and 11 interviewees reported at least one sister currently known to be drinking. In total, 28 of 40 brothers, or 70%, were currently drinking at the time of the study and 21 of 32 total sisters, or 65%, were drinking.

In total, the respondents identified ten of the 40 brothers as having developed drinking problems and eight of the 32 sisters as having developed drinking problems. Brothers with a history of drinking problems were reported in nine of the 20 families, while sisters

with a history of drinking problems were reported in seven different families.

In only one family, however, was there both a sister and brother who had developed drinking problems.

As for the respondents themselves, 14 of 20 were current drinkers at the time of the interview and 11, or 55%, admitted to having had a history of personal drinking problems.

**FIGURE 12**

FAMILY ROLE	# OF RESPOND. IN ROLE	# OF RESPOND. WITH DRINK PROB.	% OF THOSE DEVELOPING DRINK PROB.
CHIEF ENABLER	2	1	50%
HERO	9	5	56%
SCAPEGOAT	2	1	50%
LOST CHILD	1	0	0%
MASCOT	6	4	67%
<b>TOTALS</b>	<b>20</b>	<b>11</b>	<b>55%</b>

**CORRELATION BETWEEN FAMILY ROLE AND DRINKING PROBLEMS**

When the existence of personal drinking problems is correlated with the gender of the respondents, the results which occur are different from what might be predicted in a similar group of Anglo adult children of alcoholics. That is, most researchers predict a 40-60%

occurrence of drinking problems among children of alcoholics, and predict the higher rates to be among male children.

In this sample, eight of the twelve female respondents, or 67%, reported drinking problems, while only three out of eight of the male respondents, or 37.5%, acknowledged personal drinking problems. Possible explanations of the relatively high rate of drinking problems for female respondents and the correspondingly low rate for male respondents are two-fold.

The high female rate may reflect a gender difference in willingness to disclose personal problems. The traditional Mexican/American male, on the other hand, must appear as a strong and able provider, without any problems.

Another explanation is that acculturation increases women's participation in drinking activities and when this happens, the amount of drinking by the men who are present is reduced. (See Figure 13 on following page).

**FIGURE 13**

RESPONDENTS		HAVE HAD DRINKING PROBLEMS	%
FEMALE	12	8	67%
MALE	8	3	37.5%
TOTALS	20	11	55%

**CORRELATION BETWEEN GENDER AND PERSONAL DRINKING PROBLEMS**

## CHAPTER V

### SUMMARY AND CONCLUSIONS

The concept of treating non-alcoholic members of alcoholic families or "co-dependents" is relatively new, with little existing research. The current theoretical concepts are based on clinical experience with primarily white, middle class families. The purpose of this project was to obtain information about the accuracy of the prevailing theoretical model of family roles of co-dependents in alcoholic families when applied to Mexican/American families.

The specific aims of the research were to determine: 1) whether the family roles of co-dependents in Mexican/American families are common to the current theoretical model developed by Black and Wegscheider; and 2) whether other roles exist in Mexican/American families which are not found in that model.

Twenty interviews were conducted with Mexican/American adult children of alcoholics currently residing in Santa Clara, Santa Cruz and San Mateo counties. The sample consisted of twelve females and eight males with a mean age of 39.8 years.

The majority of respondents, 13, had some college education or better, and 18 of 20 had at least a high school education. Eighty percent were employed at the paraprofessional or professional level. The results of the acculturation assessment portion of the interview schedule showed the majority of the sample fell into a highly acculturated, second generation category with both parents born in the United States and both sets of grandparents born in Mexico.

Parental alcoholism was acknowledged as a problem which had affected the subject's life by all respondents. Fourteen subjects cited their father as the alcoholic parent, one subject identified his or her mother, and in five families, both parents were identified as alcoholics. The researchers know of no study which breaks down the incidence of alcoholism by gender of parent; however, in our country it is a well accepted fact that alcoholism is more prevalent among males than females. Therefore this sample with 19 alcoholic fathers and six alcoholic mothers is probably within the norm.

From the information obtained from this sample of twenty families, it appears that the theoretical family roles which have been derived from work with primarily

Anglo alcoholic families are indeed applicable to the family roles in Mexican/American alcoholic families whose members are primarily second generation and highly acculturated.

