

# The Irish and Substance Abuse

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**T**he production and use of alcohol is embedded in the cultural fabric of the people of Ireland. The use of other drugs enjoys no such cultural accommodation and, as a result, is proportionally in minimal evidence. But culture, like patterns of substance use, is not a static entity (Cheung, 1993). In Ireland profound cultural changes are discernible, whereas among Irish Americans, the level of cultural affinity to Ireland varies as generations grow more distant from the Emerald Isle. It is difficult to predict the configuration of cultural traits or the level of ethnic affinity that may influence a client's behavior. Yet it seems essential for the clinician to have a sense of the dominant themes of the cultural heritage that may enter the therapeutic process. It is equally important to realize that Irish Americans, as an ethnocultural group, represent a variety of subgroups associated with "the Ireland" they left.

Although the heavy-drinking Irishman is a cultural stereotype, some researchers question the influence of ethnicity as determinative of drinking patterns. They claim that demographic variables such as education, income, age, and marital status may have a significant influence on ethnocultural drinking patterns (Wilson & Williams, 1989). Nonetheless, the values and perceptions that surround alcohol and drug use in any culture seem important, although demographic variables may facilitate or hinder their expression at various times.

This chapter introduces the clinician to the Irish people and to the key cultural features of their history and offers insight into the role of alcohol in Irish life and the current use of other substances in Ireland. Common treatment issues are reviewed and clinical guidelines are recommended. An understanding of why the Irish tend to abuse alcohol may provide clues to effective prevention strategies.

Although the entire history of Ireland cannot be reviewed, some historical events will be recounted because of their imprint on the Irish psyche. This chapter chiefly focuses on the Catholic Irish, for whom their ethnic identity is still a highly significant aspect of their lives.

## HISTORY AND CULTURAL HERITAGE

Ireland is a small island, about the size of Indiana, yet its cultural influence in the world seems out of proportion to its total population of slightly over 5 million. McGoldrick (1982, 1996) describes the Irish people as being full of paradoxes: They are verbally skilled yet are tongue-tied on emotional issues; they assume responsibility yet are quick to blame; they are jovial and friendly yet avoid tenderness and affection. These paradoxes capture both the appeal and the anguish of the Irish, as this brief look at Irish historical and cultural characteristics shows.

### British Occupation

The character of the Irish people was formed by centuries of political unrest and uncertainty. For more than eight centuries the British sought to dominate Ireland and its people. Once they captured regions of the country, they replaced many of the Irish farmers with loyal Protestants from London and other cities. This practice was called plantation. The plantation of Ulster in the 17th century had left the six counties of Northern Ireland predominantly Protestant and its people

seeking to remain under the aegis of the British government. A 1921 treaty created a division of the island, with Northern Ireland remaining a province of the United Kingdom, whereas the remaining 26 counties formed the Republic of Ireland, whose population is 92% Catholic.

Although many prominent Protestant Irish contributed greatly to the Irish culture through the arts and politics, most do not see themselves as Irish. Protestant Irish immigrants to the United States tended to marry outside of their ethnic group (Fallows, 1979) and to avoid the designation of “Irish” by using the description of “Scots-Irish” (Griffin, 1992). Many have lost their sense of Irish identity, unlike most Catholic Irish.

### **Famine and Emigration**

Disaster struck in 1845 when the potato crop failed due to a plant disease called “the Blight.” Famine, exacerbated by the confiscation and exportation of available food by the British (Woodham-Smith, 1963), stalked the land. Consequently, more than 1 million people died of starvation and another million emigrated to North America and elsewhere. A new trend emerged in Irish history: Emigration became tradition. Since-1845, more than 7 million people have left the shores of Ireland for distant lands (Neill, 1979).

### **Family Dynamics**

A common Irish cultural characteristic is the experience of guilt associated with success and material goods. Any display of opulence or pretense to success incurs withering disapproval. Those who prosper have been viewed as being deceptive in some way, such as receiving money as a reward for supplying information to the British. Many of the Irish saw consorting with the enemy as more reprehensible than being the enemy itself. Strong tendencies to preserve privacy, especially with regard to family issues, are common, and few people outside the priest can be trusted with such information. This trait creates difficulty for many clinicians.

