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Abstract

Autonomy of Military Wives and
Their Recognition of Alcoholism

by Tina M. McConnell

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Research on alcoholism recognizes that alcoholism negatively affects family members. Wives of alcoholics may suffer socially, physically, and psychologically as they struggle to define the problem and look for solutions. Ambivalence about the use of alcohol and what constitutes an alcoholic in our society contributes to the difficulties a wife has in defining whether her husband has an alcohol problem. This is compounded by the relaxed attitude toward alcohol in the military. Feminist research points out the tendency to pathologize women by labeling wives of alcoholics as enablers and codependents. Autonomy, a concept which is defined as, the quality of being self-governing, may have an impact on the duration and extent of consequences that are experienced by these wives. The purpose of this study was to look at the association between autonomy and recognition of alcohol severity in a pilot sample of 49 military wives at the Ob/Gyn clinic of Madigan Army Medical Center at Ft. Lewis, Washington.

Autonomy was measured with the Worthington Autonomy Scale. Recognition of alcohol severity was measured using vignettes that indicated three levels of alcohol use: 1). social drinker 2). problem drinker, and 3).alcoholic. There was no correlation between autonomy and recognition. Frequencies indicated a narrow range of scores with a mean of 3.22, indicating a homogenous group with a high level of utonomy. These subjects correctly identified the severity of alcoholism 31-80% of the time in the vignettes and often chose a response which magnified the severity of the problem. These results indicate that, given a cluster of symptoms, ambivalence is not severely impairing the ability of military wives to define an alcohol problem. The responses to vignettes suggest that some symptoms are stronger indicators of a problem than others. The responses to the vignettes also suggest that these women may be better served by using their own definitions rather than the definitions developed by the medical profession.

Master's Thesis

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Signature Lina M McConnell

Date March 16, 1998

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Introduction

Ambivalence surrounding alcohol use and misuse in our country has contributed to problems in defining, diagnosing and identifying pathological use of alcohol. Ambivalence extends from the medical professional to the individual lay person. Ambivalence can have a significant impact on the wives of alcoholics as they experience losses and stress while they struggle to define their husband's problem using societal norms. The military subculture which has it's own set of norms regarding alcohol use, norms that have persisted for several years, increases the likelihood of ambivalence in military wives regarding their husband's alcohol use. Development of autonomy and learning to identify alcoholism in a spouse may mitigate the negative social, psychological and physical impact of prolonged ambivalence for military wives by decreasing their reliance on definitions set by the societal norms.

The purpose of this study is to describe autonomy levels of military wives and their ability to recognize symptoms of alcoholism and to determine if there is a correlation between recognition and autonomy. The conceptual framework guiding this study includes a description of autonomy, empowerment and oppression as related concepts and their hypothesized influence on an individual's ability to achieve or maintain health through self care. Recognition of alcoholism allows a spouse who is

affected by it to take steps toward limiting the consequences, even when the consequences are a result of a spouse's alcoholism.

The following literature review includes definitions of alcoholism by the medical profession, the consequences of alcoholism on an alcoholic's wife, the problem of alcoholism in the military, the cultural influence on military wives and educational efforts to prevent or recognize alcoholism. These are factors hypothesized to negatively influence the development of autonomy in military wives.

Chapter I: Conceptual Framework

The conceptual framework for this study consists of a combination of Orem's self care deficit theory of nursing and of Friere's (1970) philosophy of education referred to as "conscientizacion". Conscientizacion means education for critical consciousness and allows us to place nursing theory in a political and sociocultural context, therefore, addressing the numerous elements having an impact on an individual's well-being.

Paulo Freire, a Brazilian educator, presented a philosophy and methodology for teaching which distinguished the oppressed from the oppressors in society (Minkler &Cox, 1980). Freire writes of the oppressed as being unsure of themselves; "Almost never do they realize that they, too, know things they have learned in their relations with the world and with other men. Given the circumstances which have produced their duality, it is only natural that they distrust themselves". (Freire, 1970, p. 50.). In his method of educating, dialogue is the means by which the oppressed liberate themselves. The process of liberation from oppression involves 1). reflecting upon aspects of their reality 2). looking behind these immediate problems to their root causes 3). examining the applications and consequences of these issues and 4). developing a plan of action to deal with the problems collectively defined (Minkler & Cox, 1980). Freire's method uses facilitators or teacher-learners to assist the oppressed in this process. Freire's philosophy

was cited as the basis for the concept of empowerment (Hawks, 1992; Sheilds, 1995).

The concept of empowerment has been applied to many disciplines including: education, sociology, anthropology, women's studies, theology, public health, and nursing (Sheilds, 1995). The concept of empowerment is one of interaction, interaction that can occur in dyads, small groups, organizations, communities and society (Vogt & Murrell, 1990). Methods of empowering include education, leading, mentoring/supporting, providing, structuring and actualizing (Vogt & Murrell, 1990). Other conceptual developments view empowerment as a process which is positive, dynamic, developmental, and democratic (Gibson, 1991). Gibson (1991) also views empowerment as reflecting a "female view of power". Outcomes of empowerment include a positive self concept, personal satisfaction, self efficacy, a sense of mastery, a sense of control, a sense of connectedness, self development, a feeling of hope, social justice, improved quality of life, increased problem solving skills, improved communication, and leadership skills, increased satisfaction with job or school, increased responsibility and autonomy (Gibson, 1991; Hawks, 1992). Women identify and experience empowerment as trusting one's own judgment, having a voice and speaking out, perceiving more choices, contributing, balancing responsibility, connectedness and important to the emerging sense of self (Shields, 1995). The women in Shields' study describe

independence as important to their emerging sense of self. Empowerment has applications at the societal and the individual level.