Wegscheider (1981) identifies and describes five roles which are adopted by co-dependents in order to provide more structure and stability in the family system in response to the alcoholic's decreased ability for healthy functioning. Each of these roles were described to the respondents, who were then asked whether any member of their families fit the description. The Chief Enabler role was identified in 15 families; the Hero role in all 20 families, the Scapegoat role in 18 families, the Lost Child role in 17 families, and the Mascot role in 12 families. The cumulative frequency of the existence of the identified roles was 82%.

The second thrust of the research was to look for other roles, yet unidentified, which might exist in Mexican/American alcoholic families. The twenty households which made up this study included 92 children, 40 parents and one extended family member. In the total group, there were eight family members who did not appear to fit Black and Wegscheider's model.



The first of these were two female children whose primary coping pattern was to absent themselves physically from the alcoholic family. Unlike Lost Children who absent themselves by retreating to their rooms or into their fantasy worlds, these members took on what the researchers call the Absent Child role, and were rarely at home. They preferred to spend all their free time at the homes of their friends and in other outside-the-home activities. In Wegscheider's theoretical framework, the Scapegoat also withdraws from the family, spends increasing amounts of time away from home, and relies on his peers to fill his unsatisfied need for belonging. But the Scapegoat typically gets into increasing amounts of trouble, which was not the case for these two young women. Therefore the researchers consider this role to be nonconforming to the prevailing theoretical model. It is unclear whether this role is culturally specific to Mexican/American families or could be generalized to any alcoholic family.

"Macho", the Spanish word for male, has many secondary meanings. It was used by five respondents to describe a male sibling. In three cases, the Macho sibling was described in positive terms, as being

dignified and as commanding the love and respect of other family members. In the other two cases, the Macho role was described in negative terms as arrogant, overbearing, and without concern for others, especially women.

The Positive Macho role is similar to the Hero role in the projection of a positive image, but different in two important ways. First, the Positive Macho role is gender specific to males, while the Family Hero role is not. Second, the Positive Macho role commands high personal regard from other family members, while in the dominant culture, Heros are often so compulsively driven to achieve that their interpersonal skills remain underdeveloped, isolating them from friends and family members. This does not seem to be the case for Positive Machos in Mexican/American families. Both aspects of the Positive Macho reflect the influence of traditional family roles in Mexican/American families as discussed by Caetano (1987) and Panitz, et al. (1983).

The Negative Macho role bears some resemblance to the Scapegoat role in its aggressive, hostile qualities. However, this role, like its positive counterpart, is culturally based and gender specific to

males. Panitz points out that exhibiting Negative Macho traits will most likely elicit negative responses from the majority culture and its institutions, resulting in unfortunate consequences for which the time honored remedy of the Mexican/American culture is alcohol. This could mean that Negative Machos, like Scapegoats, are particularly at risk for chemical dependency, or the ultimate physical damage, suicide.

The final role which fell outside the existing theoretical framework was that of an extended family member. This person was the alcoholic parent's mother, who lived with the family. She was described as an "arrimada", or someone who feels unwanted, burdensome and has a martyr-like attitude. In behavior this grandmother would most resemble a Chief Enabler because she was described as always smoothing things over for her alcoholic son.

Of the four nonconforming roles discussed above, the three roles of Positive Macho, Negative Macho and Arrimada are roles which the researchers believe to be culturally determined family roles or cultural variations of existing roles, possibly unique to Mexican/American alcoholic families. Because of the small size of the sample, more research is needed in

order to determine whether these findings about family roles in Mexican/American alcoholic families can be generalized.

The final part of the study explored patterns of alcohol consumption by respondents and assessed the existence of personal drinking problems among them. Fourteen of the 20 respondents were current drinkers at the time of the interview, and 11 respondents, or 55%, acknowledged personal drinking problems. Since most current research predicts that, without intervention, 40-60% of children of alcoholics become alcoholic themselves, this figure falls within the expected norm. (Ackerman, 1981) Researchers further predict that sons of alcoholics are four times more likely than other sons to become alcoholics, while daughters of alcoholics are three times more likely to become alcoholics. (Woodside, 1988) However, in this study, eight of the 12 female respondents, or 67%, reported drinking problems, while only three out of eight of the male respondents, or 37.5%, acknowledged personal drinking problems.