Even within the family, it is common that family problems go undiscussed, especially if there is perceived shame associated with the problem (McGoldrick, 1982,1996). Behavior that threatens the moral respectability of the family, such as a wife’s drinking or a son’s drug abuse, will likely be shame inducing and, when possible, will be withheld from others in the family. Unresolved problems create distance and resentment and, finally, the unspoken sentence of isolation. Pride and the need to keep up appearances forces many to choose to suffer alone rather than cause embarrassment to the family (McGoldrick, 1982, 1996).

Intergenerational and gender boundaries are strong, and, as a result, communication is more likely to occur within the same generation and gender (Hines, Garcia-Preto, McGoldrick, Almeida, & Wehmann, 1992). It is important that clinicians appreciate the impact of this dynamic on data gathering.

### **Use of Language**

Like many oppressed people, the Irish tend to use metaphor, innuendo, and ambiguity to obscure and disguise their meaning (McGoldrick, 1982, 1996). Thus, although they have an engaging style, the Irish often speak a language that can easily confuse the outsider. As noted by Morton (1978), “Talk in Ireland is a game with no rules” (p. 20). Clinicians who are accustomed to directness may find that their Irish clients exhibit a mastery of indirect use of language. Objective truth is less significant than telling a story with flair. Clients may provide little information when questioned and try to distract the questioner from an unacceptable line of discussion. O’heithir (1987) claims that for “the Irish, words become/a form of action that ultimately renders action unnecessary. Therapeutic issues that have been discussed may seem to many Irish clients to be resolved—without requiring any behavioral change.

## **Role of the Church**

It is difficult to overstate the power of the Catholic bishops in Ireland. The bishops ensured that the laws of the land were consistent with Catholic teaching, especially on issues such as divorce and abortion. Dissident voices were quickly silenced.

The Church effectively controlled education for decades. Although these schools were outstanding, male and female roles were clearly defined and kept separate. The Church's teachings on sex and sexuality focused on "sins of the flesh." The consequent sexual repression resulted in the avoidance of overt tenderness and affection among many Irish couples. The emphasis on sexual acts rather than on relationships has been viewed as resulting in feelings of guilt regarding sexuality and the inability of many Irish Catholics to have fulfilling intimate relationships (Buckley, 1994). Drinking alcohol has been seen as providing a temporary remedy for this guilt (Teehan, 1988).

Traditional Catholic theology's view of the world as a "valley of tears" offered comfort to a population who suffered under brutal penal laws and frequent famines. Suffering was to be accepted as a natural consequence of one's sinful nature. This may explain the general fatalistic tendency of the Irish (McGoldrick, 1982). This metaphysical approach to life may provide a coherent way of understanding suffering but does little to reduce its sting. Alcohol appears to be the elixir of choice to dispel the gloom and make painful situations tolerable (Teehan, 1988).

## **Irish Culture in Transition**

Since the 1960s, major changes in Irish society have occurred that have led many to describe the Ireland of the late 1990s as a "new Ireland." The reforms of the Catholic Church in the early 1960s converged with improved access to advanced education, increased economic opportunities, and an expanding media—the result being the development of the "new Ireland."

## **THE IRISH IN THE UNITED STATES**

The Irish frequently claim that St. Brendan, an Irish abbot, was the first European to arrive in America, almost 1,000 years before Columbus. Although this claim remains in dispute, Irish immigration to the United States since the Great Famine is well documented. More than 43 million Americans now consider themselves to be of Irish descent (Griffin, 1992).

Almost 2 million Irish Catholics settled along the East Coast of the United States between 1830 and 1860. By 1870, one in five voters in New York City had been born in Ireland. Their living conditions were unpleasant; the Irish were subjected to massive social discrimination and were generally viewed with derision (Lender & Martin, 1982). Familiar with institutional violence and injustice at the hands of the British, the Irish knew how to resist it. They deepened their allegiance to the Catholic Church, shaped its growth in America, built their own parochial schools, and established their own civic organizations (Lender & Martin, 1982). These actions served to keep the Irish cohesive as a group and made them a force to be reckoned with once they entered the political process.

