

**THE EXPERIENCES OF COUPLES
IN RELATIONSHIPS
CHARACTERIZED BY ALCOHOL DEPENDENCY**

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ABSTRACT

The study focused on the experiences of Xhosa-speaking couples in relationships characterized by alcohol dependency. The goal was to generate greater understanding of the descriptions of relationship issues faced by alcohol dependent respondents and their partners. Specifically, the study focused on exploring how the alcohol dependent respondents relate to their partners, their behaviour at home when drinking prior to their admission for rehabilitation, the experiences of their partners in living with alcohol dependent partners and how they coped with the situation. In order to meet this goal, literature and empirical studies were conducted. The literature study focuses on the alcohol dependent individual's behaviour, his emotions, relapse, the family's coping strategies, alcohol and marital problems and the role of the social worker as part of the rehabilitation team.

During the empirical research phase, a non-probability purposive sampling procedure was adopted. Fifteen alcohol dependent clients who were admitted for treatment and rehabilitation at Thembelitsha Rehabilitation Centre (TRC) were selected. These clients were admitted to TRC during the period starting from January 1997 to June 1999 and were discharged to their homes during the research study. To collect data, interviews were conducted separately to a total of thirty respondents. Two interview schedules were used, one for the alcohol dependent respondents (Appendix A) and the other for their partners (Appendix B).

This study revealed a remarkable consistency in the descriptions of relationship issues faced by alcohol dependent respondents and their partners. These are abusive behaviours by alcohol dependent respondents. The partners were reluctant and feared challenging the behaviour.

The way in which partners responded to drinking and the reactions of alcohol dependent respondents are indicative of the difficult issues faced by the couples. The study also revealed that couples experience communication, financial and sexual relationship problems. The study concludes with recommendations based on the research findings.

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INTRODUCTION

TO

THE STUDY

CHAPTER 1.

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

In South Africa, as in many countries throughout the world, alcohol dependency is considered a major social problem which affects not only the dependent individual, but also his family, the community and society in general (Swart 1995:2). According to Sartor (1998:1), the repetitive use of alcohol impairs the individual's physical, psychological, spiritual and social functioning. The problems caused by alcohol dependency can put stress on the family in a number of ways (National Institution on Alcohol Abuse and Alcoholism 1996:3). The family relationships become strained because of the abusing individual's change in mood and behaviour patterns. This may, and often results in physical violence and emotional abuse (Parry, Pluddemann, Bhana, Bayley and Potgieter 2000:1; Leonard and Quigley 1996:537; Gelles and Loseke 1993:182). In their struggle to cope, the family members become involved in behaviours that are not constructive for themselves nor for the alcohol dependent individual (South African National Council on Alcohol and Drug Dependence 1999:5)

Umtata, which is in the Eastern region of the Eastern Cape province is no exception to the problem of alcohol dependency. A study conducted in Umtata amongst large scale government employees, confirms that there is alcohol dependency in Transkei (Maphoyi 1991:16). The report in the statistical bulletin of 1992 (Msengi 1990:1) reflects that approximately 4 million people live in the Transkei and among them there may be as many as 48 000 alcohol dependent individuals.

Prior to the establishment of a rehabilitation centre for alcohol dependency in Umtata the service was provided by the psychiatric unit of Umtata General Hospital. A group of

concerned Transkeians, several of whom were already involved in the treatment and rehabilitation of alcohol dependent individuals formed an organization for the purpose of erecting a rehabilitation centre. The centre was called Thembelitsha (a Xhosa name for a new hope) and has been providing services for the alcohol dependent individuals and their families since 1994.

1.2. **REASONS FOR THE CHOICE OF RESEARCH SUBJECT**

The social worker is often the first person to be approached by the family, employer or by the dependent individual. One of the primary roles of the social worker is that of assessing the seriousness of the problem and linking the dependent person with treatment (Leibovits 1991:4).

I am employed by the Department of Welfare since December 1990. During my first five years of my practice, I was attached to the psychiatric unit of Umtata General Hospital. Apart from other duties, I was involved in the rehabilitation of alcohol dependent clients. I experienced working with alcohol dependent clients as the most complicated and challenging task. During my practical experience with alcohol dependent clients, I have noted with great concern and interest the following:

- Although the alcohol dependent clients clearly understood their problems and co-operated fully during the treatment and rehabilitation process, some relapsed immediately after returning back to their families.
- When the alcohol dependent clients relapsed and absented themselves from work, their non-drinking partners did not hesitate to come and arrange for sick leave for their partners.

- The alcohol dependent clients reported a number of complaints when they came for aftercare services, such as, among others, feelings of non-acceptance by their families, boredom and loneliness.
- The non-drinking partners reported that their alcohol drinking partners behaved in a challenging manner when they were drunk.
- In some instances the non-drinking partners reported their dependent partners as drinking during weekends only, while they were drinking everyday.

The above situations have stimulated my interest to explore the experiences of couples in relationships characterized by alcohol dependency.

1. 3. **AREA OF STUDY**

The study was conducted in Umtata which is part of the Eastern Cape Province.

Umtata was the capital town of the former Transkei which was granted semi-independence by the former “White” South African government in 1976. The Eastern Cape is predominantly rural in character and it is classified as the second poorest province in South Africa (Household Survey Central Statistical Services 1995: 1).

According to the Human Science Research Council annual report on poverty, Transkei areas of the Eastern province have high levels of poverty, and as a result, this area has been allocated R13 million to relieve poverty (The Daily Dispatch 20 September 2000:4).

Umtata is in the Eastern region of the Eastern Cape province. The province is divided into five regions namely, Western (A), North (B), Central (C), Eastern (D) and North Eastern regions (E). According to the 1996 Population Census provided by the National Central

Statistics Services, the total population of Umtata is 261123 (Human Science Research Council 1999:3).

1.3.1. **Welfare services for alcohol dependent clients**

According to the records in the Department of Welfare, the professional welfare services in Umtata are provided by the magisterial and hospital social workers. The number of social workers in these service centers is eight at the magisterial offices and five at the general hospital and it includes two supervisors. These social workers are employed by the Department of Welfare. As stated in the previous section, this area is one of the previous disadvantaged areas of the Eastern Cape province and it has limited resources focusing on alcohol dependency, hence Thembelitsha is the only rehabilitation centre in Umtata. Thembelitsha is a non-governmental organization but its staff members are seconded by the Department of Health. As a non-governmental organization, the centre depends on the government subsidy from the Department of Welfare, fund-raising and donations for funding its programme. At present, this centre has no social worker.

1.4. **DEFINITION OF CONCEPTS**

The concepts used in this chapter are defined as follows:

1.4.1 **Alcohol dependency**

According to Cochraine (1994:6), when one uses alcohol excessively, one's body becomes dependent physically or psychologically. Physical dependence occurs when the body gets used to the presence of alcohol and starts to need it in order to function, whereas psychological dependence occurs when the individual believes that they need to carry on taking alcohol in order to cope with life. In line with this definition, Langenbucher, Chung,

Morgenstern, Labouvie, Nathan and Bavly (1997:341) maintain that tolerance, withdrawal and use of alcohol to avoid withdrawal are the main aspects of physiological dependence in alcohol dependency.

1.4.2 **Alcohol dependent individuals**

Alcohol dependent individuals are those excessive drinkers whose dependence on alcohol has attained such a degree that they show a noticeable mental disturbance or interference with their bodily or mental health, their personal relations and their smooth economic functioning, or who show the prodromal signs of such development (Cochraine 1994:6; Eastman 1984:20). Alcoholics Anonymous (1993:21) defines alcohol dependent individuals as those people who cannot control their drinking and whose drinking interferes with their day to day lives, provoking problems and conflict that get worse as the time goes on. Alcohol dependent individuals, therefore, are those individuals who drink alcohol excessively such that it affects their social lives and health in a negative manner.

These definitions emphasize that alcohol affects not only the physical and mental health of an individual, but the interpersonal relations as well as the economic functioning of that individual. This then suggests that the focus of intervention should involve the personal and environmental factors, which include the alcohol dependent individual's family system and the community.

1.5. **THE GOALS OF THE STUDY**

The goals of the study are:

- To explore and generate a greater understanding of the experience of couples in marital and non-marital relationships with alcohol dependent partners focusing on:
 - the dependents' reason for admission.

- relapse.
 - behaviour at home prior to admission.
 - partners' responses to drinking.
 - description of relationship.
 - contact person when experiencing problems.
 - women's experiences in living with alcohol dependent partners.
 - previous and present coping mechanisms.
- To lead the respondents (alcohol dependent clients and their partners) in separate interviews to tell their stories, using the interview guide.

Other objectives are as follows:

- To collect, analyze and present data in order to generate knowledge regarding the study.
- To make recommendations regarding the study.
- To make recommendations for further empirical research studies.

1.6. **RESEARCH DESIGN AND METHODOLOGY**

1.6.1 **Design**

The research design used for the study was an exploratory design. Grinnell (1998:225) states that the purpose of exploratory research study is to explore, "nothing more - nothing less." It makes it possible to build a foundation of greater ideas and tentative theories, which could be explored later with more precise and more complex research designs, and yield new insights into a topic for research (Kvale 1996:100; Grinnell 1998:225; Rubin and Babbie 1997:109).

1.6.2 **Methodology**

In order to explore the experiences of couples in relationships characterized by alcohol dependency, qualitative methodology was used. In qualitative methodology, the aim is not to provide definite answers, but rather to explore the depth of meaning that people attach to their experiences (Grinnell 1990:188; Yegidis and Weinbach 1991:99).

I used purposive sampling in this study. Bailey (1987:94) states that the researcher uses his or her judgment about which respondents to choose and picks up only those who best meet the purpose of the study. Fifteen couples were selected on the basis of their situation and experience, their willingness to participate, the nature of the research aims and my knowledge of the local rehabilitation centre (Huysamen 1994:175; Rubin et al 1997:266; Babbie 1998:194).

1.6.3 **Literature study**

To support the empirical process of my study, I also relied on the literature review. My focus was on the alcohol dependent's behaviour, his emotions, the family's coping strategies, alcohol and marital problems, the role of the social worker as part of the rehabilitation team and aftercare.

1.7. **THE PROBLEMS AND LIMITATIONS OF THE STUDY**

- The number of respondents is small and is not representative of all alcohol dependent husbands and their wives. However, this study provided valuable information regarding the difficult experiences faced by these couples and limitations which are addressed in the recommendations.

- The study took longer than expected due to delayed appointments secured with the respondents and travelling involved.
- Some of the respondents who met my criteria for the study had moved from their previous addresses to other areas which were unknown, and the process of tracing them was time consuming.
- While the aim was to report verbatim what the respondents had to say, I recorded the responses in writing. This would be better accomplished had the interviews been tape recorded.

1.8. **ORGANIZATION OF THE RESEARCH**

This research is divided into chapters which consist of the following:

1.8.1 CHAPTER 1: INTRODUCTION

The aim of this chapter is to provide the reader with insight into the reasons for the choice of the research subject, the definition of concepts, goals and objectives, the method of research, problem and limitations of the study.

1.8.2 CHAPTER 2: THEORETICAL BACKGROUND ON ALCOHOL DEPENDENCY

This chapter provides the reader with the theoretical background on alcohol dependency. The key concepts used in the chapter are defined by different authors, including myself. The chapter focuses on the learning, biological and socio-cultural theories in relation to alcohol dependency. A brief discussion on the drinking patterns and culture is provided. The chapter concludes with a discussion on the management of alcohol dependency.

1.8.3 CHAPTER 3: THE EXPERIENCES OF COUPLES IN RELATIONSHIPS CHARACTERISED BY ALCOHOL DEPENDENCY

This chapter focuses on the literature regarding the experiences of couples in relationships characterized by alcohol dependency. The key concepts used in the chapter are defined by different authors, including myself. The literature focuses on the alcohol dependent individual's behaviour during his drinking and the strategies that the family uses to cope with the situation. The chapter concludes with a discussion on the major role played by social workers in the management of alcohol dependency.

1.8.4 CHAPTER 4: METHODOLOGY AND RESEARCH DESIGN.

The aim of this chapter is to provide the reader with insight on how the study was conducted in terms of the research design, methodology, sample, data collection tool, procedure and data analysis.

1.8.5 CHAPTER 5: PRESENTATION AND DISCUSSION OF FINDINGS

This chapter presents the findings of the study. These findings are linked to literature in the form of discussion. The chapter ends with a summary of findings revealed.

1.8.6 CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

The aim of this chapter is to provide the reader with the conclusions drawn from the study while recommendations are made.

THEORETICAL BACKGROUND

OF

ALCOHOL DEPENDENCY

CHAPTER 2

THEORETICAL BACKGROUND OF ALCOHOL DEPENDENCY

2.1. INTRODUCTION

According to the Encyclopedia of Social Work (1987:135), there is no definite, single cause of alcohol dependency. Instead, various factors interact to produce the disorder. In trying to identify the causes of alcohol dependency, Fontaine and Cook (1991:450) emphasize the learning, biological and socio-cultural factors. The learning theory views alcoholism as a set of behaviours that are learned and maintained while the biological theory argues that alcohol abuse is inherited. However, the socio-cultural theory emphasizes the social approval and availability of alcohol. Although these theories explain the multiplicity of factors which contribute to alcohol dependency, I will focus on the socio-cultural theory because of its relevance to the study. Moreover, an individual is not an island, he/she belongs to a family which in turn belongs to a society. In the former Transkei region, where the study has been conducted, the family and society both contribute to the shaping of an individual, hence the relevance of the socio-cultural theory in this study.

From my practice experience, I have also observed that, the psycho-social factors cannot be ignored since most clients reported loneliness, boredom, family arguments, peer pressure, parties and traditional functions as contributory factors to their drinking. This chapter will discuss the learning, biological and socio-cultural theories in relation to alcohol dependency. The first section of the chapter will define the key concepts which are used in this chapter. The concepts are defined by a variety of authors. The chapter concludes with a summary of the three theories and their implications for social work practice.

2.2 **DEFINITIONS OF TERMS**

2.2.1. **Alcohol dependent individuals**

According to the World Health Organization (WHO) in (Eastman 1984:20), alcohol dependent individuals are those excessive drinkers whose dependence on alcohol has attained such a degree that they show a noticeable mental disturbance or interference with their bodily or mental health, their personal relations and their smooth economic functioning, or who show the prodromal signs of such development. Alcohol dependent individuals, as defined by Alcoholics Anonymous (1993:21) are people who cannot control their drinking and whose drinking interferes with their day to day lives, provoking problems and conflict that get worse as the time goes on. Coleman, Butcher and Carson (1984:398) state that alcohol dependent individuals are individuals with serious drinking problems, whose drinking impairs their life adjustment in terms of health, personal relationships and/or occupational functioning.

According to the Defining Social Work Dictionary (1984:57), alcohol dependent individuals are those who, because of their craving for alcoholic liquor and their inability to control their use of it, use it to such an extent that it has a detrimental psychological, social and physical effect on them, even though they may be aware of the serious consequences. Alcohol dependent individuals, therefore, are those individuals who drink alcohol excessively so that it affects their social lives and health in a negative manner.

These definitions emphasize that alcohol affects not only the physical and mental health of an individual, but the interpersonal relations as well as the economic functioning of that individual. This suggests that the focus of intervention should involve the personal and environmental factors, which includes the alcohol dependent individual's family system and the community.

2.2.2 **Alcoholism**

Alcoholism, as defined by Stanhope and Lancaster (1988:865) is a chronic disease characterized by repetitive and often compulsive drinking that produces injury to the drinker's health and other aspects of life, including marital status, career, interpersonal relationships and other required societal adaptations. According to Orford (1995:345), alcoholism is a chronic condition which emanates from various factors such as personal, environmental and denial, among others. This condition usually requires admission to a rehabilitation centre for treatment and rehabilitation. Due to the affiliation of rehabilitation centres to psychiatric hospitals or units, my practical experience has been that alcohol dependent clients feel stigmatized when they are admitted to these centers because their relatives and friends label them as psychiatric patients. This attitude causes the alcohol dependent individuals to delay coming for treatment, and their problem continues. Alcoholism, as defined by the Defining Social Work Dictionary (1984:57), is the condition of one who uses alcoholic liquor to such an extent that it has a detrimental psychological, social and physical effect on him/her use of it even though he may be aware of the serious consequences. Alcoholism can therefore be defined as an illness caused by the individual's loss of control of his/her alcohol consumption which affects not only his/her health but his/her marital life, employment and other areas of his/her social life.

2.2.3 **Alcohol abuse**

Alcohol abuse, as defined by the Encyclopedia of Social Work (1987:61) refers to frequent drinking to the point of drunkenness or intoxication or drinking that results in negative social consequences and that compromises role obligation and interpersonal relations. As already defined under alcoholism above, according to Stanhope and Lancaster (1988:685), alcohol abuse is compulsive and repetitive drinking that produces injury to the drinker's health and other aspects of life including marital status, career and interpersonal relationship. Alcohol abuse can therefore be defined as the misuse of alcohol consumption

by the individual which is characterized by the individual's inability to control his/her alcohol intake such that it affects his/her health and social life. The individual consumes alcohol not for medical purpose but for one or more of the following purposes: to change him/herself, and to enhance his/her ability to function in certain situations such as social or sexual ones.

2.2.4 **Family**

The family, as defined by the Dictionary of Social Welfare (1982:73) is a group of people who are related by marriage, blood or adoption, who constitute a single household at least for a period. According to the Dictionary of Social Welfare (1982:73), the family assumes an important function in the welfare context because it is the locus for distribution of care obligations, it is the matrix for much socialization of children and parents and it is sometimes a scene and source of many troubles such as family violence, among others. According to Barnes (1992:10), traditionally the family is the primary social group into which individuals are born and upon which they initially depend for nurture and for the physical and psychological protection offered by intimate relationships. Again, by traditional definition, it is a unit of more than one generation. Normally a proportion of the members of a family live in one household. Members of family are connected by a series of interactions over time which create relationships. These connections influence and constrain the individuals both internally and externally. The Encyclopedia of Social Work (1987:576) provides two definitions of the family, the first definition being a situation when two or more people construct an intimate environment in which they generally share a living space, commitment and a variety of roles and functions which are usually considered part of family life. The second definition of a family refers to a family of origin, the family of blood and kinship. The Encyclopedia of Social Work (1987:576) states that the family is psychologically important to all human beings, whether close ties have been maintained or not. In line with these definitions, the researcher defines the family as a group of blood related people such as parents and children. This definition is extended to include a group of people who are descendants from common ancestor. It is

relevant to the people of the former Transkei where the study has been conducted, especially in the rural areas, where the family members depend on each other for survival, support and guidance.

2.2.5 Relapse

A relapse refers to any return from an advanced stage of recovery from alcohol dependency to the previous stage (Wayne, Rosemarie and Collins 1996:196; Galizio and Maisto 1985:3). A relapse can therefore be defined as drinking again after being treated and rehabilitated for alcoholism and returning to the same state of health and morals. These definitions imply that the individual exposes her/himself to the problems she/he experienced before treatment. From the researcher's practical experience, antecedents of relapse are high risk situations which include personal and environmental events. Antecedents of relapse refer to events or circumstances that precede relapse. In most cases, alcohol dependent clients are pressurized by their relatives and employers to submit themselves for treatment and rehabilitation. Due to denial, lack of motivation to stop taking alcohol and lack of insight into the problem, very few of them come for counseling voluntarily. These factors may also cause the alcohol dependent clients to relapse after treatment.

2.3 CAUSATIVE THEORIES OF ALCOHOL ABUSE

2.3.1 Learning Theory

According to learning theories by Murray and Huelskotter (1987:20), alcohol dependency is a conditional response. The individual presumably finds in alcohol a means of relieving anxiety or the unpleasant feelings. Each drink relieves tension, thus the behaviour is reinforced and this eventually makes drinking to be a habitual pattern of coping with stress.