There are several possible explanations of the relatively high rate of reported drinking problems for female respondents and the correspondingly low rate for

male respondents. The high female rate may simply reflect a sex role difference in willingness to disclose personal problems. The traditional Mexican/American male must appear as a strong and able provider, without any problems. Also, Panitz (1983) points out that the structure, dynamics and value systems of the traditional Mexican/American family seem to encourage alcohol abuse by men, as well as the on-going denial of this abuse. As the family provider, the male feels justified in participating in heavy drinking with his friends after a hard day's work. Women, concerned with the security of their children, are likely to tolerate their husband's drinking as long as he provides adequately and does his heavy drinking outside the home. Hence the reporting of fewer drinking problems among the male respondents.

Another possible explanation relates to the effects of acculturation on Mexican/American families. Caetano and Medina-Mora (1986) have found that Mexican/American women who rank high in acculturation have more liberal attitudes toward alcohol consumption than other Mexican/Americans. Jean Gilbert's research (1985) also suggests that acculturation increases women's participation in drinking activities, and that when

this happens, the amount of drinking by the men present is reduced. However, Gilbert found that in general, the rate of alcohol abstinence declined in progressing generations, while the rate of frequency of daily drinking increased.

In conclusion, it seems fair to say that this study serves to underscore the results of current epidemiological research dealing with patterns and effect of alcohol use and abuse in Mexican/American families. The sample used in this study, though small in size, apparently reflects the larger scene quite accurately.

Recommendations for Future Research: Currently, a wide body of literature exists which describes the theoretical model of family roles in an alcoholic family used in this study. However, this model is based on clinical findings and case narrative, and, as yet, there has been little research to validate the clinical observations. Although this model has become popular in the alcohol treatment and education fields, and clinicians often view co-dependents within the framework of the five typical roles, (chief enabler, hero, scapegoat, lost child, mascot), research on these roles is sparse. More studies such as this one are

needed to confirm or deny this model, as well as to explore the long-term implications for co-dependents. Long-term research could be critical in providing a more solid foundation for prevention and intervention efforts by practitioners to help members of both mainstream and minority alcoholic families. Similar studies could also use control groups of Mexican/American families without alcoholism evident or families with differing levels of acculturation to test the model further.

To date, most studies which look at alcoholism in Mexican/American families are epidemiological in nature. The one known exception to this is the more clinically oriented study of alcoholism and Mexican/American families in the San Jose area by Dr. Jose Cuellar of the Pacific Institute of Research and Evaluation in Berkeley, soon to be released. This and other such studies are greatly needed to increase clinical knowledge and cultural awareness of family structure and dynamics in the alcoholic households of one of this country's fastest growing minority groups. Sociocultural issues could be a major factor in determining the ability of members of Mexican/American families of alcoholics to both access and to

participate in treatment.

Implications for Practice: This study appears to confirm the validity of the prevailing theoretical family role model when applied to Mexican/American alcoholic families. This information could have diagnostic implications for practice. Specifically, it could be used to enhance the predictive abilities of a practitioner working with this population. Finding evidence of one or more family members assuming roles of the theoretical model should alert practitioners of the possibility of the existence of family alcoholism.

This study also has pointed out the importance of being aware of the influence of traditional, sexually defined family roles as well as the influence of the level of acculturation on family members when working with Mexican/American alcoholic families. Practitioners also should be on the alert for unique versions or culturally determined variations of the roles seen in mainstream alcoholic families. And finally, practitioners must be aware of the possibility of an increasing rate of alcoholism among highly acculturated, at risk Mexican/American females, and the possibility of a strong, culturally based denial of drinking problems among Mexican/American men.



Ethics and Public Policy Issues: An ethical problem that is present in much of the research concerning children of alcoholics is the identification of subjects as potential alcoholics. Although this identification can be helpful in motivating prevention efforts, it can also be harmful if the label is used to abridge an individual's rights and opportunities, or, in a more subtle way, if it changes the expectations of parents, teachers, bosses or peers. This points up the need for adequate confidentiality protections, especially in school-based or work-based programs. This ethical problem can be magnified two-fold when applied to children of alcoholics who are also children of acculturation. Even greater care must be exercised in efforts to provide services to these populations.