During the 1980s, Irish immigration to the United States began to increase following a decline during the previous 20 years (Griffin, 1992), although numerous undocumented immigrants make it difficult to get precise numbers. These immigrants from the "new Ireland" are more educated, articulate, self-confident, and self-directed than their predecessors. They are not given to the guilt of their ancestors. Gone, too, is the limiting concern about what the neighbors will think. Many see themselves as citizens of the world who have warm feelings for the land of their birth. They still have the lilting brogue and are only slightly more direct in expression. Many still like to drink; however, they are more open to therapy.

## **ROLE OF DRINKING IN IRISH CULTURE**

That the Irish who drink heavily seems beyond dispute, yet the cause of this phenomenon, as well as the full scope of the problem, has received little scholarly attention (Greeley, 1981; Stivers, 1976). *Uisce beatha* is the Gaelic term for whiskey, generally translated as “blessed water.” Alcohol in all its forms has played a significant role in Irish life.

In the early 18th century, the invention of gin led to a period of heavy drinking throughout Britain and Ireland (Stivers, 1976). For the next 100 years, abstinence movements made significant progress in containing this gin epidemic, and it is estimated that more than half the people of Ireland were total abstainers prior to the Great Famine of the late 1840s (Greeley, 1981). However, heavy drinking became a widespread method of coping with the devastation of the famine. Moreover, young males displayed their masculinity by “drinking like men,” implying a demonstration of tolerance for alcohol. Such excessive male drinking has been seen as a form of compensation for the scarcity of opportunity to attain adulthood through land ownership or marriage (Stivers, 1976).

Concern about giving legitimacy to the stereotype of the Irish as heavy drinkers has caused the extent of drinking problems among the Irish to be discounted or minimized. For example, the low reported death rates from liver disease and cirrhosis (Stivers, 1976) may be explained by the reluctance of many physicians to identify these conditions as the cause of death on death certificates in order to spare families perceived embarrassment associated with the stigma of alcoholism. Yet, when consumption rates are analyzed, taking into consideration that 11 % of Irish men and 23 % of Irish women are lifetime abstainers and that a high percentage of the population of Ireland is under the age of 15, we can conclude that a large percentage of Irish men drink heavily (Harrison, Carrhill, & Sutton, 1993).

### **The Role of the Pub**

The pub in Ireland serves as a social center. There neighbors meet, exchange stories, and celebrate whatever is topical. As a symbol of manliness, acceptance, and affirmation, there is an obligatory practice of “treating” or “standing your round” in Irish pubs (Stivers, 1976). In practical terms, this custom means that if five people enter a pub together, each one in turn is expected to purchase a round of drinks and therefore to consume five drinks. This practice often results in individuals consuming more alcohol in order to avoid being labeled as “not standing.”

### **The Pledge**

During the early part of the 19th century, some Church leaders grew concerned about the excessive use of alcohol (Malcolm, 1986), and through the tenacity of Father Theobald Matthew, the Pioneer Total Abstinence Association was founded in 1835. The movement gave spiritual meaning to abstaining from alcohol and required its members to recite certain prayers for the sins of intemperance. It became common for adolescents to take a pledge to abstain from alcohol until at least age 21; most children still make that promise today.

An unintended consequence of the Pioneer movement to this day is the Irish tendency to view alcohol in extreme terms—that is, good versus evil; abstinent versus drunk. For this reason, the Irish are likely to deal with an alcohol problem by embracing abstinence more easily than other ethnic groups do (Valliant, 1983). Ireland has a higher proportion of lifetime abstainers than almost any country outside the Islamic world (Malcolm, 1986).

### **Use of Other Drugs**

Ireland is similar to most countries in that a wide variety of drugs have become available in the past 20 years. Unlike alcoholism, drug addiction is largely unacceptable in the Irish culture. It exists in the major cities chiefly among unemployed youth and is frequently associated with youth violence. It is now estimated that there are 5,000 heroin abusers in Dublin (Cusack, 1996),

and marijuana use is common in urban areas, but the preference for alcohol is so dominant that all other addictions pale by comparison. Vigilante groups have been known to violently put drug pushers out of business. Some authors have claimed that the drug problem in the major cities of Ireland is more extensive than is generally acknowledged (Henderson, 1994) and is enhanced by the Irish tendency to avoid talking about it.