Drinking as stated by Eastman (1984:109) is re-inforced by its consequences. For example, if the taste of alcohol was unpleasant and the effects of it were disliked, drinking will not be re-inforced and it will less likely occur again. Furthermore, if the anxious person finds that alcohol reduces anxiety, he/she is likely to drink when he/ she is provoked by anxiety.

The learning theory to alcohol abuse as stated by Coleman et al (1984:70); Bandura (1997:38) argues that most human behaviour is learned. They further argue that the individual learns how to achieve the desired goal which may be to obtain something that is rewarding or to avoid something that is unpleasant. The behaviour is strengthened by being repeatedly associated with a reward or with the avoidance of some aversive condition. This suggests that alcohol abuse like any other behaviour is learned. The individual learns to relieve anxiety by drinking alcohol and further drinking is re-inforced by reward which in this case is the reduction of anxiety.

In line with Murray and Huelskotter (1987:20); Eastman (1984:109); Coleman, et al (1984:70) states that alcohol brings immediate changes to how an individual feels. It can be used to wipe away all the pains that one experiences. It also gives one power over things that make him/her feel powerless. This argument suggests that one of the reasons why people drink is to escape from pain. It further states that as one drinks, he/she becomes less equipped to manage difficult situations. In my experience, alcohol dependent clients revealed that when they drink alcohol, they become less interested in day to day realities such as their employment and domestic affairs. This, then means that according to this theory, they learn to neglect their responsibilities and continue to drink.

Alcohol dependency, as reported by Lahey and Ciminero (1980:60) is learned and influenced by social, cognitive and psycho-social processes. They state that individuals learn to be dependent on alcohol even though biological predisposition may also play a role in the development of alcohol abuse. Miller and Cooper (1988:301) state that through observational learning and communications, individuals learn about alcohol abuse from parents, peers, books, films and the media. Some of the expected consequences of alcohol

will be learned in this way. The likelihood that an individual will have direct experience on heavy alcohol abuse will depend on a wide range of psycho-social factors including occupation, personality, sub-culture, price and availability. In communities in areas such as the former Transkei, where traditional beer is served at functions, the youth become exposed to drinking. This is because usually they have their own share of traditional beer during these functions. However, this does not necessarily lead to alcohol abuse but it illustrates the availability of alcohol in this community.

The learning theory on alcohol dependency, as stated in the Encyclopedic Handbook of Alcoholism (1982:680) focuses on the interaction of four factors in the growth and persistence of alcohol abuse which are as follows:-

- a) Positive and negative re-enforcement.
- b) Tension reduction.
- c) Modelling.
- d) Cognitive factors.

a) According to the Encyclopedic Handbook of alcoholism (1982:680), in **positive re-enforcement**, the general consequences of drinking are typically re-inforcing. These include the immediate relaxing physiological effects of alcohol, the attention and approval of friends, as well as the positive changes in the person's behaviour.

The changes in a person's behaviour include being more friendly and talkative. The basic principle is that a stressful situation leads to unpleasant feelings which in turn lead to excessive drinking. This argument states that the more this sequence occurs, the more likely it is that the person will drink excessively to cope with stress. This means that as stress increases, the re-inforcing properties become important. In advanced stages of alcoholism, another factor which causes the alcoholic pattern to persist is to reduce the discomfort of withdrawal symptoms. Lawson, Peterson and Lawson (1983:9) emphasize the reinforcement of excessive drinking due to the alcohol dependent individual learning that alcohol provides relief from distress. In time, drinking for relief becomes a habit and

the alcohol dependent individual is unaware that a dependency is forming. In practice, the poor family situations and economic status contribute to alcohol abuse. Alcohol dependent clients reported quarrels at their homes because the financial needs could not be met. Some of the clients attended to had been discharged or suspended from duty due to unauthorized absence from duty and those who were still in employment received no remuneration as their absence was treated as leave without pay. To reduce stress caused by these situations, the alcohol dependent clients drank alcohol.

b) Although the **tension reduction** properties are apparent, it is not clear how important this fact is in maintaining drinking behaviour and contributing to relapse. Lahey and Ciminero (1980:60) state that in the early 1960's it was believed that tension reduction was the primary explanation for the growth and persistence of alcoholism. They maintain that in recent years, it has been found that alcohol does not always reduce anxiety, depression and other unpleasant conditions especially in chronic alcoholics. In summary, Lahey and Ciminero (1980:60) suggest that the role of discomfort reduction is very complex because some stresses do appear to lead to increased drinking in alcoholics whereas others do not.

c) The third learning factor which explains alcoholism is **modelling**. Coleman et al (1984:71) state that alcohol dependent individuals choose models with whom they can strongly identify such as parent and friends. This suggests that a person observes the parents' behaviour. In a society like the Transkei, where strong emphasis is placed on kinship and family ties, it is easy for individuals to model recognised individuals in the society, not necessarily the immediate family.

d) The fourth learning factor which explains alcohol abuse focuses on **cognitive processes**. This view as stated by Marlatt and Rosenow (1980:201) emphasises that alcohol dependent individuals expect alcohol to transform their experience in a positive way. The alcohol dependent individuals also expect alcohol to enhance their social and physical pleasure, social performance and experience; power and aggression; increase assertiveness and reduce anxiety. It is this thinking that contributes to individuals drinking. I agree with this theory and

accept that it is applicable to alcohol dependent individuals. With reference to my practice experience with alcohol dependent clients, some reported that alcohol made them feel free and to become assertive. The alcohol dependent individuals also reported that it washed away their frustrations and tensions. As a result, when the alcohol dependent individuals were confronted by painful and hurting situations, they resorted to drinking. Others reported that alcohol made them to feel bold and confront people and situations they were afraid of when they had not consumed alcohol. This suggests that whenever they wanted to challenge things whether at home, work or in the community, they drank alcohol for boldness. This theory is relevant to the area of study. From my practical experience, the frustrations and painful conditions as reported by the alcohol dependent individuals included unemployment, homelessness and lack of resources. This implies that the social worker has to identify and understand the events or situations that precipitate drinking and the consequences that maintain it, to be relevant in helping the alcohol dependent clients.

2.3.2 **Biological Theory**

The biological theory of alcohol dependency as stated by the Encyclopaedia of Social Work (1987:135) rests on the assumption that alcohol dependent individuals are constitutionally predisposed to develop physical dependence on alcohol. A number of studies of twins and adoptees support the probability of a strong genetic component in alcoholism. Kaij (Encyclopaedia of Social Work 1987:135) found that the rate of concordance for alcohol abuse in identical twins was 54 percent whereas for the same sex fraternal twins, it was 28 percent. Children of alcohol dependent individuals who were adopted close to birth and raised without knowledge of their biological parents have high rates of alcohol abuse, whereas sons reared by alcohol dependent individuals but whose parents are not dependent on alcohol, have low rates of alcohol abuse.

According to Kaplan and Sadock (1985:3) alcohol dependency runs in families. Alcoholism in the family is the strong predictor of alcoholism occurring in particular individuals. It is maintained by Kaplan and Sadock (1985:3) that twin adoption studies document a strong genetic component to the predisposition to develop alcoholism. In line with Kaplan and

Sadock (1985:3), Goodwin and his colleagues (in Eastman 1984:103) conducted a series of studies in Denmark and their findings suggest an inherited predisposition toward alcoholism. Adults who had at least one alcohol dependent parent were carefully selected and interviewed. Some of the subjects were adopted soon after birth by non-drinking foster parents. The sons of the alcohol dependent individuals were about four times more likely to develop alcoholism than were sons of parents who are not dependent on alcohol.

In agreement with Kaplan and Sadock (1985:3), Lahey and Ciminero (1980:136) maintain that some evidence suggest that biological predisposition, possibly controlled through genetic transmission may be important in alcoholism. Considerable evidence has shown that alcoholism tends to run in families as it is quite common to find that alcohol dependent individuals had a parent, usually the father who was dependent on alcohol. However, Lahey and Ciminero (1988:136) do not necessarily mean that the alcohol dependent individual learned the behaviour from a parent. Miller and Cooper (1988:307) on the other hand suggest that some individuals may inherit certain characteristics that will make them more or less likely to become dependent on alcohol. Individuals who are not dependent on alcohol may have an adverse reaction to alcohol because of physiological difference. While I find the evidence which supports the genetic influence impressive, the cause and effect relationship however, remains unclear.

2.3.3 **Socio-cultural Theory**

The attempts to present the factors which are important in establishing drinking patterns in a community have been adequately presented by Fontaine and Cook (1991:453). The socio-cultural theory, as stated by these authors focuses on how the cultural values and attitudes influence people's drinking behaviour. They state that those cultures whose religions or moral values prohibit or extremely limit the use of alcohol have lower incidence of alcoholism. This theory is based on the fact that values, perceptions, norms and behaviours are passed on from one generation to another. This further states that the exposure to the use of alcohol may influence the development of alcohol dependency.

As an extension to culture, which is transmittable, learned and shared, Pittman (in Coleman et al (1984:78) developed a system consisting of four cultural attitudes which affect the individual's drinking patterns. These are:

- i) Abstinent Culture - The cultural attitude is negative and prohibitive towards any type of alcohol intake.
- ii) Ambivalent Culture - The cultural attitude towards alcohol is one of conflict between co-existing value structures.
- iii) Permissive Culture - The cultural attitude allows alcohol intake but it is negative towards drunkenness and alcoholism.
- vi) Overpermissive - The cultural attitude allows both drunkenness and alcoholism.

With the stated cultural attitudes in mind, Kessel and Walton (1965:71) suggest three principal categories which determine drinking patterns in a particular socio-cultural setting. The first being incitement, which are factors predisposing to alcohol consumption. For example, leisure time at the disposal of the individual; an opportunity which refers to the availability of alcohol within the community; and lastly an example set by the model. This includes the tradition and pattern of drinking established between the parents, child and community at large.

According to Coleman, et al (1988:411), the degree of stress and inner tension, the attitude towards drinking all produced by culture, the degree which culture provides substitute means of satisfaction, and other ways of coping with anxiety, contribute to alcohol dependency. The above authors believe that the culture of many societies has become dependent on alcohol as a means of reducing tension. This, according to Coleman, et al (1988:411), is made worse by the availability of alcohol and social approval of drinking. The former Transkei is no

exception to this, boys are exposed to traditional beer during cultural activities such as boy's initiation and wedding ceremonies, among others. This argument is further supported by Lazare (1980:65) who states that man is a social being and social groups shape, direct, orient and validate his behaviour and experience. According to Lazare (1980:65), certain cultural norms regarding drinking patterns, the type of alcohol consumed, the social situation and the quantities consumed may differ from one social group to another. The alcohol dependent individual's drinking pattern is assessed in comparison with the normal patterns of his/her own social group. This suggests that alcohol becomes the focus of the individual's total life and this development is a key sign of a serious drinking problem. In severe cases, alcohol becomes a substitute for all meaningful interpersonal relationships. It has been stated in the introductory section of this chapter that some alcohol dependent clients reported, among other reasons, loneliness and boredom as causes for their drinking.

With reference to the socio-cultural theory, Eastman (1984:85) states that alcohol is widely used to reduce anxiety and tension. This implies that gatherings like meetings which are likely to induce anxiety become less inducing when alcohol is consumed. According to Eastman (1984:88), many people are first introduced to alcohol during a family celebration such as birthdays, weddings and Christmas days. Young children also see their parents drinking happily and they view drinking as symbolizing independence. It is also seen as deviant for a non-drinker to refuse alcohol when in the company of drinkers. As a result, one may drink so that he/she becomes accepted by that particular group.

Some occupations, according to Eastman (1984:50) expose individuals to excessive drinking and these are listed as:

- **Alcohol Producers:** Those working in the brewing and distilling of wine producing factories.
- **Alcohol Retailers:** Barman, hotel and restaurant staff and caterers.

- **Those who drink a lot of water:** Heavy and manual workers.
- **Those whose occupation result in group cohesiveness that extend to social activities:** Officers in armed forces.

According to the Encyclopedia of Social Work (1995:2339), the availability of outlets that sell alcohol beverages influences both the rate of alcohol consumption and the presence of alcohol related problems. Furthermore, there have been few organized efforts to use alcohol control policies to restrict the sales of alcohol. This study argues that another approach to reduce alcohol related problems is to raise the price of alcohol beverages which discourages alcohol consumption, particularly among the youth. Another cause of alcohol abuse as stated by the Encyclopedia of Social Work (1995:2340) is that the alcohol industry actively promotes its products in the communities on billboards and in the broadcasting media. Alcohol advertisements glamorizes drinking and this encourages the heavy consumption of alcohol, whereas, the negative consequences of alcohol are minimized.

The socio-cultural theorists emphasize exposure, availability, cultural drinking patterns, example and inappropriate use of leisure time as factors which contribute to alcohol abuse. Drinkers resort to alcohol to cope with anxiety. Alcohol is regarded as a socially and legally acceptable substance which receives support both from the advertising industries as well as liquor trade. Alcohol is advertised on the television, in newspapers, magazines, on radio and outdoor billboards. These advertisements tend to portray alcohol as a pleasure-inducing drink. As a result, some people think that they become popular and successful when they drink alcohol. The alcohol industry also sponsors a wide range of recreational and sporting events and it distributes promotional material. These promotions create the impression that the use of alcohol is a normal part of everyday social life.

It is common practice that when people relax, or partake in most celebrations, alcohol is served. Even in all the cultural functions that symbolize the African tradition, whether it is held in the rural or urban areas, alcohol is served. It is a fact that drinking used to follow strict cultural norms and values, but it is presently common for youth to drink. In the past, according to Kayongo-Male and Onyango (1984:45), black people used to drink a low content of home-made beer called “umqombothi”. The consumption of this beer was restricted to the elderly during special occasions and they adhered to strict behaviour and norms. The men were more frequent drinkers than women whose main task was to brew it. The introduction of strong liquor such as brandy increased the consumption patterns drastically and it resulted in alcohol dependence and alcohol related problems.

People drink alcohol because of various reasons and these include the following:-

- To forget their poor social circumstances.
- To get confidence.
- To please friends.
- To relax and have fun.
- Because they have nothing to do.
- Lack of recreational facilities.
- Alcohol is available, not only from the bottle stores but shebeens in the community which are easily accessible.

2.3.4 Drinking patterns and culture

This section briefly highlights the drinking patterns and culture of the population of Umtata where this study was conducted. It is important that with the three theories previously discussed, in mind, a section on the drinking patterns and culture is presented.

Umtata has both urban and rural population. The traditional way of life and customs are preserved by the population. The families still have attachments to their extended families that stay in the rural areas, although a gradual shift exists because of the high cost of living, lack of spacious houses, among other reasons. The majority of the population practice African and Christian religion. The cultural rituals such as the girl's initiation, referred to as "intonjane" and boy's circumcision, called "ulwaluko", are still practiced. Other African people, especially those who stay in rural areas still believe in ancestors and they remember to inform their ancestors of all the important events such as births, marriages, initiations, death and thanksgiving. These events are marked and they are not finalised if traditional beer is not served. The chiefs are still recognised and are respected as heads of tribes, especially in the rural areas.

Whenever there is a cultural event, irrespective of whether the activity is held in the rural or urban townships, alcohol is served. Men, women and youth are provided with their share of alcohol and meat. The members of various age groups sit separately and young men do not eat from same dish as their seniors. The type of alcohol which is served includes traditional beer (umqombothi), brandy, wines and beer. At present, some of the wines used include champagne and fruit-based wine which are popular with the youth and women. Those who drink indulge in alcohol during these functions and for others, this is their first experience of alcohol consumption.

The district of Umtata has few recreational facilities for adults, youth and children. Some adult males engage in indoor sport such as darts and this sport is played in public bars and hotels where alcohol is available. These cultural patterns expose people to drink and in a way, it suggests that alcohol is accepted.

2.4 **Management of alcohol dependency**

With reference to the definitions of alcohol abuse in the previous sections of this chapter, it is acknowledged that the management of this condition requires a multi-disciplinary approach. This multi-disciplinary team may consist of nurses, medical practitioners, psychiatrists, social workers, clinical psychologists, after-care counseling officers, occupational therapists and ministers of religion. This team, as stated by Gilbelman (1999:253) work in variety of settings, including health facilities, inpatient and outpatient substance abuse treatment centers, mental health centers, schools and the workplace.

One of the treatment methods for alcohol is the detoxification programme which is usually conducted in hospital settings. Detoxification, as stated by Gilbelman (1995:253) seeks to help the alcohol patients to withdraw from alcohol and other drugs by gradually reducing the dose of the abused drug. Other treatment programmes are the inpatient and outpatient programmes. An example of the inpatient programme provided at Thembelitsha Rehabilitation Centre requires the alcohol dependent patient to be admitted for a period of seven weeks for treatment and rehabilitation. This programme provides a supportive and safe living environment for alcohol dependent patients who want to stay free from alcohol. The patients' needs are addressed by the multi-disciplinary team by focusing on the patients' assessment, medical and psychological treatment, alcohol information and education, budgeting, problem-solving skills, behaviour modification, assertiveness training, relaxation, family and marital counseling, to mention only a few. After a period of about seven weeks, the patients are discharged to their homes and they come to the hospital or centre for the after-care programme after two weeks. Although they are discharged, they are supervised by the team for a period of two years.

The outpatient programme focuses on helping the clients change their addictive behaviours without their admission to hospital. Primary prevention is important in combating alcohol abuse. The social workers play a leading role in the prevention programmes for alcohol

abuse. These programmes target mainly the youth although they aim to improve the well being of all the community members.

2.5 **SUMMARY**

This chapter has discussed three theories (i.e. learning, biological and socio-cultural) to explain the factors which contribute to alcohol dependency. These theories overlap with each other although they have different approaches. The learning theory relates well to the socio-cultural theory and it emphasizes the fact that alcohol abuse is learned like any other behaviour through observation and communication with parents and peers. The learning theory also emphasizes modelling which exposes children to learn drinking from their parents, peers and community. In line with the learning theory, the socio-cultural theory emphasizes culture which is learned, shared and transmittable. It also states that children see their parents drinking happily and they view drinking as a symbol of independence and pleasure. These two views suggest that the example set by parents and the community in terms of drinking patterns contribute to alcohol abuse of children. Both theories agree that people drink to cope with stress. The biological theory differs from the two theories as its main argument states that alcohol dependency is inherited and it tends to run in families.

Although the learning and socio-cultural theories explain the causal factors of alcohol dependency, they do not explain why some people who grow up in alcoholic homes and those who experience high levels of emotional distress do not become alcoholics. The biological theory seems to provide an explanation to such questions. The researcher believes that this is a challenge to social workers to become familiar with the theoretical background of alcohol dependency. This background is very important to the social worker's planning of interventive strategies as it provides relevance to practice.

THE EXPERIENCES OF COUPLES

IN RELATIONSHIPS

CHARACTERISED BY ALCOHOL DEPENDENCY

CHAPTER 3

THE EXPERIENCES OF COUPLES IN RELATIONSHIPS CHARACTERIZED BY ALCOHOL DEPENDENCY.

3.1 INTRODUCTION

Alcohol abuse as described by authors such as Turner (1983:194), Jesse (1989:105) Janzen and Harris (1986:224) is a family illness. This argument does not mean that the family is in some way responsible for alcohol abuse, but suggest that family members, especially the non - drinking partner, are caught up in the pathological process of the alcoholic's illness in such a way that parallel emotional and behavioural problems are developed. It is a common situation in the treatment and rehabilitation of alcohol abuse that clients have an occasional relapse with drinking while some others drop in and out of therapy. Coleman and Strauss (1988:407), Stanhope and Lancaster (1988:686) identify possible areas leading to the relapse of alcohol dependent clients as caused by living in a high risk environment, lack of close relationships with family and friends, and enabled by the family members. This argument further states that the educational programs for such clients should be based on helping them to achieve more satisfactory adjustment in key areas of their lives such as marriages, employment and social relations. It is not enough, according to Coleman et al (1984:410), to teach clients to live without alcohol if the social environment remains hostile and threatening. Craving is believed to play an important role in the occurrence of relapse in abstinent substance addicted persons in their natural setting (Franken ; De Haan ; Van Der Meer, Hofmans and Hendriks (1999:81) .