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**APPENDICES**

**APPENDIX: A****PERMISSION TO SOLICIT FOR RESEARCH VOLUNTEERS**

I, the undersigned officer of \_\_\_\_\_  
\_\_\_\_\_, agree to the solicitation of volunteers to participate in a research study investigating family roles in Mexican/American alcoholic families. The investigators are Debbie Hunt and Mark Rowe, graduate students at the SJSU School of Social Work. I understand that this solicitation will occur during the business portion of said meeting and will not interfere with the main program. I further understand that complaints about procedures may be presented to Dr. Diane Schaffer, Special Project Chairperson at (408) 924-5800. I have received a copy of this form for my file.

---

**DATE**

---

**OFFICER'S SIGNATURE**

---

**INVESTIGATOR'S SIGNATURE**



**APPENDIX B: FLIER****SJSU SCHOOL OF SOCIAL WORK: MASTER'S RESEARCH PROJECT**

**SINCE LITTLE RESEARCH HAS BEEN DONE ON THE EFFECTS OF ALCOHOLISM IN MEXICAN/AMERICAN FAMILIES, WE ARE INVESTIGATING FAMILY ROLES IN JUST SUCH FAMILIES. IF YOU GREW UP IN A MEXICAN/AMERICAN HOME WHERE ALCOHOL WAS RECOGNIZED AS A PROBLEM, AND WOULD LIKE TO VOLUNTEER TO COMPLETE A 30-45 MINUTE CONFIDENTIAL INTERVIEW, PLEASE CONTACT US AT:**

**DEBBIE HUNT  
STUDENT BOX 46           OR  
(415) 851-8125 (MESSAGE)**

**MARK ROWE  
STUDENT BOX 82  
(408) 286-8388 (EVES.)**

## Appendix C: Consent Form

**AGREEMENT TO PARTICIPATE IN RESEARCH AT SAN JOSE STATE UNIVERSITY****RESPONSIBLE INVESTIGATOR: Debbie Hunt/Mark Rowe****TITLE OF PROTOCOL: Family Roles in Mexican American Alcoholic Families**

I have been asked to participate in a research study that is investigating family roles in Mexican/American alcoholic families. The results of this study should further our understanding of how the family members survive and adapt in an alcoholic family of this cultural background.

I understand that:

- 1) I will be asked to answer about 60 questions during an interview administered by Debbie or Mark, which will last 30-45 minutes.
- 2) The possible risks of this study are the discomfort of self disclosure or sadness associated with family memories.
- 3) The possible benefits of this study to me are to have an increased awareness of the effects of growing up in an alcoholic family and the possible decision to get help for unresolved issues.
- 4) The results from this study may be published, but any information from this study that can be identified with me will remain confidential and will be disclosed only with my permission or as required by law.
- 5) Any questions about my participation in this study will be answered by Debbie Hunt/Mark Rowe, (415) 851-8125, (408) 286-8388. complaints about the procedures may be presented to Dr. Diane Schaffer, Special Project Chairperson at (408) 924-5800. For questions or complaints about research subject's rights, or in the event of research-related injury, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies and Research) at (408) 924-2480.
- 6) My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with San Jose State University.
- 7) I have received a copy of this consent form for my file.

**I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE.**

---

 DATE

---

 SUBJECT'S SIGNATURE

---

 INVESTIGATOR'S SIGNATURE

Interview Schedule: Demographic Information

1. What is your birthdate? \_\_\_\_\_
  
2. Sex of respondent.  
     male  
     female
  
3. How many brothers and sisters were in the family you grew up in?  
     brothers  
     sisters
  
4. Can you tell me their first names and sex starting with the oldest and ending with the youngest? Be sure to include yourself in the list.
  
  
5. Respondent's birth order in family. \_\_\_\_\_
  
6. What is the highest grade in school you have completed?  
    Grade 12 or less \_\_\_\_\_  
     High School Diploma  
     GED  
     Some College /Undergraduate  
     Completed College  
     Graduate School
  
7. What kind of work do you do?  
     Homemaker  
     Farmworker  
     Paraprofessional  
     Student  
     Professional  
     Other Specify \_\_\_\_\_
  
8. What is your marital status?  
     single  
     married  
     separated  
     divorced  
     widowed  
     living with someone as though married

ACCULTURATION RATING SCALE FOR MEXICAN AMERICANS

82

ADAPTED FROM

(Cuellar, Harris, Jasso, 1980)