### **Irish Women and Their Use of Alcohol and Other Drugs**

In the Irish family women play a dominant role, which they execute skillfully. They tend to make all significant decisions while giving the appearance that the father is the authority and head of the house. The mother in the home, like the priest in the community, enforces the moral code (Stivers, 1976).

Traditionally, Irish women received equal educational opportunity, which may account for their high representation among the professions (Greeley, 1981). Their role is generally more empowered than in other cultures, and they seem to be aware of that power. It is common for young Irish women to be convinced that they can change the drinking behavior of a fiancé once they are married. When this plan becomes unattainable, they are generally praised for “putting up with himself” and fall into the role of martyr. For these Catholic women, leaving an alcoholic husband is not seen as an option —these wives have “made their bed” and now they “must sleep in it.”

Drinking patterns among Irish women have dramatically changed since 1960, resulting in substantial increases in consumption (Corrigan & Butler, 1991). Traditional Irish women seldom drink, but when they do it is usually done at home, alone. Contemporary Irish women drink with men in social situations, although problem drinking for women is severely sanctioned by the culture. Social disapproval of alcoholism among women is very strong, leading to very high levels of denial. In one study (Corrigan & Butler, 1991), 53% of the female patients attempted to deny their drinking, even though they were in treatment for the problem, and fully 61% had prior inpatient treatment. Fifty-eight percent of these women also used tranquilizers, 55% used sleeping pills, and 13% used marijuana (Corrigan, & Butler, 1991).

### **Irish Adolescent Drinking**

Although the Irish accept heavy drinking in men as being normal, in general, parents tend to insist on abstinence from their adolescent children, who often drink secretly. Adolescent access to alcohol in Irish pubs is restricted by government legislation, although it is not uniformly enforced. There are scant data on high school drinking patterns in Ireland. In one study by Grube, Morgan, and Kearney (1989), 47% of high school students reported using alcohol at least once in the previous 30 days, which is slightly below comparable studies of adolescent behavior in the United States. This study identified significant gender differences with regard to alcohol use: Males were six times more likely than females to have used alcohol.

### **Intravenous Drug Use and AIDS**

During the early 1990s, there were close to 1,500 documented cases of HIV seropositivity in Ireland (Bradley, Bury, O’Kelly, & Shannon, 1993; Henderson, 1994). These numbers may have been understated because AIDS is still considered a “gay disease,” and many infected people attempt to keep their condition secret (Henderson, 1994). Ireland has a much higher proportion of HTV transmission through intravenous drug use than do many other European countries (Johnson et al., 1994). Between 1990 and 1992, intravenous (IV) drug use accounted for 89% of all HTV patients who presented for treatment (Desmond, Murphy, Plunkett, & Mulcahy, 1993), and a needle exchange program in Dublin found that one in six participants were HIV seropositive (Johnson et al., 1994).

The rate of AIDS infection among women and children has been rising dramatically (Henderson, 1994). The stigma associated with IV drug use by women socially inhibits them

from purchasing sterile syringes and needles; thus needle sharing is more common among women, placing them at increased risk of developing HTV and hepatitis C (Barnard, 1993; Smyth, Keenan, Dorman, & O'Connor, 1994).

### **ALCOHOL AND DRUG USE AMONG IRISH-AMERICANS**

Evidence of alcohol problems among the Irish in America in the second half of the 19th century and the early and mid-1900s can be seen in the numbers of arrests for drunkenness and disorderly conduct and of alcohol-related deaths. In these categories, the Irish ethnocultural group outranked all other nationalities. A study of admissions to all hospitals in New York between 1929 and 1931 concluded that alcohol-related admissions of Irish people were substantially higher than those for all other ethnocultural groups (Stivers, 1976). Moreover, a 1950 study of arrests for “drunkenness” in the state of Connecticut showed that Irish Americans had the highest percentage of arrests among the 10 ethnocultural groups studied, and studies of alcohol consumption rates during 1960 placed those of Irish background above all others with regard to heavy drinking (Stivers, 1976). Yet another study found that 51% of the Irish-born males admitted to New York psychiatric hospitals had alcohol-related diagnoses, whereas only 4% of Italian-born men had similar diagnoses (Muhlin, 1985).