The first section of this chapter defines the key items which are used in the chapter. The chapter focuses on the experiences of couples in relationships characterized by alcohol dependency, with emphasis on the alcohol dependent individual's behaviour, the family's coping strategies with particular focus on the children and the non - drinking partner, the

non drinking partner's role, alcoholism and marital problems and the role of a social worker. Most of the literature which has been reviewed is not South African and it is mostly based on the studies of western white men. While my research topic has received little attention in the previous studies in South Africa, my findings suggest that alcohol dependency is a universal problem that manifests itself in universally consistent ways irrespective of the culture of the dependent person. The findings are presented in chapter 5.

3.2 **DEFINITION OF TERMS**

3.2.1 **Al Anon**

Al Anon, as defined by Alcoholics Anonymous (1993:21) is a fellowship of spouses of alcohol dependent individuals who share their experiences with one another so that they can learn effective ways of living with their alcohol dependent husbands or wives . Coleman et al (1984:416), define Al Anon as a movement designed to bring spouse of alcohol dependent individuals together to share common experiences and problems, to gain understanding of the nature of alcoholism and to learn techniques for helping the alcohol dependent individual deal with the problem of alcoholism. Al Anon as defined by the Encyclopedic Handbook of Alcoholism (1982:987) is a highly effective non-professional therapeutic and educational resource for spouses, as well as the families and friends of alcohol dependent individuals.

Al Anon is therefore a support group for the partners, spouses and relatives of alcohol dependent individuals. They share their experiences about living with alcohol dependent spouses or partners or relatives and how to cope under such circumstances. The group usually meets once a week, depending on its goals and commitments.

3.2.2 **Alateen**

Alateen, as defined by Alcoholics Anonymous (1993:21), is a fellowship of young people whose lives have been affected by the alcoholism of their parents. According to Coleman et al (1984:416), Alateen is a movement designed to bring children of alcoholic dependent parents together to share common experiences and problems, to gain understanding of the nature of alcoholism, and to learn techniques and to help the alcoholic dependent parent deal with the problem of alcoholism. Alateen, as defined by the Encyclopedic Handbook of Alcoholism (1982:993) is a fellowship for children of alcohol dependent parents whose age range between 12 and 20. Alateen members strive to separate themselves from the alcohol dependent parent and his problems and focus on taking responsibility for their own behavior and happiness. This programme encourages the development of productive ways of coping, not only with alcohol-related family problems, but also with concerns in all areas of life . Alateen is therefore a support group for the children of alcohol dependent parents. The group members share their experiences and learn from each other positive ways of coping with alcohol dependent parents.

3.2.3 **Alcoholics Anonymous (AA)**

Alcoholics anonymous, as defined by the Encyclopedia of Social Work (1995:2116) is a self help group for alcohol dependent individuals and it is a resource for meeting the needs that are not easily addressed in a professional relationship. Alcoholics Anonymous (1993:21) defines its organization as a fellowship of men and women who share their experiences, strengths and hopes with one another so that they stay sober and help other dependent individuals to achieve sobriety. Coleman et al (1984:416) state that Alcoholics Anonymous is a non-professional counseling programme in which both person-to-person and group relationships are emphasized. This programme lifts the burden of personal responsibility by helping alcohol dependent individuals to accept that alcoholism is bigger than they are. This group provides mutual help and reassurance through participation in a group composed of others who have shared similar experiences so that many alcohol

dependent individuals gain insight into their problems as well as a new sense of purpose and also learn effective coping techniques. Alcoholics Anonymous, according to Zimberg (1982:139), is a leaderless self-help group based on the assumption that alcoholism is a disease and recovery involves complete abstinence. Alcoholics Anonymous is therefore a support group for alcohol dependent individuals who want to remain free from alcohol. They meet and share their experiences and advise each other on how to remain free from alcohol.

3.2.4 **Co-dependency**

Co-dependency, as defined by Fontaine and Cook (1991:451), is a term used to describe the non-alcohol dependent partner who remains in the relationship despite its problems. The non-drinking partner tries obsessively to solve the problems created by the alcoholic. In line with this definition, the Encyclopedia Handbook of Alcoholism (1982:668) uses the term co-alcoholism to refer to co-dependency. Co-dependency or co-alcoholism as defined in this handbook refers to the coping patterns that develop in the family members who hope that the alcohol related behaviour will improve. The role of the co-alcoholic, as stated in the Encyclopedia Handbook of alcoholism (1982:668) has been termed as that of the “enabler”, as the co-alcoholic is the one who enables the alcohol dependent individual to continue his or her behaviour. The researcher defines co-dependency or co-alcoholism as a situation where the family members, particularly the non-drinking partner relies on the alcohol dependent individual or is controlled by the alcohol dependent individual for her behaviour.

3.2.5 **Enabling**

Enabling as defined by the South African National Council for Alcoholism and Drug Dependence (1993:4), is a term used to describe any behaviour, which serves to protect the alcohol dependent individuals from the consequence of their behaviour. According to

Eastman (1984:93) enabling is a variety of maladaptive coping skills which the family members use in dealing with the alcohol dependent individual. Vaillant (1983:40) claims that enabling involves denial of family members and other contact persons that their member is dependent on alcohol . This means that as the alcohol dependent individual continues to drink, the contact persons such as parents, partner, spouses, relatives, friends, supervisors and co-workers are a factor in enabling the condition to become chronic. Their denial makes them fail to confront the alcohol dependent individual immediately on identification of the problem. Enabling is therefore the coping strategy which family members use to deal with the alcohol dependent individual's behaviour.

3.2.6 **Non -drinking partner**

A non-drinking partner in this study refers to a person who does not drink and who has an emotional and sexual association with an alcohol dependent individual in a marital or non-marital relationship.

3.2.7 **Role**

The Dictionary of Social Welfare (1982:166) define the role as the activity normally expected of any particular social position. According to the Defining Social Work Dictionary (1984:94), the role refers to the behaviour patterns of an individual within a particular social context. The researcher defines the role as an expected function or obligation to assume a function by virtue of a position.

3.3 **THE ALCOHOLIC'S BEHAVIOUR**

The South African National Council for Alcoholism and Drug Dependence (1993:3) reports that the alcohol dependent individuals controls the emotions and behaviors of those

closest to him effectively by using different manipulative tools. The first tool reported in this report is anger which the alcohol dependent individual uses to protect him from confrontation. Whenever his drinking is challenged, he becomes excessively angry, thereby preventing family members from talking about the subject again. In this way, he has effectively assured that his behavior will go unchallenged. The alcohol dependent individual also uses his power to arouse anger when he succeeds in making the family angry, and uses this as an excuse to drink. This anger is aimed at silencing those closest to him, namely, the non-drinking partner and children, and may be expressed physically or verbally by assaulting his partner or making threats which frighten her. According to Makofane (1997:6), most women in the black community do not recognize emotional or psychological abuse by their partners as abuse. Makofane (1996:6) states that men usually abuse women psychologically by humiliating them verbally, harassing them in public by calling them names and intimidating them. In my practice experience with alcohol dependent clients and their families, I have received reports from the non-drinking partners. For example, alcohol dependent partners used to come home drunk and behave in a challenging manner, such as opening doors and windows and making loud statements such as "Ndifikile endlwini yam" meaning "I have arrived in my house". It is these statements and behaviours that threaten the non-drinking partners to keep quiet because they do not know the meaning behind such statements. This example shows how the alcohol dependent individuals succeed in manipulating their non-drinking partners, to get away with their drinking without being challenged. Alcohol as stated by Gelles and Loseke (1993:182-194) is associated with violence. According to Soul City (1996:10), alcohol is a disinhibitor and releases violent tendencies, and one is likely to become aggressive when under the influence of alcohol. However, in my opinion, the alcoholic's behavior is some form of denial which is presented in the form of violence to silence the non-drinking partner. Gelles and Loseke (1993:182) define aggression as any malevolent act that is intended to hurt another person. Research studies on homicide, assault, child abuse and wife abuse according to Coleman and Strauss (1983:104-124) found substantial association between alcohol abuse and violence. According to Gibelman (1995:258-259) people who abuse alcohol may experience an array of behaviours that are secondary to

their addiction but that inflict extreme pain and hardship on the self or others. Some of the behaviours as stated by Gibelman (1995:261) are anger, insults, criticism, bad mood, irritability and losing the temper over little things.

This is consistent with the literature which states that the person's behaviour changes when they are using alcohol, some get aggressive, louder and violent, while others become quiet or sad (South African Council for Alcoholism and Drug dependence, 1999:2).

Another tool which the alcohol dependent individual uses according to the South African National Council for Alcoholism and Drug dependence (1993:4) is blaming. He blames those closest to him for all his problems. In this way, the alcohol dependent individual creates a sense of guilt in the family and this makes the family members pay more attention to their own behaviour than the behaviour of the alcohol dependent individual. The family members, particularly the non-drinking partner thinks that she has caused the alcohol dependency of her husband. This thought becomes a painful feeling that she should have done better to stop his excessive drinking and through this manipulation the drinking is allowed to continue. However, South African National Council for Alcoholism and Drug Dependence (1999:2) emphasizes that no person is responsible for alcohol abuse in another person. However, through lack of knowledge, those close to the alcoholic may unwittingly, allow the illness to persist undetected, support its development and contribute to the avoidance of treatment. In line with the above, the Encyclopedia Handbook of Alcoholism (1982:667) claims that the alcohol dependent individual repeatedly tries to control the non drinking partner and avoids responsibility through subtle, passive-dependent techniques. Fighting frequently occurs when the alcohol dependent individual and the non-drinking partner blame each other. The alcohol dependent individual's manipulative behaviour discussed are related to the stages of coping used by the family which are discussed in the section below.

The following are common denial statements by alcohol dependent individuals:

- I can stop myself, I don't need help.
- I can stop drinking for few days and I can restrict myself.
- I'm not an alcoholic, just a heavy social drinker.
- I'm not doing harm to anybody.
- I must have a "regmaker" before I can get going in the morning.

(South African National Council for Drug and Alcohol Dependence 1999:3)

3.4 THE ALCOHOL DEPENDENT INDIVIDUAL AND HIS EMOTIONS

During the course of drinking, the alcohol dependent individual is prone to feelings of guilt about drinking itself, his own dependency as a husband, a father and an employee. Guilt as defined by Brickman, et al (in Bennet 1995:19) is a painful experience of self-approach resulting from belief that one has done something wrong. Brickman et al (in Bennet 1995: 18) give a theoretical framework for understanding, helping and coping behaviors which is useful for examining attribution of responsibility for alcoholism. According to Brickman, et al (1982:18) guilt, shame and blame are common responses displayed by the alcohol dependent individual. They define shame as a painful feeling of having lost the respect of others because of improper behavior or incompetence, among others. Shame takes the form of embarrassment on the part of the alcohol dependent individual about his behavior when drunk. In the same view, Miller (1995:35) states that guilt comes up when one thinks that he has caused the pain or he has failed to prevent pain. Sometimes people hide their guilt feelings, because they are in pain (Miller1995: 35). It is common occurrence, according to Brickman et al (in Bennet 1995:19) that blame is experienced by alcohol dependent individuals. Blame is defined as the accusation of the self, someone else or something else. As it has been reported in the previous section, the alcohol dependent clients reported emotions of guilt, shame and blame and these painful feelings, in turn resulted in them continuing to drink. Shame is a bad feeling about who one is (Miller1995: 36). When one feels shame, he thinks that he does not measure up to

others. In the same view Denzin (1987:51) claims that alcohol dependent individuals believe that they can control their own destiny. They have learnt that alcohol makes them feel better. They create problems and wait for others to take care of them, and in the process become dependent on others. As this dependency increases, they continue to think that they are in control of their lives.

3.5 THE FAMILY'S COPING STRATEGIES

The problems faced by any person, according to Zastrow (1995:220) are usually influenced by the dynamics within the family. This view stems from the fact that the family is an interacting system and therefore, change in one member affects the others. In the same view, Turner (1983:194), Jesse (1989:6); Janzen and Harris (1986:224) claim that the family members, especially the non-drinking partner becomes entangled in the pathological process of the alcoholic's illness in such a way that parallel emotional problems are developed. According to South African National Council for Alcoholism and Drug Dependence (1993:2) family members become involved in the following behaviours that are not constructive for themselves or for the alcoholic.

3.5.1 The non -drinking partner's reaction

The non-drinking partner starts to experience anxiety about the alcohol dependent individual's alcohol use. This anxiety is coupled with disbelief that there could possibly be a problem, because the family, particularly the non drinking partner has a misconception that alcohol dependent individuals are those "dirty people" who are seen on park benches. In order to cover up this anxiety and protect their family, the members deny that the problem exists. My practice experience has observed certain behaviours which are characterized by denial. For example, family members, especially non-drinking partner

tend to deny excessive drinking by minimizing the extent of drinking by using statements like “ my partner drinks during weekends”. The South African National Council for Alcoholism and Drug Dependence (1993:3) further states that non-drinking partner avoids discussion about alcohol abuse and pretends as if there is no problem. Anger and resentment towards the alcohol dependent partner, as stated by Gibelman (1995:262), are in some cases repressed and is conflict unchanged for fear of causing drinking episodes. The non-drinking partner’s experience of dealing with her alcohol dependent partner is that he tends to justify his drinking, especially when he is asked about it. Other members of the family, therefore, opt for other means of coping with the problem, such as taking over domestic responsibilities which were supposed to be done by the alcohol dependent partner. Yet the outside world may view them as a happy family. However, according to the Encyclopedic Handbook of Alcoholism (1982:667), the family relationship becomes strained because of frequent arguments and tension. The alcohol dependent individual’s aggressive behaviour, which has been discussed in the previous section (3.3), affects the non-drinking partner’s reaction to alcohol abuse.

Sikitha (1997:11) states that mainly in patriarchal cultures, women abuse is often viewed as normal and mandated in family relations. As a result, abused women believe that it is acceptable for a husband to beat his wife once in a while. In line with Sikitha, I have received such reports from the non-drinking partners during my practical experience with alcohol dependent clients and their families. Some of the non-drinking partners viewed the alcohol dependent husbands’ physical abuse as a symbol of love. The non-drinking partner stated that according to their culture, it is normal for a husband to beat his wife and failure to do so implies that he does not love his wife. In line with the above, some women are not ashamed to have been beaten, but rather feel this is a symbol of their men’s love for them (Ferguson-Brown1998:14). Another factor which prevents the non-drinking partners from effectively confronting alcohol abuse of their partners is the caring aspect. The non-drinking partners reported that they have not only experienced their partners as alcohol dependent individuals but have experienced love and care from their partners. The following is a statement which reveals how they view their partners: “he is a nice person

when he is drunk". This suggests a challenge to social workers working with non-drinking partners, to understand the dynamics involved in their relationships.

According to the South African National Council for Alcoholism and Drug dependence (1993:1), since the alcohol dependent individual is responsible for his own actions, denials can be broken if family members have support and knowledge about the disease. This newsletter acknowledges that alcoholism is a family disease and therefore requires prevention and treatment programmes within the family context. The non-drinking partner, as stated by Denzin (1987:50-53) maintains a lie that the alcohol dependent individual is not dependent, and that is denial. It is during this stage that contrasting emotions such as anger, resentment, fear and anxiety are experienced. These emotions, according to Denzin (1987:50-53), are built on denial and shame. The family members, particularly the non-drinking partner learn how to hide their true feelings and press them through a mask. The non-drinking partner becomes deprived of her selfhood and is made to feel inferior. Although the alcohol dependent individual's behaviour causes pain to the family, the non-drinking partner's emotion of love turns to pity which results in the attitude of helping. In the same view, the Encyclopedic Handbook of Alcoholism (1982:668) label the coping patterns that develop in the family members of the alcohol dependent individual as the disease of co-alcoholism. This claim states that in the early phases of co-alcoholism, there is denial and rationalization, with the hope that alcohol related behaviour will improve. There is also responsibility of guilt for the alcohol dependent individual's behaviours and some withdrawal. This way of coping, according to Denzin (1987:53); Stanhope and Lancaster (1988:684); Jesse (1989:175); Poterfield (1990:85) and South African National Council on Alcoholism and Drug Dependence (1993:4) does not help, but it encourages the disease to persist. According to the South African National Council on Alcoholism and Drug Dependence (1993:4), the non-drinking partner becomes pre -occupied with the alcohol dependent partner's alcohol dependency. She attempts to control his pattern of drinking and the consequences of alcohol dependency. She also tries to cover up for the alcohol dependent individual. Family life becomes increasingly unmanageable as other family members become so tense and anxious that physical and emotional symptoms start

to develop. The family is intimidated into keeping quiet about the alcohol dependent individual's abuse because he becomes angry when the subject is brought up. With reference to this stage, I have noted from practical experience with the alcohol dependent individuals and their families that as the family members begin to adjust to the drinking problem, the family roles shift. The alcohol dependent individual gives up his role as a parent and abandons household chores and maintenance, and the non-drinking partner takes over. Other situations on the shifting of roles in the family are discussed in the next section.

The non-drinking partner as stated by Denzin (1987:50), displays inconsistent reaction to alcohol abuse. In some instances, she responds in a nurturing way while, at times, in a punitive way. At times, the non-drinking partner displays both behaviors. The family, including the non-drinking partner according to Denzin (1987:50), experiences a lot of emotions during this stage and these are expressed in various forms, such as the family members taking greater responsibility to make the home appear normal or isolating themselves from the community to avoid embarrassment. In the same view, Leibovitz (1991:1) claims that an addiction in an adult does not relate to him alone because his problem influences the systems and environments within which he/she interacts. As the alcohol dependent individual progresses into the disease of alcohol dependence, it is most common for the non-drinking partner to become increasingly pre-occupied with his behavior. This pre-occupation is referred to as co-dependency. The combination of dependence and co-dependency affects the children in the family because the parents become unavailable, irresponsible, inconsistent and unpredictable. The non-drinking partners' reaction, according to Leibovitz (1991:1), is what she thinks makes sense to her. She acts and reacts in manners, which makes life easier and less painful for her and her children temporarily. As the problems around alcohol dependency become worse, the non-drinking partners behavior becomes an attempt to destabilize the family system. Later in life, this way of coping creates more problems.

During the course of alcohol dependent individual's drinking behaviour, the non-drinking partner, as stated by Brickman et al (in Bennet 1995:19), experiences various emotions such as guilt, blame and shame. She becomes guilty about the drinking because she sees herself as responsible in some way. She blames herself for the drinking and thinks that it is because of her incompetence that the drinking persists. Miller (1995:35) states that the non-drinking partner experiences shame about herself. She takes the alcohol dependency of her partner as a personal failure and thinks that a better wife would be able to help her partner. Miller (1995:36) further states that the alcohol dependent individual and his partner are two separate people and the behavior of the alcohol dependent individual should not make his partner feel inferior. Sikitha (1997:12) states that it is common for abused women to take responsibility for their partners' alcohol abuse because the abuser rarely admits the responsibility. My practice experience with the alcohol dependent clients and their families confirms the above. The non-drinking partners reported that their in-laws blamed them for the alcohol abuse and violence of their husbands. They reported that their in-laws encouraged them to be patient and work the problem out for the sake of the children and the marriage vows. According to Lamla (1985:23), the desertion of a husband by his wife in the African culture meets with strong family disapproval and she is referred to as "idikazi" as a term of disappropriation. The term "idikazi" is derived from the verb "ukudikwa" (to be disgusted with) and the noun "umzi" (a homestead). It refers to a wife who is "fed up" with married life. However, today this term is also applied to an unmarried woman. The life of an "idikazi" has a problem when it comes to inheritance. Although her child is accepted by his or her father, there is always a stigma of being fatherless attached to him or her. The child may be referred to as "umgqakhwe" or "ivezandlebe", meaning that he or she is illegitimate.