- 9) If you were not born in the United States, how old were you when you immigrated?
- 10) How many years have you lived in the United States?  
 Less than 5  
 5 - 10  
 10 - 20  
 20 +
- 11) In what country was your mother born? \_\_\_\_\_  
(If in US) And in what country were her parents born? \_\_\_\_\_  
In what country was your father born? \_\_\_\_\_  
(If in US) And in what country were his parents born? \_\_\_\_\_
- 12) What languages do you speak?  
 Spanish  
 Bilingual  
 English  
 Other ie: French \_\_\_\_\_
- 13) What language do you speak at home?  
 Spanish  
 Bilingual  
 English  
 Other \_\_\_\_\_

- 14) Can you read in Spanish?  
 Yes  
 No
- 14a) (If yes) How well would you say you read Spanish?  
 Fluently  
 Some  
 Very Little
- 15) Can you read in English?  
 Yes  
 No
- 15a) (If yes) How well would you say you read English?  
 Fluently  
 Some  
 Very Little
- 16) Which radio and T.V. programming do you prefer?  
 Spanish  
 English  
 Both
- 17) How much contact do you have with Mexico?  
 Visit regularly  
 Visit occasionally  
 Never visit

FAMILY ALCOHOLISM

84

To better understand the effects of alcoholism on the family members of Mexican/American families, I would like to ask you some questions about your childhood and adolescence.

- 18) Were one or both of your parents alcoholic?
- 19) Did your mother/father drink alcohol also?
- 20) Did anyone else in the household drink a lot? (if yes)  
Was your \_\_\_\_\_ alcoholic?
- 21) Did the alcoholic person(s) in your family ever seek help for the problems related to alcoholism?
- 22) Have you ever sought out counseling to help yourself with problems or feelings related to your parent's alcoholism?
- Individual treatment
  - Family treatment
  - Group counseling
  - Self help group(Al-Anon/ACOA)
- 23) Did any other members of your family ever seek help for problems associated with your parent's alcoholism?
- 
- 23a) If yes, did they go to:
- Individual treatment
  - Family treatment
  - Group counseling
  - Self help group(Al-Anon/ACOA)

## Alcoholic Family Roles

85

In order to survive the stress and pain associated with having an alcoholic parent or parents, the children and other family members often take on roles and behaviors which allow them to cope with this problem and bring more stability into their lives. Please listen to the following description and then tell me if it sounds like anyone in the family you grew up in. . .

### Family Role #1

This person is the one the alcoholic depends on the most to make excuses for the alcoholic related behavior, and to hide or fix the alcoholic's mistakes. This person sometimes will lie for the alcoholic and often takes on more family responsibilities as the alcoholic becomes less responsible. This person almost always puts other peoples' needs first.

24. So far, does this sound like anyone in your family? \_\_\_\_\_  
(If YES) What was \_\_\_\_\_'s health like?

Another form of this role is a person who spends a lot of energy trying to control the alcoholic and frequently confronts the alcoholic about the drinking, creating a lot of friction.

25. Did you or anyone else in your family ever take on this role? If YES, record first name, sex, and birth order/family position.

- 
26. Was there anything else that \_\_\_\_\_ did that might be important for us to know?

27. What is (his/her) life like now in terms of (his/her):

- A. Family life?
- B. Job?
- C. Physical Health?

28. Did anyone else take on this role? (If yes, repeat questions 2 and 3.)

Family Role #2

86

This person is very responsible, hard working and organized. This person often excels at school, can be a star athlete, does what is right and is usually quite serious. This person brings pride and honor to the family.

29. Did you or anyone else in your family ever have to take on this role? If YES, record first name, sex, and birth order/family position.

- 
30. Was there anything else that \_\_\_\_\_ did that might be important for us to know?

31. What is (his/her) life like now in terms of (his/her):
- A. Family life?
  - B. Job?
  - C. Physical Health?

32. Did anyone else take on this role? (If yes, repeat questions 2 and 3.)

Family Role #3

This person often breaks rules or gets into trouble. He or she often does poorly at school, and may drop out or get pregnant in their mid teens. This person may begin to use drugs and alcohol at an early age. This person uses negative behavior to get attention from the family.

33. Did you or anyone else in your family ever have to take on this role? If YES, record first name, sex, and birth order/family position.

- 
34. Was there anything else that \_\_\_\_\_ did that might be important for us to know?