Despite these findings, some people believe that the Irish have been unfairly stereotyped as heavy drinkers and that this stereotype emerged from Irish immigrants in England and the United States in the early part of this century. These immigrants were frequently overrepresented by young, single males who were hard workers, drank excessively, and were not strangers to the police (Walsh, 1987). Some later studies even showed that the Irish American drinking patterns were within the norm for all Americans (Stivers, 1976).

Current data on drinking problems among Irish Americans are scarce because more recent studies tend to investigate drinking and drug use patterns among African Americans, Hispanic Americans, Native Americans, and Caucasians in general and do not focus on distinctions among ethnic Caucasians. However, a recent study by the National Opinion Research Center found that 40% of Irish Americans indicated that a drinking problem existed in their homes during their childhoods (National Opinion Research Center, 1997), reflecting a very high rate of alcohol-related problems.

Studies also indicate that the Irish consume alcohol to relieve stress and that they frequently deliberately seek intoxication (National Opinion Research Center, 1997). These findings confirm those of an earlier comparison, study of alcoholics in treatment in Ireland and Canada by Teehan (1988). Teehan found that the Irish drank for relief from painful feelings or for mood alteration, whereas the Canadian alcoholics drank for social facilitation and sexual enhancement (Teehan, 1988). The “painful feelings” that were identified by the Irish included guilt, low self-esteem, and anxiety.

Nonetheless, the impact of negative stereotyping on drinking among Irish Americans cannot be overlooked, because it is both imposed and accepted. Irish Americans may drink more than the native Irish in large part because they are expected to do so to fulfill the prevailing cultural stereotype. They seem to accept these expectations—making it a self-fulfilling prophecy (Greeley, 1981; Stivers, 1976). The Irish in Ireland have no such stereotype to fulfill and so are spared this method of demonstrating their “Irishness.” It is theoretically possible that the Irish American stereotype may extend back to Ireland in the future—the result of tourism, telecommunication, and the appeal of the stereotype itself.

For the Irish Americans, the pub continues its role as a social center in the United States. Irish immigrants and their offspring find hospitality, exchange leads on employment opportunities, meet fellow Irish people, and are regaled with Irish music and song in these pubs. Because the pub has such a significant social dimension, it is difficult for those in recovery programs to avoid the feeling of isolation associated with not going to the pub. This is an important issue that has to be addressed during treatment.

## CLINICAL INTERVENTIONS

The development of a therapeutic relationship is central to all effective therapy. In dealing with the Irish, it is essential to keep a friendly distance. The first step should be to determine the level of cultural identification. Individual clients of Irish background may range from those who hold **to** traditional Irish values to those who may have minimal knowledge of either Ireland or its culture. Those who were raised in Irish enclaves in the United States are more likely to have significant exposure to their Irish heritage and to have a close psychological attachment to their Irish ethnicity.

Clients influenced by the more traditional culture are usually older and more restricted in sharing their feelings. When working with such clients, the clinician should avoid exploring feelings and adopt a more didactic approach. For example, appealing to the client's sense of responsibility is usually a more effective, culturally syntonetic strategy. Every opportunity should be taken throughout treatment to affirm the client and bolster self-esteem. The use of instructional videotapes that highlight priests in recovery may help to reduce the sense of guilt and shame likely to be felt by many such clients. Many find Alcoholics Anonymous (AA) appealing and helpful. Shy, cynical, and even supercilious people seem miraculously unembarrassed at AA meetings (O'Faolain, 1996).