Orem's self care deficit theory of nursing contains concepts that are very similar to the concept of empowerment. Dorothea Orem developed a theory which includes the theory of self care, the theory of self care deficit and the theory of nursing systems. In her theory, an individuals ability to engage in self care depends on the powers possessed by the individual. Examples of these powers include: Ability to reason within a self care frame of reference, motivation, ability to make decisions about care of self and to operationalize these decisions, and ability to consistently perform self-care operations, integrating them with relevant aspects of personal, family, and community living. These abilities as a whole are termed self care agency. Self care is defined as "learned, goal oriented behavior that exists in concrete life situations directed by persons to self or to the environment to regulate factors that affect their own development and functioning in the interests of life, health or well being" (Marriner-Tomey, 1994. p 182.). Self care is affected by self-concept, level of maturity, culturally derived goals and practices, scientifically derived health knowledge possessed by a person, placement in the family constellation, and membership in social groups exclusive of the family (Orem, 1995. p106.). A self care deficit occurs when the demands for self care are unable to be met by

the self care agency because the abilities are not operable or adequate for knowing and meeting the demand. The nursing system includes a supportive-educative component which is for situations "where the patient is able to perform or can and should learn to perform required measures of externally or internally oriented therapeutic self care but cannot do so without assistance" (Marriner-Tomey, 1994). Methods of assistance are similar to those for empowerment. They are: acting or doing for, guiding, teaching, supporting, and providing a developmental environment (Marriner-Tomey, 1994).

Empowerment is the interaction between nurses and patients that enhances an individual's self care agency. The theories of self care and empowerment are useful in the treatment of military wives who may face a self care deficit as a result of ambivalence in defining alcoholism.

Orem's concept of agency is synonymous with autonomy. Autonomy is defined as "The quality of being self-governing." (Anderson, Worthington, Anderson & Jennings (1994). Autonomy is a concept which was originally viewed as a masculine trait and carried connototations of separation and detachment, a concept which was seldom applied to women. Feminist theorists in addressing the gender differences of autonomy, attempted to develop theories of women's development that explained this difference between the genders (Surrey, 1991, Chodorow, 1989, Jordan, 1985,). Recent researchers

have criticized these theories of women's development as presenting a dichotomy, viewing autonomy and it's opposite, relatedness, as mutually exclusive without recognizing the importance of autonomy for women (Berlin & Johnson, 1989; Jenkins, 1996; McBride, 1990; Yanay, 1994; Yanay& Birns, 1990; Martin & Light, 1984). Yanay and Birns (1990) identify 3 theoretical approaches that explain gender differences in autonomy. They are: 1). psychoanalytic, 2). socialization, and 3). historical and material reasoning which combines the theories of value and private property. For the purpose of this study, this author endorses the latter by supporting the development of autonomy in women and identifying factors which limit autonomy, especially in the case of military wives and wives of alcoholics. From the historical and material reasoning perspective, dependency and autonomy are seen as byproducts of women's and men's economic and social relations and are determined by social structures such as capitalism and partriarchy. Gender roles have the capability in this social persepective of leading to oppression based on what is valued and what is not.

Jenkins, (1996) in a longitudinal study, found that women who were self-defining versus social-defining were more autonomous which meant that they possessed the capacity to function independently within relationships. They also concluded that self-defining women are not less invested in their roles as mothers or wives, but that their

behavior in these roles was more deliberate, strategic and flexible (Jenkins, 1996). Martin & Light (1984) found educational levels correlated with women's attitudes toward autonomy and that "education serves to benefit women's mental well-being". Several authors have defined autonomy (McBride, 1990;Yanay, 1994; Jenkins, 1996; Anderson et al, 1994). McBride (1990) cites definitions of emotional and instrumental autonomy. She also cites a definition of autonomy in women as "believing in one's ability and taking steps toward fulfilling goals along with a feeling of power". McBride asserts that autonomy allows women to lose reliance on unhealthy relationships and experience individuation, interdependence and mutual cooperation. She suggests that women be encouraged to define themselves, not be defined by others. Das Gupta (1995) points out that autonomy levels in women rise and fall throughout their lifespans and that the society in which they live is a contributing factor. Yanay (1994) also identifies the importance of the social context of autonomy and presents a motivational model of autonomy. Her study identified authenticity, freedom of expression, as an element of autonomy in university faculty and noted that conformity in girls in distress was not antithetical to autonomy but that competence represented a form of autonomy (Yanay, 1994).

This study uses the concept of agency and autonomy interchangeably. The

military culture and the focus of the medical diagnositic criteria for alcoholism are viewed as oppressive forces which impair the military wives' ability to develop autonomy and engage in self care. The use of the self care deficit theory puts this problem in the context of nursing where empowerment may take place.

Chapter II: Literature Review

Defining Alcoholism

The use of alcoholic beverages has been documented throughout history. History also tells us that our attitudes toward alcohol's use or misuse have fluctuated. The result of these fluctuations has led us to ambivalence regarding the definition of alcoholism. Blacker (as cited in Hanson, 1995) cites ambivalence as a contributing factor to high rates of alcoholism in some cultures. Wilkinson (in Hanson, 1995) also identified a lack of ambivalence as one of five elements common to cultural drinking patterns that lead to low rates of drinking problems. In the United States, attitudes toward alcoholism have undergone an evolutionary process. Since 1785, alcoholism has been considered a sin, a crime and finally, a disease. This evolution has been termed "medicalization of deviance" and medicalization is seen as a form of social control (Schneider, 1978). The medicalization of alcoholism means that the medical field has been tasked with defining alcoholism. This establishes the medical field as an authority on defining alcoholism.