35. What is (his/her) life like now in terms of (his/her):
- A. Family life?
  - B. Job?
  - C. Physical Health?

87

36. Did anyone else take on this role? (If yes, repeat questions 2 and 3.)

Family Role #4

This person is quiet, independent, and stays out of everyone's way. He or she spends a lot of time alone, often in their room. This person may spend many hours watching TV, listening to music or doing creative projects. This person may be overweight, and, as a young child, may have had imaginary friends

37. Did you or anyone else in your family ever have to take on this role? If YES, record first name, sex, and birth order/family position.

- 
38. Was there anything else that \_\_\_\_\_ did that might be important for us to know?

39. What is (his/her) life like now in terms of (his/her):
- A. Family life?
  - B. Job?
  - C. Physical Health?

40. Did anyone else take on this role? (If yes, repeat questions 2 and 3.)

Family Role #5

This person provides relief and humor by being funny and charming during stressful times. This person is usually active and can be hyperactive. He or she jokes around a lot and likes to be the center of attention. This person is very likeable and may be considered the "family pet".

41. Did you or anyone else in your family ever have to take on this role? If YES, record first name, sex, and birth order/family position.

88

- 
42. Was there anything else that \_\_\_\_\_ did that might be important for us to know?
43. What is (his/her) life like now in terms of (his/her):  
A. Family life?  
B. Job?  
C. Physical Health?
44. Did anyone else take on this role? (If yes, repeat questions 2 and 3.)

Family Role #6 "Other"

45. Have we covered all the family members or have we left someone out?
46. How would you describe \_\_\_\_\_'s role?
47. How would you describe \_\_\_\_\_'s attitudes and behaviors?
48. Was there anything else that \_\_\_\_\_ did that might be important for us to know?
49. What is (his/her) life like now in terms of (his/her):  
A. Family life?  
B. Job?  
C. Physical Health?

- 50) Do any of your brothers drink wine, beer or liquor presently? If yes, how many brothers drink? \_\_\_\_\_
- 50a) Have any of them had problems with drinking? If yes, how many? \_\_\_\_\_
- 51) Do any of your sisters drink wine, beer or liquor presently? If yes, how many sisters drink? \_\_\_\_\_
- 51a) Have any of them had problems with drinking? If yes, how many? \_\_\_\_\_
- 52) Do you drink wine, beer or liquor presently?
- 53) Have you ever had problems with drinking?

Offer the interviewee the M.A.S.T. and scoring key, to be taken home for self testing and scoring. Provide the respondent with the Alcoholics Anonymous referral phone number for the area.

## M.A.S.T. TEST

1. Do you feel you are a normal drinker? YES \_\_\_\_\_ NO \_\_\_\_\_
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening before? YES \_\_\_\_\_ NO \_\_\_\_\_
3. Does your spouse (or parents) ever worry or complain about your drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
4. Can you stop drinking without a struggle after one or two drinks? YES \_\_\_\_\_ NO \_\_\_\_\_
5. Do you ever feel bad about your drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
6. Do friends or relatives think you are a normal drinker? YES \_\_\_\_\_ NO \_\_\_\_\_
7. Do you ever try to limit your drinking to certain times of the day or to certain places? YES \_\_\_\_\_ NO \_\_\_\_\_
8. Are you always able to stop drinking when you want to? YES \_\_\_\_\_ NO \_\_\_\_\_
9. Have you ever attended a meeting of Alcoholics Anonymous (AA)? YES \_\_\_\_\_ NO \_\_\_\_\_
10. Have you gotten into a fight while drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
11. Has drinking ever created problems with you and your spouse? YES \_\_\_\_\_ NO \_\_\_\_\_
12. Has your spouse (or other family members) ever gone to anyone for help about your drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
13. Have you ever lost friends or girl friends/boy friends because of drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
14. Have you ever gotten into trouble at work because of drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
15. Have you ever lost a job because of drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
16. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
17. Do you ever drink before noon? YES \_\_\_\_\_ NO \_\_\_\_\_
18. Have you ever been told you have liver trouble? YES \_\_\_\_\_ NO \_\_\_\_\_
19. Have you ever had delirium tremens (D.T.'s), severe shaking, heard voices or seen things that weren't there after heavy drinking? YES \_\_\_\_\_ NO \_\_\_\_\_
20. Have you ever gone to anyone for help about your drinking? YES \_\_\_\_\_ NO \_\_\_\_\_