3.5.2 **Shifting of roles**

As stated above, in order for the family members to cope with the negative conditions that existed at home, roles are often adopted to bring some form of balance in the family. The following section discusses some of the roles adopted by the children of alcohol dependent

individuals in order to cope, that is, family hero, adjuster, placator, scapegoat, mascot and isolate.

3.5.2.1 **The family hero:** This role, as stated by Leibovitz (1991:2) is most common for the eldest child in the family who becomes a symbol of hope for the family and is expected to show the world that all is well within the family. A family hero may be expected to manage domestic responsibilities far beyond the capability of his or her age. A daughter may be a substitute mother if her mother is an alcohol dependent individual or even for a non-drinking mother who delegates her duties due to her own helplessness. The family hero becomes the family caretaker and usually excels in all his or her tasks. This according to Leibovitz (1991:2) is done to ensure that the family becomes respected by others who think that they are in control. The family hero, according to South African National Council for Alcoholism and Drug Dependence (1993:3), is often the eldest child who feels responsible for the welfare and the status of the family. He takes the attention away from his parents by focusing it on him by excelling and achieving. His behaviour is exemplary and he is admired for his achievements, especially when the situation he comes from is acknowledged. His normal needs however are not met and he experiences latent feelings of inadequacy, frustration and loneliness. The Encyclopedic Handbook of Alcoholism (1982:667) states that the non-drinking partner may encourage her elder son to take over the responsibilities abdicated by his father, placing the son in overt competition with the father in both behavior and drinking.

This role is common in the Xhosa culture and the eldest children are expected to protect the family when the need arises. This culture of responsibility is encouraged because it is expected that when the old man dies, his eldest son will inherit his properties such as cattle, land and home and will in turn take care of the family. On the other hand the eldest daughter is expected to assist her mother in the domestic chores such as childcare, cooking and making the home warm and receptive. In relation to this role, the Encyclopedic Handbook of Alcoholism (1982:667) states that daughters in alcohol dependent families feel that the alcohol dependent father prefers them to the mother and that if the mother was

more loving, the father would not drink. They believe that the ills of weak man can be cured by love, and thus tend to mirror alcohol dependent partners. This pattern of alcohol dependency is repeated.

3.5.2.2. **The adjuster:** This role as stated by Leibovitz (1991:2), is performed by a child other than the eldest. This child avoids conflict at all costs and acts silently without thinking or feeling. He is quiet and the least noticeable child and his task is to pass through life unnoticed. According to the South African National Council for Alcoholism and Drug Dependence (1992:3), the adjuster is a child who lives from situation to situation and he or she deals with problems as they occur. He or she is so flexible that she or he does not develop definite behaviour patterns.

3.5.2.3 **The placator** : This role according to Leibovitz (1991:2), is performed by the most sensitive child who tries to lessen tension and pain in the family . According to the South African National Council on Alcoholism and Drug Dependence (1992:3), the placator works very hard to keep everybody happy and often takes everyone's needs in to consideration. He hides his own unhappiness and problems behind those of other people.

3.5.2.4 **The scapegoat:** According to South African Council for Alcoholism and Drug Dependence (1992:3), this child diverts the attention from his parents to himself with his negative behavior. He is often regarded as the blacksheep, who is creating all the problems. These children often do not perform well at school, exhibit anti-social behavior, have illegitimate pregnancies and abuse alcohol or drugs at a young age. The scapegoat according to Leibovitz (1991:2) is most commonly the second child in the family. This child becomes the target of the family's anger which is projected on him.

3.5.2.5 **The mascot:** This role, according to Leibovitz (1991:2) is usually performed by the youngest child in the family. The parents aim to keep the child happy due to their own guilt. This role is sometimes referred to as the clown who tries to dispel the family tension by being a comic. In the same view, the South African National Council for

Alcoholism and Drug Dependence (1992: 3) defines the mascot as the funny, cute and often beloved child who brings relief through comical behaviour. He hides his heartache disappointment and pain behind this front.

3.5.2.6 **The isolate**: The South African National Council on Alcoholism and Drug Dependence (1992:3) claims that the isolate is a quiet child who tries to bring relief to the family by making virtually no claim for attention. He develops his own interests, has no friends and has learnt that contacts with the family members and others cause pain.

The roles assumed by the children of alcohol dependent individuals as discussed in this section provide relief and protection against emotional pain. These roles, according to the researcher are based on the defense mechanisms, as they prevent children from expressing their feelings. These roles also create a false sense of security because children avoid the reality that the family is disintegrating.

3.5.3 **The role of the non-drinking partner**

The family members, according to South African National Council for Alcoholism and Drug Dependence (1993:4) adopt forms of behaviour for coping with alcohol dependent individuals, yet enabling the alcohol dependent individual. One of the easily identified roles is that of the enabler, which is assumed by almost all the members of the family, including the non-drinking partner. The enabler tries to keep peace, protect the family and the alcohol dependent individual from the consequences of his drinking. This suggests that enablers contribute to the worsening of the alcohol dependent individual's illness. Considering the shifting of roles of the alcohol individual's children, as well as the non-drinking partner's reaction to alcohol abuse as stated in the previous section, it is clear that the behaviour of the alcohol dependent individual is maintained.

The South African National Council for Alcoholism and Drug dependence (1993:4; 1999:5) provides examples of enabling behaviour as accepting the dependence lies, paying

his debts, making excuses for him to create chaos, making him rely on others by taking over his responsibilities and protecting him from contempt of outsiders. This report claims that the family's desperation to help him change, does nothing but drives him further to drinking and denial. This means that as long as the family continues to protect him, the alcohol dependent individual continues to drink and escape from pain. Other examples of enabling behaviours stated by South African National Council for Alcoholism and Drug Dependence (1993:4) include denying that drinking is a problem despite the evidence to the contrary; rationalizing the alcohol dependent individual's drinking; minimizing the problem; avoiding problems and conflicts which might cause the alcohol dependent individual to drink; preoccupation with the alcohol dependent individual's drinking and waiting for things to get better.

In line with the enabling behavior as stated in this section, I have noted from my practice experience that the behaviour of the non-drinking partner enables the alcohol dependent individual's behaviour. One example of enabling behaviour as stated by the non-drinking partners who minimize the alcohol problem is "my partner only drinks beer". The non-drinking partners also reported that they avoid quarrels at homes to maintain peace in the family. This in turn suggests that the alcoholic's behavior goes unchallenged.

According to Stanhope and Lancaster (1988:684), the family plays a crucial role in alcohol dependency. Frequently, they deny the problem and minimize the extent of alcohol abuse. They protect the alcohol dependent individual and try to hide the problem from others. As more alcohol is used, the alcohol dependent individual blames the family members for the problems, thus instilling guilt feelings of inadequacy in the family, including the non-drinking partner. To prove their self worth, the family continues to protect the alcohol dependent individual by apologizing to him and making excuses for the abuse. However, the more the family tries to control the alcohol dependent individual, the more inadequate they feel. It is only when the alcohol dependent individual comes face to face with the destruction the disease is causing, will the denial be overpowered. The non-drinking partner, as stated by Janzen and Harris (1986:228) serves a supporting role in the alcohol

dependent individual's denial. When she sees that the problems caused by the alcohol dependent individual's drinking can no longer be excused, she may seek to control the drinking in various ways, such as drinking with the alcohol dependent individual, limit money supply, disposing of alcohol on hand or by limiting affection, attention or care. The alcohol dependent individual resists such reactions to his behavior and defies. Whether the wife is denying or controlling according to Janzen and Harris (1986:228), she is unintentionally an actor in a self perpetuating exchange.

Kessel and Walton (1977:111) view enabling behaviour in the following manner. They report that the wife spends a lot of time covering up for her alcohol dependent partner . She dissembles to his employers about his lateness, his absences or his early departures from work; she tries home remedies aimed at removing available alcohol at home. She searches for bottles of alcohol, hides, controls money and also persuades the shopkeepers not to allow credit. In the same view, the Encyclopedic Handbook of Alcoholism (1982:665) states that the non-drinking partner deals with her alcohol dependent partner in a way of tolerating his behaviour. In the advanced stages, hostility, withdrawal and suspicions become generalized to one's total environment. In the final stage of co-alcoholism, responsibility for, and quarreling with the alcohol dependent individual are worsened. It is only when the co-alcoholic detaches herself from her behaviour that the alcoholic dependent person becomes motivated for treatment.

The non -drinking partner, according to Berne (in Robinson 1979:136:145) seems to be surrounded by four other roles which are as follows: -

- **The rescuer**, who pities the alcohol dependent individual and wants to help him to stop drinking . She tolerates the drinking behavior.
- **The persecutor**, who aggressively criticizes the alcohol dependent Individual.

- **The dummy**, who provides him with money for clothing although she knows that it will be used to buy alcohol.
- **The bartender** or other professional sources of supply.

According to Berne (in Robinson1979:136-145), a person may occupy one or several roles simultaneously and may be either a member of a nuclear family, a relative or an outsider. The following advice is useful for the partners of alcohol dependent individuals:

- Do not make excuses for the alcohol dependent person or pretend that there is no problem. Your honesty is needed to help the person learn to face his or her own realities. This honesty needs to be shown together with firmness and care.
- Do not take over the person's responsibilities as this may leave them with a sense of no importance and lack of dignity and reinforce ideas of low self worth.
- Do not argue with the person when he is intoxicated.
- Do not accept responsibility for the persons actions nor feel guilty about their drinking as this is their choice, not yours (South African National Council for Alcoholism and Drug Dependence 1999: 5)

3.5.4 The family crisis

Major family crisis, according to South African National Council for Alcoholism and Drug Dependence (1993:3) are likely to occur as the drinking progresses. During this phase, weary family members look for ways to escape their situation through separation, divorce and attempted suicide among others. However, the family unit still has protective feelings

towards the alcoholic dependent person. Cohen and Krause, (1971:63) state that the alcohol dependent individual becomes excluded from the family system and becomes isolated. The lines of communication are affected negatively and the family's shame and guilt overshadow feelings of hopelessness and resignation.

Most families are unlikely to seek help at this point because they believe that nothing can improve the situation. Those who seek help hope that they will get better with or without the alcohol dependent individual. In the same view, Jesse (1989:170) states that the alcohol dependent individual becomes temporarily excluded from the family, and as a parent he loses the respect of her children. The children maintain an alliance with the non-drinking parent even though the alcohol dependent parent seeks to recover from drinking. They continue to perceive the alcohol dependent parent as deviant, despite his sincere effort to undergo rehabilitation. The alcohol dependent parent seeks to belong to his family to make up for the lost time. When the family members do not respond kindly, the alcohol dependent member becomes resentful and bitter. This resentment usually results in a return to drinking. The reason why the family members do not include the alcohol dependent individual in the family, according to Jesse (1989:171), is that they no longer trust him.

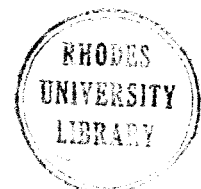
The situation for women who are dependent on alcohol becomes different according to Jesse (1989:171), as their non-drinking partners abandon them just at the point of entering treatment. He explains this by providing an example of a co-dependent partner who talked about his decision to separate from his wife during her second week of recovery. The co-dependent partner said that while his wife was drinking excessively, he felt that he had to stay at home and take care of his wife and children. He used to hate being tied down and listen to his wife, who often screamed and shouted at him in front of their children. During that time, he could not leave her because he thought that she would hurt herself or the children. Then later, he thought that it was time to leave her since she was serious about recovery. This suggests that the enabling role contribute to relapse which in turn contributes to the growth and persistence of alcohol dependency.

3.6 ALCOHOL AND MARITAL PROBLEMS

My practice experience has shown that alcoholism is an illness, which affects not only the alcohol dependent's health but also his marital life. This section focuses on alcohol and marital problems.

Janzen and Harris (1986:226) refer to a number of marital problems which are more likely in alcohol dependent couples . There is lack of cohesion in their marriages and the spouses are likely to refer to each other in derogatory terms. There is little giving or receiving affection and the participation of the alcoholic in the family effort is minimum. Spouses have difficulty in admitting marital problems and drinking serves to avoid facing them, if marital problems are mentioned in a treatment session, drinking episodes follow, and subsequent sessions revert to focus on the drinking. Al Anon, in Janzen and Harris, (1986:227) note that alcohol dependent individuals and their wives have trouble seeing their difficulties as marital, whether the alcohol dependent individual is still drinking or sober. It is also reported that spouses in alcohol dependent marriages view each other as instruments of their own bidding, as extension of self and not as separate persons. Al Anon also confirms this conception and maintains that it is destructive to believe that being married to an alcohol dependent individual puts the non-drinking partner in charge of him. Al Anon, in Janzen and Harris (1986:229) further states that “ we are so deeply involved that we treat those closest to us as though they are part of ourselves”. According to the National Institute on Alcohol Abuse and Alcoholism (1996:3), stress is a factor in alcohol dependence.

For one to understand any aspect of the social life of the African people, it is essential that one has a thorough knowledge of their system of kinship and marriage (Lamla 1985:21). In these cultures marriages are regulated by custom and are highlighted by the transfer of marriage goods and cultural ceremonies. These all mark a change in the individual's social status. The slaughtering of cows and drinking of beer is associated with ancestors and



marks a rite of passage from being single to married life. After the marriage ceremony is completed, the husband has full sexual rights over his wife. The life of a wife is hard because she has to respect her husband and her in-laws. The marital home among the Xhosa speaking people is referred to as “kwanja zoth’umlilo”, meaning “even dogs sit around the fire place”. This means that the wife must cater for everybody. She is expected to be patient even if she is irritated and must accommodate all the problems encountered. Once the marriage is contracted, it becomes binding on both sides of the alliance. It is also expected that the wife bears children and failure to do so creates problems.

3.6.1 Communication

Communication is very important in a marital relationship. According to Van Pelt (1986:77), communication in a marriage is complete when a couple can handle three principles consistently, namely talking and listening to each other, resolving conflicts through constructive methods and spending time in an intimate sharing of feelings on a daily basis. Van Pelt (1986:77) further states that communication in a marriage involves talking, listening and understanding each other. Through talking one can express his or her feelings, convey emotions and express his or her opinion.

Van Pelt (1986:78) describes what she refers to as Powell’s five levels of communication as follows:

- | | |
|----------|---|
| Level 5: | Small talk - this level involves shallow conversation. |
| Level 4: | Factual conversation - this level involves sharing of information . |
| Level 3: | Ideas and opinions - real intimacy begins at this level and thoughts and feelings are expressed. |

Level 2: **Feelings and emotions** - at this level, feelings and emotions are expressed in words.

Level 1: **Deep insight** - this level involves understanding of each other as well as self-disclosure.

Many couples experience difficulties in their relationships. Communication breakdown has been cited as one of the reasons, which leads to marital disputes. According to Van Pelt (1986:77), the lines of communication should be open from the onset when the relationship starts. The couples should talk about their expectations and whether those expectations are realistic enough for both of them to meet. The couple should define their roles, such as parenting style, household management and responsibilities, among others.

As stated above, it is difficult for communication to take place between the alcohol dependent individual and his or her partner and children. The non-drinking partner keeps quiet about her alcohol dependent partner's behaviour because he becomes aggressive when the subject is brought up. The relationship among these couples is characterized by anger, frustration and stress. More often, the couple has no time to share their thoughts, ideas and feelings, because of alcohol. Their feelings are only expressed by blaming each other, threats about separation or divorce and statements which provoke guilt. They rarely operate beyond Powell's level 3 as stated by Van Pelt (1986:78) in this section. This suggests that the sub-system of the spouses is affected because the non-drinking partner, instead of trying to improve the marital relationship, moves in a children's sub-system. This in turn makes the alcohol dependent individual feel rejected and isolated and this frustrates him such that he goes back to drinking. According to the Encyclopedic Handbook for Alcoholism (1982:666), drinking frequently triggers anger in the drinker and provocation in the non-drinking partner and other family members. Although the alcohol dependent individual may sometimes try to absorb anger by drinking alcohol, this may not be the case as it may trigger further anger. Drinking, according to the Encyclopedic Handbook for Alcoholism (1982:667) contributes significantly to

provocation, verbal abuse and physical violence. In a situation of anger provocation, violence and alcohol, it is unlikely for communication to take place between partners. In my practice experience I have found that black couples need to grow in the area of communication. Most of the Xhosa- speaking couples that I have worked with during my practice experience voiced communication problems, as a result they made use their extended families to communicate. This means of communication has an advantage to some couples, depending on their norms. Some couples stated that reporting the alcohol dependent individuals' behavior to the extended families made the situation worse, whereas others reported the opposite. One of the negative effects of alcohol, as stated by Soul City (1996:10) is that it makes one unwilling to co-operate. Communication between the alcohol dependent individual and his non-drinking partner becomes poor. According to O'Farrell, Choquette, Cutter, Brown and McCourt (1993:652), marital and family treatment (MFT) helps stabilize marital and family relationships and supports improvement in the alcoholic's drinking during and after treatment. According to these authors, behavioural marital therapy that combines a focus on drinking with the inclusion of positive couple and family activities and teaching communication and conflict resolution is a most promising Marital and Family Treatment approach.

3.6.2 Sexual relationships

According to Van Pelt (1986:148) common problems in marriage arise when one partner desires sexual relations more frequently than the other. Studies on couples indicate that coitus three times a week is average during the entire course of marriage. Frequency depends, however, on a number of factors such as age, health, social and business factors, emotional conditions and inability to communicate about sex. Van Pelt (1986:149) states that there is a connection between good sexual communication and good sex life and cites sexual problems as caused by:

- Couples who do not talk about their likes and dislikes regarding sex.
- Lack of communication about sexual matters e.g. likes and dislikes
- Belief that their partners should talk about their sexual preferences.
- Inability to keep up sexually with other changes in their relationships such as birth of their children.
- Use of sex to resolve their difficulties in other spheres of their lives.

In line with the above, the Encyclopedic Handbook of Alcoholism (1982:665) states that the alcohol dependent husband leaves his wife starved for affection and attention. As the alcohol problem progresses, his sexual performance declines. In my practice experience with the African community, I have found that it is difficult for a married woman to refuse her husband sex whether he is a dependent husband or not. This is a patriarchal community where the wife is regarded as the husband's property. The non-drinking partners become frustrated sexually because they cannot voice their opinions. It is culturally not expected in the Xhosa community for a wife to refuse sex to her husband because that would imply allegations of adultery. Other frustrations of the non-drinking partners are that the alcohol dependent husbands become sexually demanding but inadequate in performance. At times, they demand sex in the presence of children and this is embarrassing to the family. According to Makofane (1997:7), black women accommodate forced sex within a marriage because of cultural assumptions that rape can not occur between husband and wife.

According to Lamla (1985:22), the Xhosa speaking culture, particularly in Mpondoland is tolerant toward extra-marital affairs by men. Every married man is free to one or more girlfriends (amadikazi) and there is nothing that a wife can do if a husband commits adultery. In a research study conducted by Lamla (1985:22) among the Xhosa speaking people of Mpondoland, one of the respondents stated that "to be a male is to live in luxury".