The ambivalence about alcohol use was passed on to the diagnostic process. The term "alcoholism" was coined in 1849 (Keller & Doria, 1991). The term came to be applied to getting drunk, to heavy drinking, excessive drinking, deviant drinking, and unpopular drinking (Keller & Doria,1991). The medical field is a subculture whose initial focus is on physical problems. Physical problems therefore became the focus of

the definition of alcoholism. Subsequently, alcoholism was diagnosed on the basis of symptoms of addiction which were recognized as withdrawal and increased tolerance (Keller & Doria, 1991; Flavin & Morse, 1991). This definition failed to account for the early stages of the disease and its related consequences. As a result, definitions of problem drinking were added to the medical definitions. In 1960, there were five categories of pathological alcohol use; today there are two categories: alcohol abuse or alcohol dependence with alcohol dependence representing the physical dependence upon alcohol (Keller & Doria, 1991). The DSM-IV (1994) criteria for substance abuse are:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

(2) recurrent substance use in situations in which it is physically hazardous.

(3) recurrent substance-related legal problems.

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the

substance.

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

The DSM-IV criteria for Substance Dependence are as follows:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect.

(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

Currently used diagnostic tools are also regarded with ambivalence (Weinstein & Slaght, 1995). Weinstein & Slaght cite the problem of false positives and dual diagnosis with dual diagnosis creating confusion over the role of alcohol in mental illness. It is sometimes questioned whether it is the primary mental illness or a secondary problem when depression or psychosis is underlying.

While we were trying to define alcoholism, it was becoming a national health concern. The effects of alcoholism were noted to be those that affected society; things such as drunk driving, lost productivity due to absence from work and health care costs

from the resulting physical disability, accidental injury, homicide, suicide and domestic violence. Information about consequences enables us to use them to identify alcoholism rather than using quantitative measures. As a result, the identification of alcoholism relies heavily on subjective information from the individual regarding consequences he has experienced. However, the use of subjective information for diagnosis becomes problematic when consequences are experienced by the wife of an alcoholic.

The Wives of Alcoholics

Wiseman (1991) identified several consequences as reported by wives of alcoholics. The list includes: deterioration of the marriage; feelings of anger, fear, guilt; suicidal and homicidal thoughts; social isolation; loss of their social role and self esteem; stress related physical health problems and psychological problems and victimization from physical violence.

Al-Anon, a 12-step self help oganization was organized to address the needs of spouses in dealing with alcoholism. Members are exposed to factual information about alcoholism, the disease concept, and suggestions to use detachment as a means of coping (McBride, 1991). Membership is purported to result in reestablishing self esteem and independence (McBride, 1991). Actual effectiveness of Al-Anon has been difficult to establish empirically due to the anonymity of the members.

Although Al-Anon has been considered helpful to spouses of alcoholics, some of the terminology, such as co-dependent, has had a negative effect on wives of alcoholics Research has attempted to identify common personality factors among the wives of alcoholics (Miller, 1994). Terms such as 'codependency' and 'enabling' arose from these perspectives and were endorsed by members of the addictions field. People in the field have attempted to define, measure, and diagnose codependency (Fischer, Spann & Crawford, 1991). However, there is no clinical, experimental or descriptive research to support the concept of codependency (Miller, 1994). . Miller argues that the use of the codependency concept in the treatment of wives of alcoholics, has a negative impact by creating a problem within the wife when there is no problem (Miller, 1994). He also asserts that the concept of codependency limits our ability to understand and help the person who is in a relationship with an alcoholic and creates negative reactions in many women who seek therapy.

A family systems approach to treatment generalized the concept of denial, a defense mechanism used to repress emotions, to the family members of the alcoholic (Jackson, 1954). The literature concerning wives of alcoholics has implicated them as contributing to or causing their husbands' alcoholism through their own denial. Attempts to treat spouses were noted to be a difficult process (Honig & Spinner, 1986). Honig and

Spinner proposed the use of a model developed in 1954 (Jackson, 1954) identifying seven stages toward recovery for wives. The description of denial in this model is clearly contradictory as it states that wives deny the problem but that they seek advice and feel embarrassment, hurt and confusion in relation to the alcoholic's drinking behavior. Denial would serve to prevent the occurrence of these emotions. Therefore, it is not logical that it would lead to advice seeking behavior. This description and use of denial does fit the alcoholic's behavior pattern. There is other evidence to indicate that the wives of alcoholics do not experience denial. Referrals to an alcoholism clinic are initiated by general practitioners at the request of the patient's spouse (Rees, 1986). Spouses perceive family functioning differently from the alcoholic, especially in areas of affective involvement and behavior control (McKay, Maisto, Beattie, Longabaugh & Noel, 1993) and compared to spouses, alcoholics tended to under-report on the alcohol problems subscale of the MAST maintaining that they were normal drinkers (Leonard, Dunn & Jacob, 1983). Researchers have found that the spouse's behavior is an attempt to cope with the alcoholic's drinking (Moos, Finney & Gamble, 1982). While Al-Anon is a valuable source of support and information, it also endorses the idea of codependency. Asher and Brissett (1988) found that women defined codependency in broad terms, were unsure whether it was a temporary or permanent condition, differed in their views of

whether it was an innate condition or learned. The definitional themes of codependency identified by wives of alcoholics were: affliction by association and notions of caretaking and pleasing others.