**M.A.S.T. TEST - continued**

21. Have you ever been in a hospital because of drinking? YES \_\_\_ NO \_\_\_
22. Have you ever been a patient in a psychiatric hospital or in a psychiatric ward of a general hospital, where drinking was part of the problem? YES \_\_\_ NO \_\_\_
23. Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking had played a part? YES \_\_\_ NO \_\_\_
24. Have you ever been arrested, even for a few hours, because of drunk behavior? YES \_\_\_ NO \_\_\_
25. Have you ever been arrested for drunk driving or driving after drinking? YES \_\_\_ NO \_\_\_

MAST SCORE:

---

MAST SCORING KEY

92

- |     |     |     |    |     |        |     |     |    |     |
|-----|-----|-----|----|-----|--------|-----|-----|----|-----|
| 1.  | YES | ___ | NO | _2_ | 16.    | YES | _2_ | NO | ___ |
| 2.  | YES | _2_ | NO | ___ | 17.    | YES | _2_ | NO | ___ |
| 3.  | YES | _1_ | NO | ___ | 18.    | YES | _2_ | NO | ___ |
| 4.  | YES | ___ | NO | _2_ | 19.    | YES | _2_ | NO | ___ |
| 5.  | YES | _1_ | NO | ___ | 20.    | YES | _3_ | NO | ___ |
| 6.  | YES | ___ | NO | _2_ | 21.    | YES | _3_ | NO | ___ |
| 7.  | YES | _1_ | NO | ___ | 22.    | YES | _3_ | NO | ___ |
| 8.  | YES | ___ | NO | _2_ | 23.    | YES | _2_ | NO | ___ |
| 9.  | YES | _3_ | NO | ___ | 24. *  | YES | _2_ | NO | ___ |
| 10. | YES | _1_ | NO | ___ | 25. ** | YES | _2_ | NO | ___ |
| 11. | YES | _2_ | NO | ___ |        |     |     |    |     |
| 12. | YES | _2_ | NO | ___ |        |     |     |    |     |
| 13. | YES | _2_ | NO | ___ |        |     |     |    |     |
| 14. | YES | _2_ | NO | ___ |        |     |     |    |     |
| 15. | YES | _2_ | NO | ___ |        |     |     |    |     |

NOTES: \* 2 Points for each drunk behavior arrest.  
\*\* 2 Points for each DUI, drunk driving arrest.

SCORING:

- |         |   |
|---------|---|
| 1-5     | Probably Not Alcoholic (Could Be Problem Drinker) |
| 6-10    | Potential Alcoholic (Most Likely Problem Drinker) |
| 11-20   | Definitely Alcoholic                              |
| Over 21 | Chronic Alcoholic                                 |

A.A. Referral Tel. No. (415) 573-6811 or (408) 297-3555



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# SAN JOSE STATE UNIVERSITY FOUNDATION

December 8, 1988

✓  
Debbie Hunt  
145 Bear Gulch Drive  
Portola Valley, CA 94025

Mark Rowe  
1503 Padres Court  
San Jose, CA 95125

Dear Ms. Hunt and Mr. Rowe:

Your human subjects protocol number #7378 has received final approval from the Human Subjects Institutional Review Board. Attached is a copy of the final approval form with the signatures of the Chairman of the Human Subjects Institutional Review Board, Dr. Robert Hyde, and the Associate Academic Vice President for Graduate Studies and Research, Dr. Serena Stanford.

Please note that Dr. Stanford approved your protocol with the "stipulation that no solicitation occurs at SJSU." This means that "no students and/or faculty are to be involved from the School of Social Work, even if they express an interest in participation."

If you have any questions regarding this condition for approval, please call me at (408) 924-1437 or contact Dr. Stanford's office at (408) 924-2480.

Congratulations and good luck with your research!