3.6.3 **Marital roles**

Van Pelt (1986:120) argues that few couples are aware of their role performance, and failure to carry out a role can cause marital tension, and may even prove disastrous in a marriage. She states that there are four basic role patterns, which exists, namely patriarchal, matriarchal, egalitarian or co-leadership and power struggle. In the patriarchal relationship, common to South Africans, and more emphasized in the former Transkei, the husband is recognized as the undisputed head of the household. Although the wife has some authority in certain areas such as childcare, the husband dominates the relationship. He determines all policies and rules for the entire family. In the matriarchal marriage, the wife assumes the lead role as the head of the family. This can sometimes happen by default when the husband fails to direct the family. This power structure is more common when the husband is often absent. In the egalitarian or co-leadership marriage; the emphasis is on authority, household chores and responsibility. Neither the wife nor husband is regarded as the undisputed head of the household. The marriage is characterized by mutuality and reciprocity. In the power struggle marriage, the wife and husband compete for the leadership role. This competition results in a better resentful partner and confused children.

As has been stated above, in order to cope with the negative conditions that exist at home, roles are often adopted to bring some form of balance. The non-drinking partner and children assume certain roles and responsibilities abdicated by the alcohol dependent partner and he expects the family to believe in his sobriety and to trust him, whereas he has been distrustful. In the same view, the Encyclopedic Handbook of Alcoholism (1982:668) states that as the non-drinking partner takes over the full management of the family, the alcohol dependent individual is relegated to a child's' status and this perpetuates drinking.

3.6.4 Violence in marriage

Numerous studies have documented that the risk of marital violence is higher among men who drink excessively than among more moderate drinkers (Leonard and Quigley 1999:537). According to Harrison (1998:3), the relationship between substance abuse and domestic violence is a complex one, and often women are blamed for staying in such relationships, instead of men being blamed for abusing them, or society being blamed for condoning male violence. The patriarchal climate of the rural Xhosa family also allows the sense of privacy and secrecy to protect the perpetrators of violence in the family (Ferguson-Brown 1998:44). According to Lamla (1985:23), if a wife leaves her husband because of ill-treatment, her father keeps her and her husband is forced to pay the outstanding marriage goods (ikhazi). This process is referred to as “ukutheleka” in Xhosa.

3.7 THE ROLE OF THE SOCIAL WORKER

Alcohol dependency is a multi-faceted problem, which requires a multi-professional approach. For the purpose of my area of study, I will focus this discussion on the role of the social worker as part of the rehabilitation team. The social worker plays a major role in the management of alcohol abuse and the methods of social work used are casework, group work, and community work. Other intervention strategies involve marital and family therapy and aftercare.

3.7.1 Casework

The social worker-client relationship is considered to be a very important catalyst for change. This suggests that it is imperative that the social worker establishes a good working relationship with her client. In order to achieve this, application of the following social work values is of utmost importance (Skidmore & Thackeray 1982:64):

- Uniqueness
- Individual worth and capacity
- Client's right to self determination

This method is used to address the problem of the alcohol dependent client, his or her non-drinking partner and children. Separate interviews are held for individual assessment and management of client's needs. Counselling focus on teaching them coping skills to live without alcohol and to replace alcohol with some form of positive addiction such as jogging. The alcohol dependent clients are also taught positive ways of restructuring their time as well as budgeting. It is important for the social workers to recognize that the majority of clients relapse following addictions treatment (Graham, Annis, Brett and Venesoen 1996:1127). This suggests a major challenge in clinicians (Brewer, Catalano, Haggerty, Gainey and Fleming 1998:73).

The counselling sessions for the non-drinking partner focus on providing information about alcoholism and teaching positive ways of coping with the alcohol dependent partner. The social worker also holds counselling sessions with the alcohol dependent client's children who display behavior problems and learning difficulties. The Encyclopedic Handbook of Alcoholism (1982:664) terms the children of alcohol dependent parents as "forgotten children". The counselling sessions of these children identify their needs and focus on addressing them. In the same view, children of alcohol dependent individuals as stated by Jesse (1989:8) are victims of neglect, physical and sexual abuse as well as on going problems. They are forced to grow up too soon and to tolerate an unpredictable and abusive family environment. Since these children are exposed to alcohol abuse on a daily basis, they may rather rely on addictive practices such as alcohol, than on people as a way

of filling the empty lonely self. Jesse (1989:10) further states that alcohol dependent parents become self absorbed. The social worker's role is to assess if the children are abusing alcohol or not and to involve them in counselling sessions to improve the child - parent relationship.

The casework method deals with the client in totality and the family is also regarded as a client. Social workers believe that alcoholism is a family problem. According to Janzen and Harris (1986:224), the alcohol dependent individual and his family seem to be locked in a repetitive cycle. From a family system's orientation, Janzen and Harris (1986:224) state that resolving family problems and reducing family problems go hand in hand. In family counselling, the social worker focuses on helping the family and the alcohol dependent client to find new positive ways of coping in response to distress. The social workers also believe that the couple can be seen jointly to address the problems that affect them as a spouse sub-system (O'Farrel, Choquette and Cutter 1998:357). Since the alcohol dependent client and the non drinking partner have different expectations during the early phases of recovery, the social worker's role, according to Turner (1983:194), is to help them to understand and accept each others feelings and educate them regarding appropriate expectations. Patience on both sides is emphasized. The active involvement of the family members in the treatment program focusing on relapse prevention is important (Malhotra, Basu and Malhotra 1999:709).

According to Lewis, Dana and Blenvis (1988:158), no alcohol dependent individual can be treated effectively unless his or her social interactions are taken into account. In the same view, Lewis, et al (1988:160) state that the family members become trapped in a highly disordered system. They adjust to the situation, although it is unhealthy to avoid losing the alcoholic member. The only healthy response, as stated by Lewis et al (1988:160) is to open up and voice their practical problems, pain and frustrations. This action would protect the family's psychological well being and provide the best hope of bringing the alcoholic to treatment. According to this view, the social worker's role is to help the family as a whole to interrupt their rigid patterns of interaction.

The guidelines for treating alcoholism for social workers who work with alcohol dependent clients and their families, as stated by Denzin (1987:121) are as follows: -

- Treat the drinking before treating the underlying symptoms and problems caused by drinking.
- Separate the alcohol dependent client from alcoholism. Understand that alcohol dependent client's drink because of alcoholism, not because they are bad people.
- Make the alcohol dependent responsible for this treatment.
- Remove any excuses the alcohol dependent client gives for not seeking continued treatment or for drinking again.
- Help the alcohol dependent client learn from relapses.
- Help the alcohol dependent client and the family so that the recovery is possible.
- Teach family members that they relapse when they return to negative emotional thinking and when they try to control the alcohol dependent client and other people in the world.
- Help the entire family become involved in separate treatment programmes.
- Never treat the family as a group until its member has been treated individually.

- Encourage a spiritual program for each family member .This programme should include the attitude of forgiveness, care , love and understanding .
- Make self-honesty an essential part of each person's recovery programme.
- Encourage family members to share their recovery experiences with others who are still suffering from the effects of alcoholism.

According to Velleman (1992:132), when a family member comes for help, he or she becomes a client in his or her own right. It is important to ensure that both the social worker and client agree as to what goals of counselling they want to achieve. The social worker, as stated by Velleman (1992:132) should be engaged in the following task:

- Listening and helping to reduce anxiety.
- Counselling on coping methods, namely, positive ways of thinking about the problem and how to alleviate it.
- Helping to improve couple or family communication.

The social worker's role in family counselling according to Leibovitz (1991:5) is to help the family and the alcohol dependent client to find new ways of coping in response to distress. Major areas of recovery that the social worker focuses on according to Leibovitz 1991:5 are:

- Readjustment of roles.
- Helping the family to grieve for lost time and damages that occurred.

- Education and self-awareness on relapse and addiction.
- Dealing with children, helping them to come to terms with trauma, and again understanding of what they have been through.

The social worker has to understand and respect the client's cultural beliefs to make counselling successful. Mabe (1991:8) supports the recognition of culture during the intervention process and supports her claim by making an example through a case study. Her case study is summarized and only important features of culture are highlighted.

MABE'S SUMMARIZED CASE:

A male client aged 27 was admitted to SANCA Soweto clinic for treatment of a dagga dependency problem. He was charged with possession of dagga and was referred to the clinic for rehabilitation as part of his sentence. He was born in the rural areas of Natal in an extended family and was the youngest. His father died when he was 20 years old and his mother and grandfather raised him. His mother died during the year prior to his rehabilitation. No feelings of loss and hurt were expressed by client although he said he loved his mother. According to the client, his culture did not allow a man to express feelings of love and closeness to their mothers. He also stated that he had a good relationship with his wife because she respected him, and according to his culture, a man had the final say. The client smoked dagga since he was 8 years old and he did not see anything wrong in it. It is grown in his area and was used to cure asthma and colds. The client did not believe in medical doctors and used dagga as tonic.

The above case study illustrates that although the rehabilitation team indicated to the client the harmful effects of dagga as a substance and as a violation of court order, understanding of the client's culture was very important to make the intervention successful.

3.7.2 **Groupwork**

The social worker can also use the groupwork method for alcohol dependent clients, their non-drinking partners and children. Each category is grouped together for specific goals which are similar as a group, for example, a group of alcohol dependent clients. According to Herbert (1986:188) group counselling for alcohol dependent clients helps them to achieve self-direction, integrity, self-responsibility, self-acceptance and understanding of their motivation and pattern of behaviour. In the same view, Zimberg (1982:138) states that group work is most widely practiced by social workers and it is frequently utilized for financial reasons. It is particularly helpful for alcohol dependent clients who are lonely, moderately anxious, depressed and who have poor self-image. The alcohol dependent clients frequently respond more favorably to confrontation by their peers and are better able to learn new patterns of relationship in a group. The advantage of group counselling according to Herbert (1986:188) is that clients not only receive help for themselves but they have similar problems which can at least be comfortable to share and learn from. It is important for a social worker, according to Lewis et al (1988:159) that she or he understands the group dynamics, communication, decision making, sources of power and perceptual processes. With relevance to this study, group work can be utilised for a group of non- drinking partners so that they share their experiences about living with alcohol dependent partners and how to cope effectively under these circumstances.

3.7.3 **Community Work**

Social workers play a major role in alcohol abuse prevention by working with the community and conscientising them about the dangers of alcohol in the community. There are various programmes in which social workers get involved in, such as educational

programmes in schools, making students aware of the dangers of alcohol and how to live free from it. Social workers also run awareness campaigns on alcoholism and how it could be prevented the community. They also facilitate the establishment of community projects that prevent alcohol abuse and also those that provide support to the alcohol dependent individuals and their families. The social worker, as stated by Soul City (1996:31), can involve the communities in the following activities to prevent alcohol abuse:

- Formation of support groups for alcohol independent individuals and their families.
- Building of recreational facilities for the youth.
- Discouraging alcohol advertisement near the schools.
- Disseminating reading material on alcohol abuse prevention.

Some of the current challenges facing welfare service, among others are as follows:

- To build up human resources as well as physical infrastructure where services are most needed.
- To ensure that services reach those rural based communities.
- To shift services from being predominantly reactive to more proactive.
- To shift the focus of services from a curative approach to a preventative approach (Department of Welfare 1999:3)

This suggests that the social workers involved in alcohol dependency program should be in line with the above and shift their approaches to strengthen and build the capacity and self-reliance of the communities.

3.7.4 Aftercare

When the alcohol dependent client is discharged from the rehabilitation centre, his aftercare is a very important task of the social worker. According to Sartor (1998:4), the aftercare programme has to be well structured and its objectives should be as follows:

- To provide a continued support system for patients and their significant others.
- To supervise continued medication when necessary, maintenance of employment and general functioning of the client.
- To assist with the problems encountered in the process of integrating into the broader community.
- To enhance the skills and resources that the patient acquired during the inpatient phase.
- To assist the patient to remain abstinent and to lead a constructive life style.

In addition to the treatment and rehabilitation program for alcohol dependent clients, the bridging place between the treatment centre and the community is important. There is only one registered after care facility in South Africa namely Eureka Aftercare home (The Daily Dispatch 20 September 2000: 5). This facility is situated in East London in the Eastern Cape Province.

Coping skill deficits are seen as a major predisposing individual risk factor for the development and maintenance of alcohol dependence (Baer, Kivlan, Donovan 1999:16). In line with the above, a number of studies have provided a strong support for a relationship between coping and relapse prevention (Moser and Annis 1996:1101).

3.8 **SUMMARY**

This chapter has discussed how the alcohol dependent individual manipulates and controls his drinking partner with his behaviour and how this impacts on the family as a whole. This impact results in the non-drinking partner and children using coping strategies to protect the family. The non-drinking partner avoids conflicts which might cause the alcohol dependent partner to drink, and protects him from contempt of outsiders. Alcohol dependency in a family also affects the spouse subsystem because communication, the sexual relationship and marital roles become affected. The alcohol dependent partner also fails to perform his family functions. Social workers play a major role in alcohol dependency making use of casework, group work, and community work and after care.

METHODOLOGY

AND

RESEARCH DESIGN

CHAPTER 4

METHODOLOGY AND RESEARCH DESIGN

4.1 INTRODUCTION

Research begins when a researcher attempts to define an interest, solve a problem, or explain an idea. Social research is defined as the process in which one attempts to check, revise or extend the knowledge of the nature and functioning of social reality (Friedman 1998:6). In this study which involves social research, I wanted to explore the experiences of couples in relationships characterised by alcohol dependency. The aim was not to solve certain problems, but to gain an understanding of the above.

4.2 RESEARCH DESIGN

This chapter focuses on how the study was conducted in terms of the research design, methodology, sample, data collection tool, and procedure and data analysis. The research design is a plan of how the researcher plans to execute the research problem that has been formulated, its objective being to plan, structure and execute relevant project in such a way that validity of findings is maximized (Mouton 1996:175). When describing the research design, it is important that the researcher includes the information on who will be studied, what will be observed or measured, and how the data will be gathered (Grinnell 1998:143). This is necessary to ensure that the researcher remembers the original motivations of the research while being encouraged to explore the topic in different ways (Rubin and Rubin 1995:42)

An exploratory design was used in this study. I chose this design for the benefit of the study which aim was to explore and gather facts on the experiences of couples in

relationships characterised by alcohol dependency. Exploratory designs are employed in situations where the researcher knows very little about the topic or problem and when his/her purpose is to explore (Yegidis and Weinbach 1991:76; Grinnel 1998:143). While authors such as Rubin et al (1997:109) argue that exploratory studies rarely provide satisfactory answers to research questions, they are arguing from a position which assumes certain things about what can be viewed as a satisfactory answer. In a research of this kind, the aim is not so much to provide definite answers (which rarely exist), but rather to build a foundation of general ideas and tentative theories, which could be explored later with more precise and more complex research designs, and yield new insights into a topic for research. The exploratory design was specifically useful in this study, as the focus was on exploring a relatively under-studied topic and learning as much as possible from it.

4.3 **RESEARCH METHODOLOGY**

In order to explore the experience of couples in relationships characterised by alcohol dependency, the qualitative methodology was used. According to Leedy (1993:399), the nature of data is dictated by methodology. This type of methodology fitted well in this study as the aim was to explore the experiences of couples in alcohol dependent relationships. I obtained verbal information by interviewing the alcohol dependent respondents and their partners separately. I decided to use the qualitative methodology because my aim was to listen to the respondents as they described their experiences. In qualitative methodology the aim is not much to provide definite answers, but rather to explore the depth of meaning that people attach to their experiences (Grinnell 1998:143; Yegidis and Weinbach 1991:99).

For a study which uses an exploratory design and whose aim is to explore the depth of meaning that people attach to the experiences, qualitative methodology is relevant. Unlike in quantitative methodology where the focus is on counting and correlating the social and psychological phenomena (Grinnell 1998:185), in qualitative methodology, the emphasis is

placed on fully describing and comprehending the subjective meaning of events of individuals and groups caught up in them (Yegidis and Weinbach 1991:99).

4.4 **THE SAMPLE**

Seaberg in Grinnell (1998:240) states that once the researcher has stated the research problem in the researchable form, the next step is to generate relevant data that would help solve or address the problem. The researcher must decide what or whom to observe, or who must answer the questions posed in the investigation. This phase of the research process is referred to as sampling. It is a small portion of the total set of objects, events or persons that together comprise the subject of the specific research study.

The purpose of sampling is to select a set of elements from a total population in such a way that descriptions of those elements accurately portray the parameters of the total population from which the elements are selected (Rubin and Babbie 1993:219). For the purpose of this study, I selected fifteen alcohol dependent clients who were admitted for treatment to the rehabilitation centre during the period starting from January 1997 to June 1999. I had a sample of fifteen alcohol dependent respondents and their partners which made up a total of thirty respondents. I am aware that the sample is small, however, I regard it, as satisfactory in relation to my research needs since the information gathered was qualitative. This is supported by Patton as quoted by Marlow (1998:147) who argues that the validity, meaningfulness and insights generated from qualitative inquiry have more to do with the information richness of cases selected and interviewing or analytical capabilities of the researcher than the sample size. In this study, purposive sampling was relevant because I interviewed the respondents who met my criteria which was as follows:

- Clients who were admitted at Thembelitsha Rehabilitation Centre during the period starting from January 1997 to June 1999.

- They were involved in an emotional and sexual relationship with the same partners whom they were involved with before admission to Thembelitsha Rehabilitation Centre and presently.
- The alcohol dependent clients and their partners were both willing to be interviewed.

This type of sampling made it possible to use my own judgement and I selected fifteen couples on account of their situation and experience, their willingness to participate, my knowledge of the local rehabilitation centre and the nature of the research aims (Huysamen 1994:175; Rubin and Babbie 1997:266; Babbie 1998:194).

The advantage was that this method was inexpensive and easy to use. I am aware that my sample is small and it is not representative of all the alcohol dependent respondents and their partners. I do not want to generalise from the data, but I wish to provide valuable information regarding the problems and limitations which are addressed in the recommendations. This method is likely to stimulate new leads and avenues of research (De Vos 1998:244).

4.5 **PROCEDURE**

I obtained written consent from the director of Thembelitsha Rehabilitation Centre to interview the alcohol dependent clients and their partners. In addition to this, I obtained verbal consent from the respondents who were assured of confidentiality and the aim of the study was explained. I contacted the respondents at Thembelitsha Rehabilitation Centre during their appointment dates for aftercare and requested their willingness to be interviewed and also to arrange the interview dates. The interviews were conducted separately for the alcohol dependent respondents and their partners. The interviews were conducted at a place chosen by the respondents, either at Thembelitsha Rehabilitation

Centre or in their homes in the rural and urban areas of the Eastern region of the Eastern Cape Province. The interviews were conducted in Xhosa, the home language of the respondents and I jotted down field notes to record the responses. In addition to the fieldnotes, I intended to use a tape recorder but the respondents refused to be recorded on tape during the interviews and I respected their opinion. The fact that data was recorded by hand may suggest that some details from the respondents might have been missed. However, this was done because the respondents indicated that they did not want to be tape recorded. I certainly did not want to jeopardise the rapport I had with the respondents. Importantly, tape recording the interviews without their knowledge would be an unethical and unacceptable research practice. I am aware that recording ensures completeness of data, but it was important for me to get the respondents' permission. I understand that some potential respondents refuse to be interviewed when their comments are being recorded (Yegidis and Weinbach 1991:200). The interviews were carried out over a period of six months, from September 1999 to March 2000.

4.6 **DATA COLLECTION**

The data was collected by means of qualitative interviews. Qualitative interviewing is an intentional way of learning about people's feelings, thoughts and experiences (Rubin and Rubin 1995:2). I preferred to use this method because it encouraged the respondents to reflect in detail on events they have experienced in alcohol dependent relationships (Rubin and Rubin 1995:2). I found qualitative interviewing best suited for this study, considering the exploratory design and qualitative methodology which I had chosen. This study focused on exploring the experiences of couples in relationships characterized by alcohol dependency. Qualitative interviewing is appropriate when the researcher is in need of information that can best be obtained through oral communication (Yegidis and Weinbach 1991:193).