In contrast to the codependency concept and a shared denial, Asher's (1992) descriptions of the process of becoming the wife of an alcoholic is typified by definitional ambivalence, not denial or pathology. In a retrospective-prospective, qualitative study of 52 wives of men diagnosed and treated for alcoholism. Asher reported on women's experiences during and after the process of identifying alcoholism in their husbands. Her model depicts situations throughout the process that present ambivalence. Situations of definitional ambivalence are those that involve incompatible or contradictory expectations or a multitude of competing plausible definitions. The women in Asher's study managed the ambivalence by reformulating their views of themselves. Asher termed the duration of this process 'moral career'. Redefining themselves as codependent became a part of the women's process. The length of the moral career varied considerably among the women in her study.

Asher used symbolic interactionism as the framework for her study. Within this framework "the meaning of objects and events emerges withing the social process. This framework contains the following assumptions 1). the self is a social process rather than

something "thing"-like, 2) the meaning of social objects is not intrinsic but rather assigned to them, 3) there is a processual quality to interpretation, and 4) social actors are active participants in creating the social world to which they are responding. (Asher, 1992) "Through interaction, then, selves become social objects and objects of acts. An alcoholic-complicated marriage is a social object in the wife's world of social objects and she acts toward it, responds to it, and creates meaning out of it on the basis of ongoing activity." (Asher, 1992, p. 11-12).

Asher describes a particularly interesting woman in her sample. Asher labels the experience of this woman as a "negative case" or, one which did not result in disruption or alteration of her self-identity. Her case represents the shortest moral career, and the least overtly chaotic case. Asher notes that this woman had a strong sense of autonomy and that this quality is missing in most of the other cases in this phase of the moral career. It was also noted that this woman sought educational information regarding alcoholism. This study and the negative case pointed out illustrate a potential relationship between autonomy and the duration of consequences experienced by the wife of an alcoholic.

The Military and Alcohol Use

The military has been identified as being faced with a strong social norm of

acceptance of heavy drinking (Jensen, Lewis & Xenakis, 1986). A report on the alcohol abuse in the armed services from a worldwide survey in 1985 indicates pervasive use of alcohol with very little change in use since a previous survey in the 1970's (Bray, Marsden, Guess & Herbold, 1989). Alcoholism is perceived to be the primary substance problem in the military(Bray, et al, 1989). It was determined that policies in the military were identifying only late stage alcoholics (Long et al, 1977). This was especially true for personnel at higher ranks. Long et al (1977) reported experience with military officers being identified only after they were retired from active service. In contrast, a survey by Burt (1982) identified junior enlisted personnel as having the highest occurrence of alcohol dependency. Fears that treatment will damage a soldier's career may prevent him from being identified (Long et al, 1977; Jensen et al, 1986). Most of the negative effects of use in the military fell into categories of productivity, social relationships and health (Lawson & Lawson, 1989).

Military Wives

Literature on military wives indicates that their adjustment to a military lifestyle is variable. Military wives face numerous relocations of their families and numerous separations from their husbands. Klein, Tatone & Lindsay (1988) found that the factors which contribute to satisfaction among military wives; such as travel, social environment,

benefits, and spouse's job characteristics; could also contribute to dissatisfaction among military wives. These same wives identified independence as a characteristic of successful adjustment while dependence and passivity were associated with unsuccessful adjustment. Their most common recommendation to other wives was to continue self-development. Responses by wives indicated that either conformity or independence could lead to successful adjustment. Stone and Alt (1990) describe the life of military wives with this same paradox. The military wife either adapts by conforming or developing more independence. Stone and Alt then describe some of the losses for women sho conform. According to Stone and Alt, "When a woman marries a military man she moves into his world and is pressured to conform and perform as a "good " military wife." (p. 4) They are informed of their responsibility in their husband's careers. They are taught through formal, informal, blatant and subtle means that they can make or break their husband's career. They assume the same status and position as their husband's rank entails. Wives of officers are discouraged from employment based on tradition that is 200 years old. Even if they did seek employment, they end up with low paying, low status positions due to discrimination against them as transient workers or companies' tendency to promote from within and hire from the local community. Overseas assignments offer positions to the local nationals as policy dictates, limiting employment

opportunites for wives. The role expectations and military environment are examples of potential barriers to the development of autonomy in military wives.

Foreign born military wives also face difficulties in moving to a foreign country, sometimes without knowing how to speak English. Since World War II, nearly 250,000 women have become military wives (Stone and Alt, 1991. p. 129). The military implemented policies in the past to discourage these marriages. The foreign born wives, in addition to the stress of adjusting to a new culture, are sometimes subjected to discrimination further alienating and isolating them. This may make it more difficult for foreign born military wives to exhibit or develop autonomy.

The wife was referred to as a dependent until military personnel were instructed to refer to dependents as family members. "The military system doesn't recognize the woman except as an appendage to the man" (Stone and Alt, 1991. p. 121). One of the means by which wives cope with the military lifestyle and environment is by bonding with other women in the same situation. They form networks and support each other. Because the military is a hierarchical society, the network dwindles as the husband achieves higher rank leaving the commanders' wives to experience loneliness. The loneliness and isolation may foster excessive dependence on the marital relationship making it more difficult for these women to be autonomous.