Sincerely,

Jerelyn Cockriel  
Contracts and Grants Coordinator

Attachment

SAN JOSE STATE UNIVERSITY  
GRADUATE STUDIES AND RESEARCH

HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD  
PROJECT PROPOSAL REVIEW

I, the undersigned member of the San Jose State University Human Subjects Institutional Review Board, have reviewed the following proposal submitted to the Committee on October 26, 1988 by:

PRINCIPAL INVESTIGATOR: Debbie Hunt and Mark Rowe  
PROTOCOL #: 7378 DEPT.: Social Work  
PROJECT TITLE: FAMILY ROLES IN MEXICAN/AMERICAN ALCOHOLIC FAMILIES

I recommend the following action (indicate one):

- 1. Approved for clearance as involving minimal risk to Human Subjects.
- 2. Approved for clearance with risk to Human Subjects.
- 3. Approved for clearance when the following conditions are met:

4. Not Approved (return to principal investigator for following reasons):

5. Expedited Review (specify condition[s] that merit expedited review):

Joni Campbell 11/1/88  
Signature of IRB-HS member Date

OFFICIAL SIGNING FOR INSTITUTION  
[Signature]  
Chair, Human Subjects Institutional Review Board Date 10/2/88

Serena Stanford  
Serena Stanford, Ph.D. Date 12-5-88  
AAVP for Graduate Studies & Research

NOT APPROVED  
w/o CORRECTIONS  
NOTED  
HERE  
10/14/88

- ① No permission forms from Al-Anon or A&A groups included
- ② Phone numbers on consent form are incorrect
- ③ No mention is made of possible Hispanic problems - is your research to be done exclusively with English speakers? If not, where is translation?

San Jose State University Foundation  
One Washington Square  
San Jose, CA 95192-0139 (408) 924-1435

④ Use of volunteers within School of Social Work is invasive; disclosure to fellow students and students of current faculty is invasion of privacy that cannot be accepted when ongoing contact is expected.

Approved with  
modification that  
no publication occur  
at SJSU  
#4



COVER SHEET APPLICATION FORM

Prin. Investigator Debbie Hunt & Mark Rowe Title Graduate Students  
 Title of Project Family Roles in Mexican/American Alcoholic Families  
 Home Address 145 Bear Gulch Dr., Portola Valley, CA 94025- (415)851-8124  
1503 Padres Ct., San Jose, CA 95125 Home Phone (408)286-8388  
 (include city and zip)

Department School of Social Work Work Phone (408)924-5800

Funding Agency (if any) N/A Date (to be) \_\_\_\_\_  
 Submitted to Agency \_\_\_\_\_  
 Date \_\_\_\_\_

Proposed Duration of Project: From 1 Jul 88 to 1 May 89 Submitted to CPHS \_\_\_\_\_

Names/Titles of all investigators--If a student, include name of faculty advisor.

Debbie Hunt/Mark Rowe - Students  
Dr. Diane Schaffer, Faculty Advisor

Previous History of this Protocol.

New X Modification \_\_\_\_\_

Annual \_\_\_\_\_ Previous No. \_\_\_\_\_

Approval Date \_\_\_\_\_

Does this submission differ in any way from the previously approved protocol?

Yes \_\_\_\_\_ No \_\_\_\_\_

Any differences should be explained in your protocol.

Brief description of all procedures involving human subjects.

Administer a 30-45 min. interview  
to volunteer Mex/Amer. members of  
SJSU School of Social Work or Adult

Children of Alcoholics support groups.  
Participation will be solicited during  
the business portion of said mtgs.

The interview will be scheduled after  
the mtgs. and will be completed at  
the volunteer's convenience.

Subjects--Explain in detail in the protocol:

No. of Subjects Involved 20-30

Subject Population Mex/Am. Adult Children  
of Alcoholic Families

Compensation None

Control Group Involved? No

Documentation of Informed Consent-type requested.

Written \_\_\_\_\_ Short Form \_\_\_\_\_

Modification of Procedures \_\_\_\_\_

Please describe in detail in protocol and submit a copy of the form to be used.

Special Procedures \_\_\_\_\_

Radioactive material to be used? \_\_\_\_\_

What Isotopes? \_\_\_\_\_

Authorization date form Radiation Safety Committee--Approved \_\_\_\_\_

Drugs to be used? \_\_\_\_\_ IND's \_\_\_\_\_

Has FDA approval been obtained if IND (Investigational New Drug)? \_\_\_\_\_  
 Date \_\_\_\_\_

Unusual Electrical Devices to be used? \_\_\_\_\_

Has Environmental Health and Safety approval been obtained? \_\_\_\_\_  
 Date \_\_\_\_\_

SAN JOSE STATE UNIVERSITY  
SCHOOL OF SOCIAL WORK

**APPROVED**

EXAMINING BOARD:

Jose D. Wells  
Pauline Spaché MD  
Deane M. Schaff

DATE: May 16 1989