The following section will present the research interviews and questionnaire as they are the most common ways of collecting data (Grinnell 1990:219). However, more focus will be directed to the qualitative interviews, a research tool which I have used in this study.

4.6.1 **Research interviews**

I used a semi-structured interview guide based on my research questions. In this type of interview, I had some prepared questions but also had some latitude in deciding the wording and order of questions to be asked (Grinnell 1990:215). Another advantage which I had in using semi-structured interviews is that they were relevant to my respondents who were of different ages.

Questions asked in research interviews can be classified as closed ended and open ended (Grinnell 1990:215). Instead of the closed ended questions which limit the respondents to express a “Yes” or “No”, I used open ended questions because they are designed to encourage free responses without limitation of present categories. Open ended questions are often used when all the possible responses involved in a question are not known or when the researcher is interested in exploring some of the basic issues and process in a situation (Grinnell 1998:315). Open-ended questions were relevant for this study because its purpose was to generate a greater understanding of the experiences of couples in relationship characterised by alcohol dependency. These questions provided the respondents with an opportunity to describe their feelings, thoughts and experiences in their own words and there were no limitations of responses.

Closed ended questions would not be suitable for this study because the respondents would be required to choose from a list of alternatives which I would provide. Since I intended to explore and to allow the respondents to express their personal and individual feelings on the research questions, open-ended questions were well suited for this study.

There are other important advantages of research interviews which I found very useful to this study and they are as follows:

- **Naturalness and spontaneity**

Interviews usually create a natural situation for individuals to present information in the sense that most people find it easier and more natural to respond to questions orally (Gochros 1981:255). I benefited from this advantage because the interviews were conducted in casual and relaxed settings and the respondents were comfortable to speak as the interviews were conducted in Xhosa. The wording of questions was simple, clear and unobtrusive. I examined the clarity of questions by pretesting the research instrument with the assistance of my supervisor, fellow students, colleagues and Thembelitsha aftercare counsellor. After revising a few questions, I conducted a pilot study on two couples whom I have also included in this study.

- **Control over responding**

I conducted separate interviews for the alcohol dependent respondents and their partners, making use of the semi structured interview guide for each respondent. Unlike in mailed questionnaires where the researchers do not know who completed the questionnaire, I was in complete control of the research situation, because I knew which responses belonged to a particular respondent. My biggest advantage was that I was in a position to notice and clear misunderstandings on the part of the respondents as they occurred (Huysamen 1994:144).

- **Flexibility**

One of the special strengths of interviews is that it permits far more flexibility than survey questionnaires (Gochros 1981:256). In talking with an interviewer, areas which might be difficult to frame in specific questions can be explored while probing questions can be used to give responses greater depth. In the same view, Rubin and Babbie (1997:390) state that the interview method allows respondents to express their own perspectives in that the interviews provide rich descriptions of individual experiences. The qualitative methodology, the exploratory design, the semi-structured interviews and open ended questions which I used created opportunities for this advantage. I was able to initiate discussion about the responses so as to provide the respondents with the opportunity to expand on the responses more fully, thereby allowing myself to acquire more indepth information. One of the respondents (A) preferred to relate a story in answering the circumstances leading to his admission. The respondents can use stories to answer difficult or threatening questions indirectly and these are often indirect so that the interviewer figures out the meaning herself (Rubin and Rubin 1995:233).

- **Non-verbal responses**

The interview provided me with a better position to observe the body language of the respondents and to probe for explanation where necessary (Grinnell 1990:212). This advantage requires good listening and observation skills which I have as an experienced social work practitioner. In the same view, Yegidis and Weinbach (1991:193) state that interviewing for data collection is a research task that often comes quite naturally to the social work researcher.

4.6.2 Research questionnaires

A questionnaire is a set of questions to be completed by the respondents themselves themselves (Hall and Hall 1996:98). These can be sent by mail to the respondents or administered by the researcher. The advantages of questionnaires according to Grinnell

(1990:220) are that they are less time consuming, less expensive, allow anonymity and make it easy for the analysis of data. While the questionnaires may have advantages than the strengths of interviews (Marlow 1998:163), a questionnaire was not suitable for my study because it would limit my goal of generating greater understanding on the experiences of couples in relationships characterised by alcohol dependency. If I used questionnaires, I would miss out on talking directly to the respondents, and using probes for unclear responses or incomplete answers.

4.7 ANALYSIS OF DATA

The study consisted of qualitative data which I analysed by hand. After completing the interviews, I examined the fieldnotes which I recorded during and after the interviews. I read the responses paragraph by paragraph and word by word, marking off each time a particular idea was mentioned or explained (Rubin and Rubin 1995:227). The information was divided into categories, common themes and similarities which emerged from the data (Taylor and Bogdan 1984:5; Hall and Hall 1996:196). I grouped the responses under similar headings. To identify the respondents and their responses, I assigned them in alphabetical order from A-to-O.

4.8 LIMITATIONS OF THE RESEARCH

The interviews were not recorded on tape as I had planned because of the situation I encountered in the field as explained in 4.5. I am aware that this limitation may impact on my findings which may result in them to appear as not completely qualitative. However, this study provided valuable information regarding the problems faced by the Xhosa-speaking couples in relationships characterised by alcohol dependency, as well as the challenges faced by the service providers and these are addressed in the recommendations. The number of the respondents is small and does not include other alcohol dependent individuals who have not submitted themselves for treatment and rehabilitation. The study

also involved the respondents who reside in the Eastern region of the Eastern Cape province. I do not want to generalise from the data.

4.9 **VALUE OF RESEARCH**

- The research provided insight on the experiences of couples in relationships characterised by alcohol dependency.
- This study gave the respondents the opportunity to describe the relationship issues that they face.
- The findings of this study will benefit the multi-disciplinary team, community based structures and non-governmental organisations involved in the treatment and rehabilitation of alcohol dependency.

Both the Departments of Health and Welfare can use these findings to implement new programmes for the families of alcohol dependent individuals.

4.10 **SUMMARY**

The research design used in this study is exploratory in nature. A purposive sampling method was used. Fifteen couples comprising of alcohol dependent respondents and their partners were interviewed and a semi-structured interview schedule was used for this purpose. The information was divided into categories, common themes and similarities which emerged from the data. The limitations and value of the study have been highlighted.

PRESENTATION

AND

DISCUSSION OF FINDINGS.

CHAPTER 5

PRESENTATION AND DISCUSSION OF FINDINGS

5.1 INTRODUCTION

Alcohol dependence is a universal problem that manifests itself in universally consistent ways (Brewer et al 1998:74; Harrison 1998:3; Leonard and Quigley 1996:182; Graham 1996:1127; Swart 1995:2; Gelles and Loseke 1993:182). Although my study was based on Xhosa speaking alcohol dependent men and their wives, my findings confirm literature which is mostly based on studies of Western white men.

The study focused on the experiences of couples in relationships characterized by alcohol dependency. It involved 15 couples comprising of alcohol dependent respondents and their partners , thus making a total of 30 respondents. The data was collected by means of interviews and two interview schedules were used, one for the alcohol dependent respondents (Appendix A) and the other one for their partners (Appendix B).

In this chapter, I will present and interpret the findings elicited during the research study. The data and findings are presented according to the questions on the interview schedules.

Appendix A covers the following:

- Reasons for admissions to Thembelitsha rehabilitation centre.
- Year of admission.
- What happened after discharge?

- Relapse.
- Behaviour at home when drunk.
- Partner's response.
- Feelings about response.
- Length of relationship presently.
- Strengths in relationship.
- Difficulties in relationship.
- Whom to contact when experiencing marital difficulties.
- Duties in the family.
- Partner's duties.

The following is covered in Appendix B:

- Drinking history.
- Experiences in living with a drinking partner.
- Previous coping mechanisms.
- Present coping mechanisms.

- When does partner drinks most?
- Partner's behaviour at home when drunk..
- Feelings about drinking.
- Responses.
- Length of relationship.
- Description of relationship.
- Difficulties in relationship.
- Whom to contact when experiencing marital difficulties?
- Duties in the family.
- Partners duties in the family.
- When does the partner drink most?

The demographic information of the respondents is presented in the form of tables as follows:

5.2 DEMOGRAPHIC INFORMATION

The following tables provide the demographic information of the respondents in terms of their ages, educational qualifications, occupation, income, marital status, residential area and race.

5.2.1 Table 1 : Age

Age	Alcohol dependent respondents	Partners
24-29 years	-	1
30-35 years	2	3
36-41 years	3	7
42-47 years	4	2
48-53 years	4	-
54-59 years	-	1
60 years and above	2	1
Total	15	15

Table 1 indicates the ages of all the respondents. According to this table, the respondents were between 24 and above 60 years of age.

5.2.2 Table 2 : Educational Qualifications

Educational Qualifications	Alcohol dependent respondents	Partners
No formal education	-	1
Std 2-Std 5	1	1
Std 6 – Std 9	2	4
Std 10	5	3
Diploma	6	3
Degree	1	3
Total	15	15

Table 2 indicates that out of thirty (30) respondents , only one (1) had no formal education while thirteen (13) had a post-matric qualification.

5.2.3 Table 3 : Occupation

Occupation	Alcohol dependent respondents	Partners
Minister of religion	1	-
Teacher	2	4
Principal Storeman	1	-
Policeman	2	-
Watchman	2	-
Medical technologist	1	-
Driver	1	-
Trainer/Facilitator	1	1
Night shelter superintendent	1	-
Court interpreter		
Traffic officer	1	-
Nurse	1	-
Housewife	-	1
Radiographer	-	5
Laundry worker	-	1
Clerk	-	1
	1	2
Total	15	15

Table 3 indicates that the respondents are in formal employment except one alcohol dependent respondent and five (5) housewives who are unemployed. Their occupations cover a diverse range of employment.

5.2.4 **Table 4 :Income**

Income	Alcohol dependent respondents	Partners
No income	1	5
R1000-R1999	4	1
R2000-R3999	8	6
R4000-R5999	1	-
R6000 and above	1	3
Total	15	15

Table 4 shows that out of thirty (30) respondents twenty-four (24) have income except six (6) who are unemployed.

5.2.5 **Marital status**

All the respondents are married to their partners. This was relevant for my sampling as discussed previously on section 4.4.

5.2.6 **Table 5 : Residential area**

Residential area	Alcohol dependent respondents	Partner
Umtata	10	9
Engcobo	1	—
Tsolo	1	1
Qumbu	1	1
Libode	1	1
Ngqeleni	1	1
Cala	-	1
Port Elizabeth	-	1
Total	15	15

Table 5 indicates that out of fifteen (15) alcohol dependent respondents, most of them (n=10) stay in Umtata district where Thembelitsha Rehabilitation Centre is situated. From this study, it appears that most respondents who use this centre come from Umtata. This table also indicates that except for two (2) most alcohol dependent respondents (n=13) stay with their spouses. The two aforementioned respondents stay in Port Elizabeth and Cala but they come home to be with their families during weekends. This table also shows that most respondents (n=28) reside in the Eastern region of the Eastern Cape Province except two respondents who stay Port Elizabeth and Cala. (See appendix E for the map of the Eastern Cape Provincial Regions and the map of the former Transkei on page 142).

5.2.7 Race

All the respondents are Africans and their first language is Xhosa.

5.3 REASONS FOR ADMISSION

The alcohol dependent respondents were asked why they had been admitted. Out of fifteen respondents interviewed, eleven (A, C, D, E, G, H, J, KL, M, O) stated that their reasons for admission to Thembelitsha Rehabilitation Centre (TRC) was due to their excessive drinking and their inability to control their drinking. This inability to control drinking has been documented in the literature (Cochrane 1994:6) as one indication of physical and psychological addiction to drinking.

Three respondents (B, F, I) informed me that they were admitted due to health related reasons. One respondent (B) stated that he “suffered from nerves and it was difficult to sleep”. Another respondent (F) informed me that he was “half minded and could not see things clearly” while another respondent indicated that his health was not good.

Four respondents (E, I, M, N) indicated that they were admitted due to work-related reasons. One of these respondents (E) informed me that it was clear that his drinking was going to affect his work. Another respondent (I) informed me that his performance at work was not good and the other (M) stated that he “realized that he was going to be in trouble at work”. Literature (Stanhope and Lancaster 1988:685) states that employment is one of the aspects which are affected by alcohol. Coleman et al (1984:388) also stress that occupational functioning is impaired as a result of drinking. Although these respondents indicated that they were admitted due to work related reasons, only five (D, E, G, L, N) out of fifteen were advised by their colleagues about rehabilitation. One of the respondents (B) was referred by the doctor. Stanhope and Lancaster (1988:685) indicate the harm of alcohol dependency on health (see section 2.2.3)

Two respondents (A, C) were advised by their partners. In line with these findings it is emphasized that alcohol affects not only the physical and mental health of an individual but the interpersonal relations hence the partners become involved (see 2.2.2).

Five respondents (H, I, J, M, S) decided on their own to refer themselves for rehabilitation. It is interesting to note that although most respondents (A, C, D, E, G, H, J, K, L, M, O) were admitted because of their inability to control their drinking, followed by those who were admitted due to work (E, I, M, N) and health reasons (B, F, I), two respondents (A, K) indicated that their admission was due to domestic problems.

The findings reveal that all the respondents (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O) are alcohol dependent individuals since they were admitted for treatment and rehabilitation at TRC. Alcohol dependent individuals are those who, because of their craving for alcoholic liquor (A, C, D, E, G, H, J, K, L, M, O) use it to such an extent that it has detrimental psychological (A, C, D, E, G, H, J, K, L, M, O) social (A, E, I, K, M, N) and physical effect (B, F, I) on them, even though they may be aware of serious consequences (Defining Social Work Dictionary 1984:57). One of the reasons to explain alcohol dependency in the African culture is that it has religion and moral values that permit the use of alcohol (see section 2.3.4). According to socio-cultural theorists, exposure, availability, cultural drinking patterns, example and inappropriate use of leisure time contribute to the development and persistence of alcohol dependence (see section 2.3.3).

5.3.1 **General finding**

It is clear from the findings that most respondents (n=11) were admitted at TRC due to their excessive drinking and their inability to control their drinking, which indicates the physical and psychological addiction to drinking. Some respondents were admitted due to health, work and domestic problems.

5.4 **PERIOD OF ADMISSION**

The respondents had been admitted for treatment and rehabilitation for alcohol dependency at TRC during the period between 1997 and 1999. During the period of study, the respondents were discharged to their homes and were attending after care services for their conditions. Three respondents (D, F, K) were admitted in 1997, five (A, G, J, M, N) were admitted in 1998 and seven (A, B, C, H, I, L, O) were admitted in 1999.

5.5 **WHAT HAPPENED AFTER ADMISSION**

The respondents gave different reports on what happened after admission. Four respondents (B, D, H, J) reported improvements in their condition after admission, while two respondents (A, O) indicated that they occupied themselves with family and church matters and did not have time for drinking. Although five respondents (C, D, F, G, and H) indicated that they stopped drinking and stayed for a long time without drinking, one respondent (L) indicated that he was discharged without completing the program. Two respondents (M, N) indicated that they learnt about the dangers of alcohol and that there was no medication administered in the centre.

5.6 **RELAPSE**

An important issue stated by seven respondents (A, B, C, E, I, N, O) was that they had not relapsed after they were discharged and they were not drinking during the time of study. Although the respondents were rehabilitated, eight respondents (D, F, G, H, J, K, LM, N) indicated that they relapsed and seven were drinking although not as severe as previously. One of the respondents (F) reported that although he relapsed once and had fits, he was not drinking. While eight respondents (D, F, G, H, J, K, L, M) stated that they were not drinking in the past, the findings reveal that they had relapsed. This answer is interesting, as it may be indicative of the defense mechanisms such as denial, minimizing and

rationalization which the literature (Gelles and Loseke 1993:173) says are common in alcohol dependent individual and their families.

The high rate of relapse in the findings is in line with the literature that states that the majority of substance dependent clients relapse following addiction treatment (Graham et al 1996:1127; Brewer et al 1998:74; Foote et al 1999:181). These findings suggest a major challenge to the alcohol dependent treatment and rehabilitation team. It has been revealed from the findings in the previous sections that all the respondents (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O) were admitted at TRC due to their physical and psychological addiction to drinking. This addiction has been documented in the literature (Ingmar et al 1999:81) as one indication of craving (A, C, D, E, G, H, J, K, L, M, O) which plays an important role in the occurrence of relapse (D, F, G, H, J, K, L, M) in abstinent substance addicted persons in their home setting.

While the literature (National Institute on Alcohol Abuse and Alcoholism (1996:3) states that stress is a factor in alcohol dependence, only two respondents (A, K) in the findings reported that their admission was due to domestic problems. This finding supports the literature Janzen and Harris (1986:227) which says that alcohol dependent individuals and their wives have difficulty in admitting marital problems. The higher rate of relapse in the findings calls for the importance of teaching of coping skills as these two are related. (Mossier and Annis 1996:1106)

5.6.1 **General finding**

It is apparent from the findings that physical and psychological addiction is related to relapse. The findings reveal that most of the alcohol dependent respondent (n=8) relapsed although they state that they are not drinking as they did prior to their admission. This indicates some form of defense mechanisms which are common to alcohol dependent individuals (Gelles and Loseke 1993:173). Although the literature emphasizes stress as one of the factors in relapse, the findings are not specific about that.

5.7 BEHAVIOUR AT HOME PRIOR TO ADMISSION

The alcohol dependent respondents and their partners were asked about how the alcohol dependent respondents behaved at their homes before their admission. The findings reveal that a high number of alcohol dependent respondents (A, B, E, G, H, I, J, L, N, O) were abusive towards their families when they were drunk. These respondents cited examples of physical and emotional abuse, one respondent (H) indicated that “although I do not like fighting, I become irritable to my wife and we quarrel”. Another respondent (L) indicated that “ although I do not touch her, I shout her the whole night, making noise until the next morning”. Most respondents (B, D, E, G, H, I, J, L, N, O) informed me that they quarrel with their wives, they become violent and display aggressive behaviour patterns. These findings are supported by the Encyclopedic Handbook of Alcoholism (1982:667) which states that alcohol dependent individuals use anger as a strategy of control and this manipulates the partners into keeping quiet about drinking. In line with the findings, numerous studies state that marital violence is higher among alcohol dependent men (Leonard et al 1999:537; Harrison 1998: 3; Gelles and Loseke 1993: 182; Gibelman 1995: 261).

An important feature in the findings is that while most respondents revealed that they were abusive to their families, five respondents (A, C, F, K, and M) indicated no violence in their behaviors. One respondent (A) informed me that he was shy, (C) indicated that he kept quite, (F) indicated that he slept, (M) became “warm” and (K) avoided discussion and did not start quarrels. These findings are similar to the alcoholic’s denial statements stated by the South African National Council on Alcoholism and Drug Dependence (1993:3).

In addition to the abusive behaviour, the findings revealed that most alcohol dependent respondent (B, C, D, E, G, H, I, J, M, L, N) waste their money on alcohol. These findings confirm Leibovitz’s statement (1991:2) that alcohol dependent individuals fail to take proper care of their families. This suggests that when they waste money on alcohol, their

families suffer because the family needs are not met. This is contrary to the patriarchal system of being the provider and head of the family.