Education

We do not know if knowledge about the definition of alcoholism is beneficial to wives who may be experiencing consequences of their husbands' drinking because they seem to receive educational material only *after* they have identified the problem to be alcoholism. Recently, the change in focus from codependency has enabled us to look at coping skills in wives of alcoholics which may be predictive of improved functioning of the couple (Dittrich & Trapold, 1984). While this approach appears to be for the benefit of the spouse, it implies that she has a deficit that could be causing pathological drinking in her husband and that if she developed better coping skills, he would seek treatment or maintain abstinence (Rychtarik, Carstensen, Alford, Schlundt & Scott, 1988). This approach fails to address the specific needs of the wife. There is no research to indicate that wives receive education prior to or outside of participation in her husband's recovery. Contact with rehabilitation programs and personnel may be her first exposure to definitions of alcoholism. The focus of research has been on identifying consequences, causative factors and effective treatment. Preventive campaigns have been directed at pregnant women and teenagers. Education in identification is also directed at medical professionals and has been shown to increase history taking and assessment (Cowan, 1994). In a review of medical education about alcohol, Walsh (1995) reports that low

levels of medical knowledge and inappropriate attitudes are noted in the area of alcoholism. As little as one training session, designed for working with alcoholic populations, increased the objective knowledge base of counseling students (McDermott, Tricker & Farha, 1991). In the military, educational efforts are directed toward commanders in an attempt to change attitudes and facilitate early identification of alcohol abusers (Long, Hewitt & Blane, 1977). If educational efforts were directed at women and informed them of the symptoms, their knowledge may contribute to earlier identification and less ambivalence when the symptoms occur.

Summary

The effects of alcoholism on wives of alcoholics may be due in part to a lack of knowledge or autonomy, the result of oppression, or societal ambivalence regarding the use of alcohol and the definition of alcoholism. Attempts to intervene and assist the wives occurs at a late stage of the process and serves to pathologize the women. According to Freire "The oppressed are regarded as the pathology of the healthy society, which must therefore adjust these....folk to its own patterns by changing their mentality." (p. 60). Military wives, as indicated by their accounts of their lifestyles, endure a culture which may prevent or encourage autonomy. They also endure a culture who's drinking norms have been problematic and resistant to change. Additionally, there are no

educational programs to teach women the symptoms of alcoholism. Identification is left to an authoritative medical profession which itself struggles to define the problem.

The ambivalence surrounding alcoholism and the military culture represent factors affecting agency/autonomy and potentially create a self care deficit when the military wife's husband becomes alcoholic. The purpose of this study was to describe levels of autonomy and recognition of alcoholism by wives of active duty military men. Autonomy is defined as: the quality of being self-governing. Alcoholism, for the purpose of this study includes either a diagnosis of alcohol abuse or alcohol dependence. The questions presented in this study are: 1). Can military wives recognize symptoms indicating alcoholism? and 2). Is their level of autonomy a factor in recognition of symptoms indicating alcoholism?

Chapter III: Methodology

This is a descriptive, correlational study. The following chapter describes the sample, procedures, data collection, and data analysis.

Sample

The study used a non-random convenience sample of 49 military wives visiting the Ob/Gyn clinic of a major army medical center during the period of data collection. Subjects were civilian women married to a man on active duty in any branch of the military. Age of subjects was 18-45 years of age. Women who were on active duty themselves and single women were excluded.

Procedure

Subjects were informed of the study by the researcher who handed out an introduction flyer (See Appendix A) to women as they entered the clinic. They were told that the questionnaire (See Appendix B and C) was located at the reception desk. The introductory flyer indicated the criteria for participation in the study. Those clients who were interested were included in the study based on their completion of the questionnaires. Subjects reviewed the assent form and signed a consent which included an explanation of purpose, potential risks and benefits of the study, rights of the subjects regarding participation (See Appendix D). Questionnaires were completed in the

reception area of the clinic while awaiting appointments and returned to the researcher. If subjects were not able to complete the questionnaire prior to their appointment, they were asked to keep the questionnaire with them and to complete the questionnaire after their appointment and leave it with the investigator upon completion. All completed surveys were placed in an envelope and handled only by the investigator.

Data Collection

Autonomy was measured by using the Worthington Autonomy Scale which measures four dimensions of autonomy. This scale has been tested for construct validity, factorial validity and cross-racial validity. The Cronbach's Alpha for the total scale is .92. Alphas for the subscales of family loyalty, value, emotional and behavioral autonomy ranges from .68 to .83 (Anderson, Worthington, Anderson & Jennings, 1994). The developers of the scale define family loyalty as: being free of any "binding" by one's parents or family of origin. Emotional autonomy is defined as: the desire to exert self-control. Behavioral autonomy is defined as: freedom of action. Value autonomy is defined as: the ability to make moral, vocational, and religious decisions (Anderson et al, 1994). The scale consists of 40 questions that are rated on a 4-point Likert scale.

Recognition of alcoholism was measured using six vignettes which were constructed by the author. They were designed to include behaviors which meet criteria

for diagnosis of substance abuse or substance dependence. Two of the vignettes describe behaviors which by themselves do not meet criteria for a diagnosis. The amount and frequency of use were included despite the fact that amounts may only indicate a diagnosable problem in the later stage of disease known as dependence. The information in the vignettes was presented in a way which might elicit ambivalence about the severity of the problem. For example, using the phrase "he says he can handle it and never misses work" suggests that missing work would be a more severe symptom. These are actual minimizations heard in my experience with treatment of alcoholics. Each vignette was rated by the subject to indicate the level of alcohol use they believed it to represent. The options consisted of 1). occasional drinker, 2). social drinker, 3). problem drinker, and 4). alcoholic. The vignettes were reviewed by an expert panel made up of two doctorally prepared psychosocial nurses at the University of Washington to determine construct validity. For the purposes of this study, the term problem drinker corresponds to the medical diagnosis of alcohol abuse and the term alcoholic corresponds to the medical diagnosis of alcohol dependence. Four options were presented to prevent use of a "middle of the road" response. People who describe themselves as social drinkers view their use as occurring within social norms. Occassional drinkers describe themselves as such to indicate rare and infrequent use. Each of the vignettes included the amount of

alcohol consumption, and a variety of consequences of alcohol use varying in number from none to three. The number of consequences indicates the diagnosis that can be applied to that individual according to DSM-IV criteria. Demographic data was not obtained in order to encourage participation by eliminating identifying information.

Data Analysis

Frequencies were computed to determine the percentage of responses for each option in each vignette. Mean scores and standard deviations were computed for autonomy scale scores and for each of the subscales. Spearman's correlation was used to determine a linear relationship between autonomy and the correct responses for vignettes and each autonomy subscale and the correct response for the vignettes. A two-tailed test was used to determine level of significance for correlations.

CHAPTER IV: RESULTS

Forty-nine subjects completed the autonomy scale. Forty-eight subjects completed the vignettes and one subject responded to only one of the six vignettes. Some subjects responded to questions on the autonomy scale by circling two responses. When both numbers circled indicated a positive response, the lower was entered as the response. When answers circled indicated a positive and a negative response, the item was treated as missing data. The occurrence of missing data on the autonomy scale was 16 responses out of a total possible of 1960 responses (0.008%).

Vignettes

Frequencies were calculated individually and compositely. The mean number correct was 3.18. Possible scores range from zero (0) correctly identified to six (6) correctly identified. The correct responses for each vignette are as follows: #1=social drinker, #2=problem drinker, #3=problem drinker, #4=social drinker, #5=alcoholic and #6=alcoholic.

A summary of results for vignette #1 showed that fifty-five percent (55%) of the women correctly identified the drinker as a social drinker. Eight percent (8%) identified the man in the vignette as an occasional drinker. Thirty-three percent (33%) identified him as a problem drinker and four percent (4%) identified him as an alcoholic.

A summary of results for vignette #2 showed that fifty-seven percent (57%) of the women correctly identified the drinker as a problem drinker. Two percent (2%) identified the man in the vignette as a social drinker. Thirty-nine percent (39%) identified him as an alcoholic and none of the subjects identified him as an occasional drinker.

A summary of results for vignette #3 showed that thirty-one percent (31%) of the subjects correctly identified him as a problem drinker. Four percent (4%) identified the drinker in the vignette as a social drinker. Sixty-three (63%) identified him as an alcoholic. None of the subjects viewed the drinker as an occasional drinker.

A summary of results for vignette #4 showed that thirty-one percent (31%) of subjects correctly identified him as a social drinker. Thirty-six percent (36%) identified this drinker as an occasional drinker. Twenty percent (20%) identified him as a problem drinker and ten percent (10%) identified him as an alcoholic. Unlike the other vignettes, this vignette did not state the frequency of the drinker's use. This vignette had the most variation of responses as well as the highest use of the "occassional drinker" response.

A summary of results for vignette #5 showed that eighty percent (80%) of the responders correctly identified this drinker as alcoholic. Two percent (2%) of the women identified this man as a social drinker and sixteen percent (16%) identified the man in the

vignette as a problem drinker. It is interesting to note that one of the consequences for the drinker in vignette #5 was that his wife left him because of his alcohol use. This vignette had the highest percentage of correct responses.

A summary of responses for vignette #6 showed sixty-five percent (65%) correctly identified the drinker as alcoholic. Four percent (4%) of responders identified this man's drinking behavior as occasional. Two (2%) identified him as a social drinker. Twenty-five percent (25%) identified him as a problem drinker.

With the exception of vignette #4, 65% of the subjects chose the correct response or a magnified response (e.g. choosing alcoholic when the correct response was social or problem drinker, or choosing problem drinker when the correct response was social drinker). The combined percentage of correct and magnified responses reached as high as 96% on vignette #2. Responses to vignettes are displayed in Table 1.

VIGNETTE	#1	#2	#3	#4	#5	#6
OCCASIONAL	8%	0	0	36%	0	4%
SOCIAL	*55%	2%	4%	*31%	2%	2%
PROBLEM	33%	*57%	*31%	20%	16%	25%
ALCOHOLIC	4%	39%	63%	10%	*80%	*65%
CORRECT OR MAGNIFIED	92%	96%	94%	61%	80%	65%

Table 1 Summary of Vignette Responses * Indicates correct response

Worthington Autonomy Scale (WAS)

The range of scores for the WAS are 40-160. Subscale scores range from 10-40 for each of four scales. The definition of Family Loyalty autonomy is: Free of "binding by one's parents or family of origin, value autonomy is: ability to make moral, vocational, and religious decisions, emotional autonomy is: desire to exert self-control, and behavioral autonomy is: freedom of action and accepting responsibility for one's actions. Cronbach's alpha for the total WAS reported by Anderson, Worthington, Anderson & Jennings (1994) was .92. Developers of the scale report mean subscale scores of:

SUBSCALE	MEAN
Family Loyalty	2.810 (SD=0.545)
Value	3.173 (SD=0.407)
Emotional	3.213 (SD=0.342)
Behavioral	3.142 (SD=0.389)

In this population of 49 military wives, the mean WAS score was 3.22 using the 1-4 scale with a standard deviation of .27. The Cronbach's alpha for the total WAS was 0.83. Cronbach's alpha for subscales were: behavioral= . 6329, emotional = .5340, value = .5617, and family loyalty = .7724. Mean subscale scores were:

Family Loyalty	3.14	(SD=0.52)
Value	3.30	(SD=0.32)
Emotional	3.25	(SD=0.30)
Behavioral	3.19	(SD=0.33)

Correlations between autonomy scale and subscales and correct responses to vignettes were computed using two-tailed Spearman's correlation coefficient. A correlation of .290 was found between behavioral autonomy and a correct response to vignette #5 ($p<.05$). The correlation between emotional autonomy and a correct response to Vignette #1 was .284 ($p<.05$). There was no significant correlation found between the mean WAS and identification of alcoholism as indicated by a correct response in the vignettes.