It is interesting to note that the answers given by the alcohol dependent respondent do not differ much from those given by their partners to similar questions. Most of the partners (Mesdames B, C, D, F, G, H, I, J, L, N, O) affirm that alcohol dependent respondents are abusive. Although two respondents (C, F) reported themselves as not abusive, their wives denied that. One respondent (E) reported himself as abusive while his wife (Mrs. E) denied this and she indicated that “ he is problematic with money but he has a good personality”. Other respondents (Mesdames A, K, M) indicated that their partners are not abusive. This is consistent with the literature which states that most women in African communities do not regard emotional or psychological abuse by their partners as abuse (Makofane 1996:6)

It is interesting to note from the findings that the respondents (Mesdames A, E, K, M) minimized the behaviours of their husbands when they were drunk. (Mrs. A) stated that “he never did frightening things”, although she said that his behaviour was “painful and embarrassing”. This is consistent with the literature which says that the partners of alcohol dependent individuals often respond to alcoholism and family violence by denying the problem, minimizing rationalizing and isolating (Denzin 1987; 50; Stanhope and Lancaster 1988:684; Gelles and Loseke 1993:173).

5.7.1 **General finding**

The respondent and their partners indicate that abuse is common. However, some partners and alcohol dependent men disagree on whether or not the men are abusive, and if so, how abusive they are. These differences in opinion are interesting as they may be indicative of some of the defense mechanisms such as denial or rationalization which are common in alcohol dependent husbands and their wives (Denzin 1987:50; Stanhope and Lancaster 1988:684; Gelles and Loseke 1993:173)

5.8 WIVES' RESPONSES TO DRINKING

The findings reveal that the respondents were unhappy about their alcohol dependent men's drinking and they responded differently. Five respondents (Mesdames A, C, E, G, H) stated that they did not like their partners' drinking. Three respondents (I, J, K) indicated that their partners kept quiet about their drinking while four respondents (D, F, J, K) reported that their partners shouted at them, three respondents (D, K, L) revealed that their partners threatened to leave them. One respondent (B) indicated that his wife once left him and he had to pay a cow to her family to get her back, as it is a custom among Africans (Lamla 1985:23)

From the interviews with the wives of alcohol dependent respondents, the findings revealed that seven respondents (Mesdames A, F, G, H, K, L, M) did not confront their alcohol dependent men, instead they talked to them when they were sober. These findings also reveal that seven respondents (Mesdames B, C, D, E, and H, I, O) were passive to their husbands' drinking. One respondent (Mrs. B) stated that "I did nothing, I gave him money when he demanded it as I was afraid of him". These findings go hand in hand with the literature which say that the partner of the alcohol dependent individual play the role of an enabler by trying to keep peace (South African National Council for Alcoholism and Drug Dependence 1993:4). These findings suggest a relationship between the behavior of the alcohol dependent individuals and the behaviour of their wives. The Encyclopedic Handbook of Alcoholism (1982:667) states that alcohol dependent respondents' behavior affects the responses of their wives and this is in line with the findings. These findings go hand in hand with the Encyclopedic Handbook of Alcoholism (1982:667) which states that alcohol dependent individuals use anger as a strategy of control and this manipulates the wives as they are intimidated to keep quiet about the drinking. Furthermore, in the patriarchal relationships common to Africans, the behaviour of a husband is not challenged by his wife (see section 3.6).

The findings also confirm the literature on enabling which states that the partners maintain the alcoholics' drinking behavior by performing the roles of rescuer, persecutor, dummy and bartender in order to cope with the problem of alcohol dependency (Berne in Robinson 1979:136-145). Other examples of enabling behavior include denying that drinking is a problem despite evidence to the contrary, avoiding conflicts and waiting for things to get better (South African National Council on Alcoholism and Drug Dependency 1995:5) (see section 3.5.3).

5.8.1 **General Findings**

While the findings revealed that the respondent were unhappy about their alcohol dependent men's drinking, their responses differed. A high number of respondents (n=7) did not confront their alcohol dependent respondent men when they were drunk. Other seven respondents (n=7) became passive. These findings agree with the literature which says that the alcohol dependent individual's behaviour affects the wives responses (Leibovitz 1991:1; Denzin 1987:50; Encyclopidic Handbook of Alcoholism 1982:667).

5.9 **FEELINGS OF ALCOHOL DEPENDENT RESPONDENTS ABOUT THEIR PARTNER'S RESPONSES**

The findings reveal that the alcohol dependent respondents have a variety of feelings about their partners' responses. While five respondents (B, L, H, N, O) felt bad about their partners responses, the other five (E, F, G, K, L) indicated that they felt remorseful and apologized when they were sober although they proceeded with their behavior when they were drunk. One respondent (A) indicated that he was ashamed about his partner's response and one (D) indicated that he was happy about how his partner presently does things. Four respondents (C, I, J, M) reported that they felt guilty about their wives' responses. Brickman as quoted by Bernet (1995:18) states that guilt is common response

manifested by alcohol dependents. These findings suggest that most alcohol dependent respondents (A, B, C, E, F, G, H, I, K, L, M, N, O) had unpleasant feelings about their partners' responses to their drinking, except one respondent (D) who indicated that he was happy. These findings open up the possibility of respondents who sought relief of their unpleasant feelings from alcohol (Lawson, Peter and Lawson 1983:18). To get relief from these unpleasant feelings, the respondent learnt to drink alcohol (Bandura 1997:38; Miller 1995:67).

5.9.1 **General findings**

It is noted from the findings that most alcohol dependent respondents (n=14) had unpleasant feelings about their wives responses to their drinking. This finding may have opened up a possibility of them to seek relief from alcohol (Lawson, Peter and Lawson 1983:9).

5.10 **LENGTH OF THE RELATIONSHIP**

The findings reveal that five respondents (B,C,G,K, M) have been in marital relationships with their wives for a period between one to ten years. Eight respondents (D, E, H, I, J, L, N, O) had been in marital relationship for a period of between eleven to twenty years. One respondent (A) had been in a marital relationship with his wife for more than twenty years, while another respondent (F) did not remember the length of his relationship with his wife estimating this to be ten years and over. The answers of alcohol dependent respondents agreed with those of their wives.

5.11 **DESCRIPTION OF THE RELATIONSHIP**

The alcohol dependent respondents and their partners were asked to describe their present relationship. The alcohol dependent respondents reported a change in their relationship now that they were not drinking because they were now responsible and could now discuss

family matters with their wives. Four respondents (A, H, N, and O) indicated that their relationship was very good. Seven respondents (B, C, D, E, and G, I, M) described their relationship as better than before and three respondents (F, K, and L) indicated that their relationship was good. These findings agree with O'Farrel et al (1993:65) who state that marital and family treatment helps stabilize marital and family relationships. Despite these answers, one respondent (J) indicated that he quarreled all the time with his wife and she did not trust him even though he had changed his ways. It is common for the wife of alcohol dependent individual to continue to perceive her husband as deviant despite his effort to undergo rehabilitation because she does not trust him (Jesse 1989:170).

It was interesting to note from the findings that the partners did not see things differently from their alcohol dependent men. One respondent (Mrs. J) agreed with her husband, she informed that "love ended from my side". This finding is a serious revelation because Jesse (1989:170) states that most partners are unlikely to seek help at this point because they think that nothing can improve their situation and those who do hope that they will get better with or without the alcohol dependent husband. Ten respondents (Mesdames B, C, D, F, and G, H, I, M, N, O) indicated that their marital relationship was better than before. However, two respondents (Mesdames A, E) indicated that "marriage requires tolerance, nothing is easy". One respondent (Mrs. K) revealed that she cannot say that they are not happy "it is his drinking". Another respondent (Mrs. L) informed me that their relationship was not a good one, "it is an uncertain life". This is consistent with the situation in the Xhosa speaking marriages as explained by Lamla (1985:21) in section 3.6.

One of the important factors revealed in the findings is that communication was affected in alcohol dependent relationships. The view held by Cohen and Krause (1971:63) is that communication is affected negatively in alcohol dependent relationships. The findings revealed that the alcohol dependent respondent did not communicate their feelings to their partners and these were revealed when they were drunk. For example, Mesdames (B, G, H, K, and O) reported that their unemployment was brought up when their husbands were drunk and these made them to feel uncomfortable. This is consistent with the literature

that says that alcohol dependent individuals and their partners only express their feelings about separation or divorce and statements which promote guilt when they are drunk (Brickman et al in Bennet 1995:19).

5.11.1 **General findings**

The respondents and their partners indicated a positive change in their marital relationship since discharge from the TRC. However, a few reported differently, for example, only one alcohol dependent respondent reported that he and his wife quarreled all the time. While the wives also reported a positive change in their marital relationship, only two indicated tolerance in their marriage suggesting that they had to accept their situation despite the circumstances. These findings further supported the view that communication is affected in alcohol dependent relationships.

5.12 **STRENGTHS IN RELATIONSHIP**

The findings indicate that six alcohol dependent respondents (B,C, F, I, N, O) based their strength in their relationship on communication , while two of them (A,F) based it on religious grounds. One of the respondents (B) indicated that caring provided strength in their relationship while two of them (D, O) based it on understanding and listening to each other. Other respondents (H, C) based this aspect on love while three (E, L, N) respondents based this aspect on supporting each other. One respondent (L) said that “ there is no one between us who can do without the other.” One respondent (G) based this aspect on their interest to build a family and (C) based this aspect on children while one respondent (K) based this on his partner’s good qualities.

There was a slight difference on how the wives answered this question. Mrs. A indicated that the strength in the relationship was Christianity as her husband reported it. Only three respondents (Mesdames B, F, I) based this aspect on communication. Two respondents

(Mesdames C, G) reported love, planning together and honesty, while Mrs. D based this aspect on mutual understanding. While two alcohol dependent respondents (E, H) indicated children as their strengths, four different respondents (Mesdames G, H, L, O) identified the strength in their relationship as the children. This finding may be indicative of the respondents' feeling of security in their marriage by having children as this is stated in the literature (Kayongo- Male and Onyango 1984:56). To have children among the Xhosa speaking wives is one of the ways of meeting the expectations of marriage (see section 3.6).

5.12.1 **General finding**

The findings revealed a variety of factors which the respondents viewed as strengths in their relationships. It appeared from the respondents' answers that what they viewed as strengths was related to their beliefs.

5.13 **DIFFICULTIES IN RELATIONSHIP**

The findings revealed a variety of difficulties as expressed by the respondents. The alcohol dependent respondents expressed their difficulties as problematic children (A, O); partner (B, K, M); financial (C, J); being childless (N, O); partner's source of income (G) and separation due to transfer (I). Four respondents (F, H, K, L) did not think they had difficulties now that they had stopped drinking. Two respondents (D, E) did not remember any difficulties they experience. On the other hand, their partners indicated their difficulties as financial (Mesdames A, D, J); unemployment (Mrs. B); alcohol (Mesdames G, H, K, L, M); children (Mesdames I, N, O). One respondent (Mrs. C) indicated that it was too early to tell and two respondents (Mesdames E, F) stated that there was nothing bad. These responses agreed with the literature by Janzen and Harris (1986:226) which explain the difficulties to admit marital problems by couples in alcohol dependent relationships.

5.13.1 **General finding**

The findings revealed by the alcohol dependent respondents were problematic children, partner, finance, being childless, partners source of income and separation with wife due to transfer. The wives identified their difficulties as finance,, unemployment, alcohol and children.

5.14 **CONTACT PERSON WHEN EXPERIENCING PROBLEMS**

The findings were that most alcohol dependent respondents (A, B, D, E, F, G, H, I, K, L, M, N, O) contacted the members of their families when they experienced problems, for example, parents, brothers, aunts, sisters and cousins. Only two respondents (C, J) indicated that they did not contact any one. One of the respondents (C) said “ I realized that I was creating a loophole”. The findings from the partners were not different from their alcohol dependent husbands because they (Mesdames A, B, C, D, E, F, G, H, I, J, K, M, N, O) indicated that they contact their family members. Only one respondent (Mrs. L) did not contact anyone. These findings support the literature (Barnes 1992:10) that states that the family is psychologically important to all human beings

5.14.1 **General finding**

It is apparent from the findings that most alcohol dependent respondents and their wives (n=27) contact members of their families when they experience problems. Only few respondents (n=3) do not contact anyone.

5.15 **DUTIES IN THE FAMILY**

The findings revealed that in answering, the respondents based this question on financial grounds. Four alcohol dependent respondents (B, C, E, I) indicated that they were responsible for their children's education. Three respondents (F, C, I) bought groceries

while five (B, G, H, O, K) were responsible for the bond for their houses, three respondents (D, N, J) did things jointly with their wives. One respondent (A) had no income. This finding is in line with what is expected of husbands in patriarchal relationships (see section 3.6.3)

The findings revealed that five wives (Mesdames B, G, H, K, and O) were responsible for household chores. "I do not see myself as performing important duties since I am not employed". Two respondents indicated that they did everything (Mesdames A, L). Five respondents (Mesdames D, F, I, J, N) did things jointly with their husbands. Two respondents (Mesdames E, M) are responsible to pay for furniture, clothing, and food.

5.15.1 **General finding**

According to the research, the alcohol dependent respondents and their partners were responsible for everything in their homes, including buying groceries, paying for their children's education and bond. The alcohol dependent respondent's wives who were unemployed did not see themselves as performing important duties although they did household chores.

5.16 **PARTNERS' OWN DRINKING**

The alcohol dependent respondents' partners were asked whether they were drinking or not. The findings reveal that most respondents (Mesdames A, B, C, D, E, F, H, J, K, L, M, N, O) are not drinking and only two (Mesdames G, I) informed me that they were drinking before although they had no drinking problems.

5.16.1 **General finding**

It is clear from the findings that although most partners of alcohol dependent respondents (n=13) were not drinking, a few (n=2) had been drinking in the past.

5.17 EXPERIENCES IN LIVING WITH ALCOHOL DEPENDENT PARTNER

The response that emerged was that the wives had had bad experiences with their alcohol dependent husbands before they were admitted to Tembelitsha Rehabilitation Centre., although it has been revealed that there is change after their discharge. The common complaint is that they had bad experiences which they described either as “bad” (Mesdames A, F, H, I) or “difficult” (Mesdames B, C, F, G, H, N, O). One respondent (Mrs. K) informed me that the experience is “on and off”. Seven respondents (Mesdames A, D, F, H, M, N, O) reported that they had experienced quarrels in their homes.

It has been noted that a high number of respondents (n=12) experienced financial problems (Mesdames A, B, C, D, E, G, H, I, J, L, N, O), while two respondents (Mesdames F, K) denied this problem. It is interesting to note that although seven respondents (Mesdames B, D, F, G, H, J, O) indicated experiences of violent behaviour from their partners, four respondents (Mesdames A, E, I, K) denied this experience, “he becomes very warm, he is not aggressive, he never touched me”. It is also revealed in the findings that four respondents (Mesdames C, H, I, J,) experienced communication problems while one respondent (Mrs. F) experienced having a “mentally ill” husband who had fits as a result of alcohol. No evidence in the form of literature was found to substantiate this.

Another important feature in the findings was that four respondents (Mesdames B, C, D, and G) indicated experiencing sexual problems. Mrs. B informed me that her husband had extra marital affairs and that led to sexually transmitted diseases, bladder problems, pubic lice and his performance sexually was inadequate. Mrs. C indicated a poor relationship “you end up losing love”. Mrs. D reported that although she lost interest in sex because her husband had extra marital affairs, she consented in sexual activity. Mrs. G indicated that she felt lonely because her husband did not care about her. The sexual problems indicated in the findings are supported by the view of (Cohen and Krause 1971:82). The findings also revealed how it was difficult for the wives to refuse sexual intercourse with their

husbands. Makofane (1997:7) state that African women accommodate forced sex within a marriage because of cultural assumption that rape cannot occur between husband and wife (see section 3.6.2).

These findings also indicated that six respondents (Mesdames B, C, D, K, L, and M) experienced thoughts about leaving their husbands although they were still staying with them. The respondents had not only experienced their husbands as alcohol dependent individuals, but they had also experienced love and care from them. The following statement was made by one of the respondents (Mrs D) concerning her husband. "I think about leaving him but tolerate because he was not like that before". This is consistent with the cultural expectations as explained in section 3.6 (Lamla 1985:23).

5.17.1 **General Finding**

The experiences of the wives of alcohol dependent respondents varied between quarrels and financial problems to communication and sexual problems. Although the respondents had thoughts about leaving their husbands, they were still staying with them. This indicated some form of defense mechanisms such as denial which (Gelles and Loseke 1993:173) say is common in wives of alcohol dependent individuals.

5.18 **PREVIOUS COPING MECHANISMS**

The findings revealed that most wives of alcohol dependent respondents (Mesdames A, B, D, E, G, H, K, M, N, O) tolerated their husbands' drinking because they had hoped that they would change. This is in line with the Encyclopedic Handbook of Alcoholism (1982:668) which state that the wives of alcohol dependent individuals experience denial and rationalization with hope that alcohol related behavior will improve. These are some of their statements " I tolerated him because he was remorseful when sober", " when you love your husband, you tolerate him, especially when you have hope". Four respondents (Mesdames C, F, I, L,) coped with their husbands' situation through prayer. Only one

(Mrs. J) reported to parents. Tolerance of husbands is common among the African culture (see section 3.6).

5.18.1 **General finding**

The high number of the respondents (n=10) tolerated their husbands because they hoped that they would change and they were remorseful when they were sober. Others (n=4) coped with the situation through prayer.

5.19. **PRESENT COPING MECHANISMS**

The findings reveal that most of the wives of alcohol dependent respondents (Mesdames A, B, C, D, F, H, I, K, M, N, O) are coping better presently. Two of them (Mesdames I, L) were coping through praying. One of them (Mrs. E) has an agreement to keep her husband's bank card and another one (Mrs. G) copes by tolerating the situation.

5.19.1 **General finding**

While most of the wives of alcohol dependent respondents (n=11) in this study reported that they are coping better presently, a few indicated that they cope through praying. One of them coped by keeping her husband's bankcard and the other one coped by tolerating the situation.

5.20 **WHEN PARTNER DRINKS MOST**

The study reveals that most wives of alcohol dependent respondents (Mesdames B, C, D, E, F, G, I, K, L, M, N) indicated that their husbands had no specific time for drinking excessively, while others (Mesdames H, J, O) stated that their husbands mostly drank when they had money. Only one respondent (Mrs. A) reported that her husband drinks most when he felt hurt.

5.21 **SUMMARY**

This chapter presented the findings elicited during the research study. Most respondents were admitted at TRC because of their physical and psychological addiction to drinking. Some respondents were admitted because of health, work, and domestic problems. It was clear from the findings that most respondents relapsed although they stated that they were not drinking as they did prior to admission. The respondents and their partners indicated that abuse was common although some wives denied this. While the wives did not confront their husbands when they were drunk, their husbands had unpleasant feelings about these responses. There was a positive change in the marital relationship of these couples subsequent to discharge.

CONCLUSIONS

AND

RECOMMENDATIONS

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter consists of conclusions drawn from the study as well specific recommendations are made with a view to improving the service rendered to alcohol dependent clients. I am aware that the sample is small and is not generalisable to all the alcohol dependent individuals and their partners since I interviewed those who submitted themselves for rehabilitation at Thembelitsha Rehabilitation Centre. However, this study has revealed valuable information, which could be used to generate a theoretical model for the purpose of guiding interventions especially by social workers. This could also be useful in discovering new dimensions on the subject matter and is likely to stimulate further research. I regard the study as meaningful because as far as I am aware, it is the only research of this nature to be undertaken among the Xhosa-speaking people in the former Transkei. The conclusions focus on the following aspects:

- Behaviour at home prior to admission.
- Feelings of alcohol dependent respondents about their partners' responses.
- Relapse.
- Relationship issues.

- Previous and present coping mechanisms.
- Contact person when experiencing problems.
- Partners' own drinking.