CHAPTER V: DISCUSSION

The results of this study give us information about the autonomy of military wives and their recognition of alcoholism. In 5 out of 6 vignette cases these subjects demonstrate a high rate of recognition of the medical definitions of alcoholism and approximately one-third of them magnified the severity of the problem. This can be interpreted in several ways. First, it indicates that the medical criteria may not adequately address the problem from the wives' perspective. Second, the military culture does not impact the wives' identification of the problem such that they are less able to recognize it. In fact it would be interesting to find out if the magnified responses were a result of encountering the problem more often, heightening their sensitivity to drinking problems. One would not expect a self care deficit to occur for a military wife faced with defining alcoholism in most cases. One would expect the military wife to experience less ambivalence when defining alcoholism.

What we discovered with this study is a fairly high level of autonomy overall among military wives. In restrospect, there may be elements of a military lifestyle which may encourage a wife's autonomy, such as her husband's military duties which result in his absence from home for extended periods of time, placing her in a position of autonomy. Duplication of this study in the general population of women would help to

determine if military wives represent a unique group with respect to autonomy scores. Despite the overall high levels of autonomy and the recognition capability of these subjects, a correlation between the two variables is not seen. This may be due to the lack of variation in this homogenous group.

The vignette scores are also open to interpretation. In contrast to the other vignettes, vignette #4 did not include number of days the individual was consuming alcohol. The frequency of responses for vignette #4 show a decrease in the sesnsitivity of responses. Fewer women responded correctly or magnified the response as was the tendency in the other vignettes. It is possible that the responses for vignette #4 indicate a reliance on the frequency of alcohol use in determining extent of the problem. This minimization of the problem may increase the potential for a self care deficit.

The responses to vignette # 5 were also interesting. Eighty percent identified this individual as alcoholic. The subjects may have been responding to the drinker's failed marriage due to alcohol use. Vignette # 3 uses physical violence against the wife as an indicator. This vignette describes a problem drinker, not an alcoholic, due to the fact that alcohol dependence requires three criteria to be met. The responses to this vignette indicated that twice as many women thought him to be an alcoholic than a problem drinker. While the DSM-IV criteria for alcohol abuse require recurrent or continued

problems of this nature, one episode may be sufficient evidence for the wives. These responses suggest that some behaviors are stronger indicators for women.

Vignette #6 indicates alcohol dependence by the individual's attempt to stop and the presence of withdrawal symptoms as well as giving up a recreational activity. The drinker in Vignette #6 was viewed by 65% these women as being alcoholic. However, 31% selected a minimized response. The responses for this vignette suggest that the individual's attempts to quit may create ambivalence for the wife.

One of the limitations of this study is the random use and combination of behaviors or events used in each vignette. It may be useful to study which behaviors wives view as stronger indicators of an alcohol problem. While the vignettes include a wide range of events or behaviors leading to a diagnosis, these things do not present themselves in this fashion in reality. The process occurs over time, with each symptom occurring at a different point in time creating situations which create definitional ambivalence. The presentation of all the consequences at once may have the effect of reducing ambivalence. The vignettes provide information on a wife's ability to recognize alcoholism, however, they do not inform us of the subject's source of knowledge. One source of knowledge may be previous experience with the disease which would account for improved recognition. This type of knowledge, knowledge which comes from

experience, is seen by Freire as the type of knowledge which, when people trust themselves, serves to liberate them from oppression.

The autonomy scale used in this study is a measure of autonomy related to family of origin. It may not reflect measurement of autonomy within a marital relationship. It is also possible that autonomy becomes a more relevant concept when action is required or desired by the wife in order to mitigate consequences to herself. Further research is needed to clarify the concept of autonomy and women's development of autonomy in order to determine its effect on women's relationships and self care capability. It is important for nurses to recognize a wife's experience as a source of knowledge which defines a problem more clearly for her than a medical definition will define it. Her own knowledge may serve her better than our scientifically derived health knowledge.

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Appendix A

Introduction flyer

Hello,

My name is Tina McConnell. I'm an Air Force Nurse working on my master's degree at the University of Washington.

I am conducting a study with military wives to look at their independence and their knowledge of alcohol. All women age 18-45 who are civilian married to active duty qualify for the study. I ask that you please consider taking about 10 minutes to complete the questionnaires.

The information you provide will help us to plan education for military wives.

Participating will not delay your scheduled appointment today.

Thank You!

Appendix B
Vignettes

Directions: Please read each of the following descriptions and check the category of alcohol use below which you think applies to the description. Check only ***one*** category. The individual in each of the descriptions is a man on active duty in the armed forces. He is married and has children. He may be an officer or enlisted.

#1 John goes out regularly on Fridays to the club. He drinks 3-4 beers and is usually home by midnight. He's sleepy, doesn't eat and falls asleep on the sofa.

_____ Occasional drinker

_____ Social Drinker

_____ Problem drinker

_____ Alcoholic

#2 Michael drinks 1 or 2 beers every night when he gets home from work. On weekends he plays softball and drinks 6-8 beers during that time. His wife has asked him not to drink as much but he tells her it doesn't have any effect on him.

_____ Occasional drinker

_____ Social drinker

_____Problem drinker

_____ Alcoholic

#3 Steve drinks on weekends with his friends at their home or his home. He likes to drink lite beer and mixed drinks and usually has 9 or 10 in an evening. He has gotten into arguments with his wife but has only pushed her once while drinking.

_____ Occasional drinker

_____ Social drinker

_____ Problem drinker

_____ Alcoholic

#4 Bill once drank so much at a squadron picnic he had to throw-up. He now keeps his drinking to no more than 2 beers on any day.

_____ Occasional drinker

_____ Social drinker

_____ Problem drinker

_____ Alcoholic

#5 James' first wife left him because he drank often. He drinks daily 3-4 beers, 6-12 on weekends when he's not flying. He says he can handle it and never misses work. The only time he has been grounded was for pancreatitis.

_____ Occasional drinker

_____ Social drinker

_____ Problem drinker

_____ Alcoholic

#6 Dan loves boating but knows that boating and drinking don't mix so he only takes his boat out a couple times a year. He drinks Martinis before and after dinner each night. Dan quit drinking for 2 months because he thought he might be drinking too much. He said it was no problem once he got through the withdrawal. He began drinking again when he went on leave.

_____ Occasional drinker

_____ Social drinker

_____ Problem drinker

_____ Alcoholic

Appendix C

Autonomy Scale

Directions: In reading the following statements, apply them to yourself and circle the rating that best fits you. The statements about your "family" ALWAYS mean the family with which you spent most of your childhood. Answer the questions about your family "as you remember it."

Since each person is unique, there are no right or wrong answers. Just try to be as honest with yourself as possible. *Please respond to every statemtent.*

1 = STRONGLY DISAGREE with the statement.
2 = DISAGREE with the statement.
3 = AGREE with the statement.
4 = STRONGLY AGREE with the statement.

SD	D	A	SA	
1	2	3	4	My parents always encouraged me to set my own goals.
1	2	3	4	I allow others to influence my ideas about what is right or wrong.
1	2	3	4	I can be close to someone and give them space at the same time.
1	2	3	4	I don't take time to do things for myself.
1	2	3	4	Individual privacy was taught and respected in the family in which I grew up.
1	2	3	4	I have a definite plan for my life.
1	2	3	4	I have learned to disagree with others and still like them.
1	2	3	4	I try to eat foods that are good for me.
1	2	3	4	After I became an adult, I was torn between my love for my parents and mylove for my friends and/or spouse.
1	2	3	4	I would hold to my religious beliefs even if my family and friends did not approve.

1 = STRONGLY DISAGREE with the statement.
2 = DISAGREE with the statement
3 = AGREE with the statement.
4 = STRONGLY AGREE with the statement.

SD	D	A	SA	
1	2	3	4	I trust most people.
1	2	3	4	I accept responsibility for my own mistakes.
1	2	3	4	I enjoy spending some of my free time with my parents even after I became an adult.
1	2	3	4	I am not comfortable with my sexual role.
1	2	3	4	I believe that marriage should be for life.
1	2	3	4	I don't spend my money wisely.
1	2	3	4	My parents and I could discuss almost anything after I was grown up.
1	2	3	4	I can see my good and bad points realistically.
1	2	3	4	I find it difficult to thank others for what they do for me.
1	2	3	4	I like to pay my own way when I go out with others.
1	2	3	4	I could disagree with my parents without fear of rejection after I became an adult.
1	2	3	4	If I was ordered to do something I thought was morally wrong, I would quit my job.
1	2	3	4	I avoid being with others by working too much or staying busy.

1 = STRONGLY DISAGREE with the statement.
2 = DISAGREE with the statement.
3 = AGREE with the statement.
4 = STRONGLY AGREE with the statement

SD	D	A	SA	
1	2	3	4	I can always find interesting things to do with my time.
1	2	3	4	In the family in which I grew up, we didn't knock on the door before entering another person's room.
1	2	3	4	I choose my own friends and/or mate, rather than having someone else choose them for me.
1	2	3	4	I have a genuine concern for other people's problems.
1	2	3	4	Health matters are important to me.
1	2	3	4	I was caught in the middle when my parents argued.
1	2	3	4	I feel uncomfortable exploring religious attitudes that are new to me.
1	2	3	4	The more I trust others, the more trustworthy they become.
1	2	3	4	I apologize for my part of an argument even if the other person doesn't.
1	2	3	4	After I became an adult, I felt like I was with good friends when I was with my parents.
1	2	3	4	I don't feel that I have to be good at something just because I am male or female.
1	2	3	4	My friends and family can count on me in a crisis.
1	2	3	4	I try to find the best bargains when I shop.

1 2 3 4 My parents and I learned to respect each other by the time I was grown up.

1 2 3 4 I have something valuable to offer others.

1 2 3 4 I try to be honest with people even if it may be painful to me or them.

1 2 3 4 I assume my share of household responsibilities when I live with others.

Appendix D

Consent Form

Autonomy of Military Wives and Their Recognition of Alcoholism

Investigator: Tina M. McConnell, R.N., Graduate Student, University of Washington, School of Nursing, Psychosocial and Community Health, 206-543-9491

This study is being conducted to look at two factors that may affect the way women understand alcohol use by their spouses. This information may eventually help us to reduce or prevent alcohol problems in military families.

If you consent to participate, you will be given 2 questionnaires to be completed today while you are awaiting your appointment in the clinic. It will take approximately 10 minutes of your time. If you are unable to complete it before your appointment, I ask that you keep it with you and complete it after your appointment and return it to me. While some of the questions are about you personally, neither of the questionnaires asks any information that would allow us to identify you. You are free to refuse to answer any of the questions. Participation is strictly voluntary and you may stop participation at any time. Choosing not to participate will in no way effect your care at the clinic

There are no anticipated risks or discomfort associated with your involvement in the study. Invasion of privacy is minimal since no identifying information is being obtained. I am a mental health nurse, so if you have any questions or concerns, please let me know.

Responses to questionnaires will be analyzed and results reported in my master's thesis which will be on file in the school of nursing. Results might also be presented at conferences or published in a journal. Again, this study is completely anonymous, so there will be no connection made between your participation and either the questionnaire or the reported results.

_____ _____

Signature of Investigator Date

_____ _____

Signature of Participant Date