6.2 **BEHAVIOUR AT HOME PRIOR TO DRINKING**

Consistent with the literature (Gelles and Loseke 1993:173; Leonard and Quigley 1999: 537), the abuse of families is something the respondent and their partners (with a few exceptions) agree characterizes the behaviour of alcohol dependent person prior to their admission for treatment (see section 5.7). It can be concluded from the findings that although the wives were not happy about the drinking of their alcohol dependent husbands, their responses differed (see 5.7). A high number of respondents were reluctant to discuss their husbands' drinking with them. These findings support literature which says that the alcohol dependent individuals' behaviour affect the wives' responses (Encyclopedic Handbook of Alcoholism 1982: 669; Denzin 1987:50; Leibovitz 1991:1; South African National Council on Alcoholism and Drug Dependence 1993:3).

6.3 **FEELINGS OF ALCOHOL DEPENDENT RESPONDENTS ABOUT THEIR PARTNERS' RESPONSES**

It can be concluded from the findings that alcohol dependent respondents experience unpleasant feelings such as shame, remorse and guilt about their drinking (see 5.9). Consistent with the literature (Lawson, Peter and Lawson 1983: 9), it may be possible that the alcohol dependent respondent sought relief from alcohol when they experienced unpleasant feelings.

6.4 **RELAPSE**

This study revealed that most respondents stay in Umtata where Thembelitsha Rehabilitation Centre is situated.

Most respondents in the study were admitted to TRC due to their physical and psychological addiction to drinking. Others were admitted due to health, work and domestic problems.

Consistent with the literature (Franken et al 1999:81) physical and psychological addiction play an important role in the occurrence of relapse in abstinent substance addicted persons. In this study, most alcohol dependent respondents relapsed although they stated that they were not drinking as in the past (see section 5.6).

6.5 **RELATIONSHIP ISSUES**

The findings had demonstrated a remarkable consistency in the descriptions of the relationship issues faced by alcohol dependent respondents and their partners. Abusive behaviour on the part of the alcohol dependent respondents (see section 5.7), the women's reluctance and fear at challenging the behaviour (see section 5.8), the way in which the wives respond to drinking and the reaction of the men to this response (see section 5.8) are all indicative of the difficult issues faced by the Xhosa-speaking couples. Besides abusive behavior of alcohol dependent respondent, the wives experienced communication, financial and sexual problems (see section 5.17). Although the wives had thoughts about leaving their alcohol dependent husbands, they have remained in the marital relationship.

The study revealed a variety of factors which the respondents viewed as strengths in their relationships such as, communication, religious beliefs, caring, understanding, listening to each other, supporting each other and children. The respondents regarded their difficulties

in relationships as children, partner, finance, being childless and separation with the family due to transfer at work and unemployment.

6.6 WIVES' PREVIOUS AND PRESENT COPING MECHANISMS

The wives of alcohol dependent respondents tolerated their husbands with the hope that they would change and because they were remorseful when they were sober. Others coped with the situation through prayer. I am not aware of any literature discussing prayer as a coping mechanism in alcohol dependency.

While most of the wives in this study reported that they are coping better presently, a few indicated that they are coping through prayer. One of them has an agreement with her husband to keep his bankcard and another one is coping by tolerating the situation (see sections 5.18 and 5.19).

6.7 CONTACT PERSON WHEN EXPERIENCING PROBLEMS

Most respondents contacted members of their families when they experienced marital problems. Only a few did not contact anyone (see 5.14).

6.8 PARTNERS' OWN DRINKING

While most wives of alcohol dependent respondents were not drinking presently, a few had been drinking in the past.

6.9 **RECOMMENDATIONS**

In view of my findings, I feel that the following are crucial issues which need further attention and I have grouped my recommendations into the following categories; prevention, treatment and aftercare.

6.9.1 **PREVENTION**

- **Relapse**

As alluded in the review of literature (3.7.3), prevention services are aimed at strengthening and building the capacity and self-reliance of focus groups (Department of Welfare 1999:6). For the purpose of this study, the focus groups are alcohol dependent individuals and their partners.

In view of the high rate of relapse as indicated in the findings, establishing an outreach program could address this need. Thembelitsha Rehabilitation Centre is the only centre in the Eastern region and in the former Transkei. To be able to address the problem of the lack of resources and access, the outreach programme seems to be the answer. It is recommend that this outreach programme should:

- Target health care workers in hospitals, clinics and private practice because most alcohol dependent individuals consult these when they experience physical problem.
- Involve of social workers trained in this field because families of alcohol dependent individuals seek their assistance when they experience family problems.

- Involve the community to participate by addressing the problem of alcohol dependency.
- Provide training programmes for the communities.
- **Behaviour at home prior to admission**

Although some alcohol dependent men and women in the findings denied the abuse, there was as an indication that the men were abusive. In view of these findings, it is recommended that the prevention programmes should include relationship issues and should aim at the whole person and not just drinking or other substance abuse.

- **Relationship issues**

It is important that the prevention programme should include a focus on the nature of the relationship between the dependent person and others and this may include fairly intensive marriage enrichment.

- **Coping mechanism**

I recommend that the prevention programme should include a focus on the partners of alcohol dependent individuals, teaching them about alcohol dependency, how to identify it and what to do when the partners have this problem.

6.9.2 TREATMENT

- **Relapse**

It is recommended that social workers and other rehabilitation team should teach alcohol dependent clients and their partners about the process of relapse and its symptoms so that they are in a better position to be prepared about the changes and in this way choose positive alternatives.

- **Behaviour at home prior to admission**

In working with alcohol dependent persons, the issues associated with family relationships and domestic violence are important. In addition, the treatment and rehabilitation programme should possibly include relationship issues. Group work method is important to be used with alcohol dependent clients.

- **The relationship issues**

It is important that the treatment and rehabilitation programme should include a focus on the nature of relationship between the dependent person and others and in this way include fairly intensive marriage counselling when appropriate. It is recommended that the rehabilitation programme should include a focus on teaching the couples communication skills, budgeting and how to deal with conflicts. These skills would help them to communicate better with each other without finding fault and blaming each other (Janzen and Harris 1986:226). This would also improve the way in which they used money while they were drinking and help them to deal with conflicts constructively.

- **Coping mechanism**

Although the findings revealed that the wives of alcohol dependent respondents are coping better presently, I recommend further that the prevention programme should focus on the partners in these relationships, teaching them about alcohol dependency, how to identify it, and what to do when a partner has this problem.

6.9.2 **TREATMENT**

- **Relapse**

In view of the high rate of relapse as indicated in this study, it is recommended that social workers and other rehabilitation team members should teach alcohol dependent clients and their partners about the occurrence of the process of relapse and its symptoms so that they are prepared for this as well as how they can make positive choices.

- **Behaviour at home prior to admission**

In working with alcohol dependent persons, knowledge of the issues associated with culture, family relationships and domestic violence are important. In addition, the treatment and rehabilitation programme should include relationship issues. The groupwork method has advantaged and should be used with alcohol dependent clients as it has proved to most helpful for lonely, anxious or depressed clients. The social workers are trained in this method.

- **The relationship issues**

The findings revealed how the relationships of alcohol dependent respondents were affected negatively by alcohol. Therefore, it is important that the treatment and rehabilitation programme should include a focus on the nature of the relationship between alcohol dependent person and others, and in this way should include fairly intensive

marriage counselling when appropriate. It is recommended that the rehabilitation programme should include a focus on teaching the couples communication skills, budgeting and conflict management. These skills would help them to communicate more meaningfully without finding fault and blaming each other. This would also improve the way in which they used money while they were drinking and also help them to deal with conflict constructively.

- **Coping mechanisms**

I recommend that the partners of alcohol dependents clients should be encouraged to attend the rehabilitation programme so as to learn more about alcohol dependence and they can support their partners in overcoming alcohol dependence

The findings revealed that most of them were coping better at present.

6.9.3 **AFTERCARE**

- **Behaviour at home prior to alcoholism**

The aftercare programme needs to be well structured in order to be effective with the aims and objectives of it being to provide continued support for the clients and their families, to supervise general functioning and enhance the skills acquired in patients' rehabilitation. While group work is an effective method used in alcohol dependent clients, it is recommended that this method be used after discharge. It is also recommended that the alcohol dependent client should be encouraged to form community-based support groups to be able to maintain sobriety and support each other. These groups must then possibly be monitored by social workers.

- **Contact person when experiencing problems**

While TRC provides aftercare service as to discharged clients, Umtata does not have an aftercare centre as a bridging service between the rehabilitation and community integration. I recommend that the alcohol dependent clients should be encouraged to develop a resource list of people to contact when they encounter problems. This list may not be limited to the family members only, but can include a list of former rehabilitation inmates or counsellor, in view of limited available resources.

- **Coping mechanisms**

The findings revealed that the wives of alcohol dependent respondents tolerated their husbands before their admission and they were coping better during the period of study. Limited resources are emphasized and this is a challenge to the partners of alcohol dependent respondents to initiate support groups in their areas. The social workers and other rehabilitation team members may encourage and support this initiative.

6.10 **RECOMMENDATIONS REGARDING FURTHER RESEARCH**

This section presents recommendations regarding further research although some have been discussed in this chapter. These recommendations are recapped under this section so as to get a holistic view of general ideas which could be explored at a later stage.

- While the literature states that stress is a factor in alcohol dependency, only a few respondents in this study indicated that their admission was due to domestic problems (see section 5.3.1). One can make a conclusion that alcohol dependent respondents are reluctant to admit that they had been experiencing problems at home or at work.

I recommend another research study, to explore the relationship between stress and alcohol dependency.

- It has been pointed out in this study that although most alcohol dependent respondent men were abusive before their admission, some disagreed on this. One may conclude that those differences in opinion indicate some form of defense mechanism such as denial, minimizing and rationalization, which are common to alcohol dependent clients and their wives.

It is recommended that further research with a focus on this area be undertaken to provide more insight on this phenomenon.

- It has been pointed out in this study that although the wives of alcohol dependent respondents were not happy about their husbands' drinking, most of them were reluctant to discuss drinking with their husbands. One may make a conclusion that this reluctance to discuss drinking may be due to the patriarchal system. In our African culture men are the heads of the families and wives are not expected to confront their husbands regarding their behaviour.

I recommend that further research be undertaken to explore the relationship between submission by wives of alcohol dependent men and the patriarchal domination in relationships.

- It has been revealed in this study that the wives of alcohol dependent respondents tolerated their alcohol dependent husbands because they had hope, and others coped with the situation through prayer. It has also been pointed out that although most of them are coping presently, few coped through praying.

I recommend that further research be conducted to provide more insight on Christian religion as one of the ways to cope with alcohol dependent partners.

6.11 CONCLUDING COMMENTS

The study has revealed that most alcohol dependent respondents stay in Umtata where the TRC is situated. The study has revealed a relationship between physical and psychological addiction and relapse. The study has revealed that the alcohol dependent respondents had relapsed although they stated that they are not drinking as in the past. The study also revealed that the alcohol dependent men felt ashamed, remorseful and guilty about their partners response to their drinking. The study has revealed that the wives of alcohol dependent men were abused by their husbands before they were rehabilitated. There was a positive change in the respondents' marital relationship since the alcohol dependent men were discharged from rehabilitation.

The study has provided insight into the difficult experiences of wives of alcohol dependent men (abuse, financial communication and sexual) among the Xhosa-speaking people in the former Transkei; how they coped in the past and how they were coping at present. I have found that there is a relationship between the findings, literature and the following cultural patterns:

- Acceptance of the use of alcohol in all cultural ceremonies.
- Husband, being the undisputed head of the family.
- Wife, being the minor and subjected to all forms of control by her husband.
- Wife expected to respect husband and in-laws.
- Viewing of women abuse as normal in family relations and paying of fine when this is reported.
- Expectations of wife to tolerate and accept all problems without challenge.
- Disapproval of family to leave marital home.
- Husband has full sexual rights over his wife.
- Acceptance of husband's extra- marital affairs.

This study has stimulated new ideas for further research. I would also like to recommend further research in order to assess whether my findings are area specific or general with the African cultures in South Africa. This is in consideration that my sample was small. I do not want to generalize on it. May be a more representative sample will provide findings that are different or similar to my study.

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APPENDIX A

INTERVIEW SCHEDULE FOR ALCOHOL DEPENDENT RESPONDENTS.

DEMOGRAPHIC INFORMATION

Age : _____

Occupation : _____

Educational level : _____

Marital status : _____

Monthly income : _____

Residential Area : _____

Race : _____

1. Tell me what led to your being admitted to Thembelitsha Rehabilitation Center ?

2. How long was this ?

3. What happened since then?

4. How do you behave in your home when you have been drinking ?

5. How does your partner respond to your drinking?

6. How do you feel about her responses ?

7. How long is your relationship with your partner?

8. Tell me , how do you describe your relationship at the moment ? explain your answer.

9. Tell me, what are the strenghts in your relationship ?

10. Tell me , what are the difficulties in your relationship ?

11. If you experience problems in your relationship , who do you contact for help ?

12. What are your duties in your family ?

13. What are your partner's duties in your family?

APPENDIX A

INTERVIEW SCHEDULE FOR ALCOHOL DEPENDENT RESPONDENTS.

DEMOGRAPHIC INFORMATION

IGUQULELWE KWISIXHOSA

Iminyaka : _____

Uhlobo lomsebenzi: _____

Ibakala lemfundo : _____

Umvuzo wenyanga : _____

Ubume bomtshato : _____

Ingingqi yokuhlala : _____

Ubuhlanga : _____

1. Khawundixelele , yintoni eyakhokela ukuba ulaliswe eThembelitsa Rehabilitation Centre?

2. Kwakukudala kangakanani ngoko ?

3. Kwenzeke ntoni ukususela ngoko ?

4. Uziphatha kanjani ekhayeni lakho xa uthe wasela?

5. Iqabane lakho lithini xa usele ?

6. Uziva njani yindlela enza ngayo ?

7. Lithuba elide kangakanani ninobudlelwane neqabane lakho ?

8. Khawundixelele ubuchaza njani ubudlelwane benu ngoku? Yicacise impendulo yakho.

9. Khawundixelele , ziziphi izinto ezingamandla kubudlelwane benu?

10. Khawundixelele , ziziphi izinto eziyingxaki kubudlelwane benu ?

11. Xa uhlangabezana neengxaki kubudlelwane benu , ngubani oqhagamshelana naye malunga noncedo?

12. Yeyiphi indima oyidlalayo elusatsheni lwakho? :

13. Yeyiphi indima edlalwa liqabane lakho elusatsheni lwakho ?

APPENDIX B:

INTERVIEW SCHEDULE FOR PARTNERS.

DEMOGRAPHIC INFORMATION

Age : _____
Occupation : _____
Educational level : _____
Monthly income : _____
Marital status : _____
Residential area : _____
Race : _____

1. Many people do drink alcohol when they live with partners who drink. Tell me if that is the case with you.

2. Tell me about your experiences in living with a drinking partner before and after admission to Thembelitsha Rehabilitation Centre.

3. How did you cope under such condition ?

4. How do you cope presently?

5. When do you think your partner drinks most?

6. How does your partner behave in your home when he has been drinking ?

7. Tell me how do you feel about his drinking ?

8. How do you respond to his drinking ?

9. How long is your relationship with your partner?

10. Tell me how do you describe your relationship at the moment ? Explain your answer.

11. Tell me , what are the difficulties in your relationship ?

12. Tell me , what are the strengths in your relationship?

13. If you experience problems in your relationship , who do you contact for help?

14. What are your duties in your family ?

15. What are your partner's duties in your family ?

APPENDIX B

INTERVIEW SCHEDULE FOR PARTNERS

DEMOGRAPHIC INFORMATION

IGUQULELWE KWISIXHOSA

Iminyaka	:	_____
Uhlobo lomsebenzi	:	_____
Ibakala lemfundo	:	_____
Umvuzo wenyanga	:	_____
Ubume bomtshato	:	_____
Ingingqi yokuhlala	:	_____
Ubuhlanga	:	_____

1. Abantu abaninzi bayabusela utywala xa behlala namaqabane aselayo. Khawundixele ukuba ingaba kunjalo nakuwe?

2. Khawundixelele ngamava akho ekuhlaleni neqabane eliselayo.

3. Wamelana njani neemeko ezinjalo ?

4. Umelana njani neemeko ngoku ?

5. Ucinga ukuba iqabane lakho lisela kakhulu nini ?

6. Liziphatha njani iqabane lakho ekhayeni xa lithe lasela ?

7. Khawundixelele , uziva njani ngokusela kwakhe ?

8. Uthini ngokusela kwakhe ?

9. Lithuba elingakanani ninobudlelwane neqabane lakho ?

10. Khaundixelele , ubuchaza njani ubudlelwane benu ngoku ? Yicacise impendulo yakho.

11. Khawundixelele , ziziphi izinto eziyingxaki kubudlelwane benu ?

12. Khawundixelele , ziziphi izinto ezingamandla kubudlelwane benu ?

13. Xa uhlangabezana neengxaki kubudlelwane benu , ngubani oqhagamshelana naye malunga noncedo ?

14. Yeyiphi indima oyidlalayo elusatsheni lwakho ?

15. Yeyiphi indima edlalwa liqabane lakho elusatsheni lwakho ?

APPENDIX C

LETTER OF APPLICATION TO CONDUCT RESEARCH STUDY

37 Mthunzi Ntshinka Avenue
Mbuqe Extension
Umtata
5100
06 September 1999

The Director
Thembelitsha Rehabilitation Centre
Umtata

Dear Miss Msengi

APPLICATION TO CONDUCT RESEARCH STUDY IN YOUR ORGANISATION

I hereby apply for consent to conduct a research study in your organisation. I am studying for a Masters degree at Rhodes University in East London branch. My research topic is on THE EXPERIENCES OF COUPLES IN RELATIONSHIPS CHARACTERISED BY ALCOHOL DEPENDENCY. The purpose of my study is to generate a greater understanding of the experiences of couples in these relationships. Specifically, the study will explore how the alcohol dependent individuals relate to their partners; their behavior when they are drunk; their drinking history ; the experiences of their partners in living with them and how they coped with the situation.

I intend to draw a non probability sample of 15 couples who had been hospitalised for treatment and rehabilitation for alcohol dependence at Thembelitsha during the two and a half year period ,starting from January 1997 to June 1999. The data will be collected through qualitative interviews which will be separate for the alcohol dependent respondents and their partners.

The findings of this study will be used to generate a theoretical model for the purpose of guiding interventions with the partners of alcohol dependent clients . Your organisation will be issued with a copy of my research report when the study is completed.

Yours sincerely

N.E. Mgilane

student number : 895M6030

APPENDIX D

LETTER OF APPROVAL TO CONDUCT RESEARCH STUDY

T THEMBELITSHA CENTRE

(Incorporated Association not for gain)

P.O. BOX 891

R REHABILITATION

For the Treatment and Rehabilitation of
PERSONS WITH ALCOHOL PROBLEMS

UMTATA

Phone : (047)

C CENTRE

& Fax 5325794

0833340963

THEMBELITSHA	REHABILITATION	CENTRE
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11 September 2000

Dr P. J. Coughlan
Department of Social Work
Rhodes University
P.O. Box 7426
EAST LONDON
5200

Dear Madam

APPROVAL TO CONDUCT RESEARCH STUDY:
MRS N.E. MGILANE

This serves to inform you that Mrs E.N. Mgilane has been granted permission to conduct research study at Thembelitsha Rehabilitation Centre. Her topic is on "The experiences of couples in relationships characterised by alcohol dependency".

The Centre remains committed to helping her should any problems arise regarding her research project. Further enquiries will be dealt with promptly.

Yours Faithfully



N. DABULA

Vocational counsellor

COUNSELLING OFFICER
AFTERCARE
THEMBELITSHA REHABILITATION
CENTRE
DATE: 2000.09.11

APPENDIX E

MAP OF THE EASTERN CAPE PROVINCE AND MAP OF THE FORMER TRANSKEI