The clinician should be particularly attentive to understatements by 'clients of Irish background. Any reference to physical pain or emotional discomfort should be closely evaluated, because it is likely to be much more severe than the client is willing to admit. In general, male clients may resist family involvement, wanting to handle things on their own. This preference enables the client to deemphasize the effect of the problem on others. When " families do participate, their learning about addiction and recovery should ' be the first objective. Some family members may resist going to Al-Anon due to a strong reluctance to talk about family issues with strangers.

Direct confrontation may alienate the client of Irish background. In many cases it will be unnecessary, because Irish clients tend to invest the clinician with great expertise and are likely to comply, although at their own pace. However, the compliance may be a gesture of politeness rather than a sign of genuine change. The so-called intervention (Casolaro & Smith, 1993; Johnson, 1986) whereby a group of family members and friends, under the guidance of the therapist, confront the client is usually seen as an ambush. It often increases the sense of shame and may be greeted with intransigence. Support, not confrontation, will yield superior results. It may be productive to apply the adage: "You are not responsible for your addiction, but you are responsible for your recovery."

Tests for alcohol dependence should be carefully chosen. The CAGE assessment test (Ewing, 1984; Straussner, 1993) is useful and nonthreatening, and its use in Ireland has shown it to be a more effective screen for alcohol problems than the Michigan Alcoholism Screening Test (Schofield, 1991).

As indicated earlier, patterns of indirect communication are frequently more natural to the Irish; therefore, the clinician who is specific and direct is likely to be seen as impolite or rude. The challenge then becomes one of adaptation to a more subtle verbal communication with constant need to "read between the lines."

Time and space are also important considerations in the therapeutic process. Clinicians follow a schedule of appointments and must usually end at specific times. However, Irish clients who sense that they are being rushed may interpret this as a reflection of their unimportance. Managing each therapeutic session so that the client feels that he or she is welcome and is a priority becomes important. A warm handshake at the beginning and conclusion of each session and the use of the client's preferred version of his or her first name could convey that sentiment. In addition, respect for personal boundaries is highly valued among the Irish. Such respect may be reflected through the level of eye contact. Culturally, the Irish are likely to see constant eye contact as overly intrusive, penetrating, and ultimately disrespectful. A more casual and distant approach is generally less threatening.

Although confidentiality is always important, it is especially critical when working with Irish clients. The undocumented immigration status of some only adds to their sensitivity to this issue. Usually the concern about confidentiality declines when clients become more accepting of their alcohol or drug problems.

The notion of “paying to talk” is troublesome to many traditional Irish. In a curious paradox, those of Irish background revere the art of language usage yet may see little value in talking about problems. The expectation that they should pay for such talk challenges their sense of propriety. This issue is further complicated by a cultural theme that prohibits talking about problems lest they “become worse in the talking.” This superstitious belief causes many to avoid using words such as “cancer” when referring to someone’s diagnosis. Instead, euphemisms such as “the lad” or “the lodger” are used in order to avoid the perceived negative implications of the word itself. In the same vein, it is best to avoid words such as “alcoholic” or “addict,” and references to alcohol or drug problems should be used sparingly.

It is suggested that clinicians distance themselves from collecting professional fees and, when possible, allow office staff to handle this aspect of treatment provision. Although the private practitioner can bill the client, it is important not to imply any concern that the bill will go unpaid. A hint of doubt about the client’s integrity will usually damage the therapeutic relationship and may end it without explanation. If an explanation is offered, it will be a positive face-saving reason unrelated to the truth, which the clinician may never discover.

Clinicians dealing with clients from the modern Irish culture or those acculturated to American values will find them more willing participants in therapy. Direct focus on substance abuse as the key problem and involvement of family members will be accepted much more readily. Feelings, relationships, and communication patterns can be explored gently but more directly.

Because AA is a useful adjunct to treatment, it can provide an important alternative to the pub. In addition, any concern regarding social isolation can be countered by encouraging participation in Irish social events such as those designed to provide financial assistance to Irish missionaries in Third World countries. These events are common in most major cities in the United States. There are also branches of the Irish Pioneer Total Abstinence Association throughout the country. Interventions that enable clients to deal with emotions or the daily stresses of life are likely to be important in preventing relapse.

### **A CLINICAL VIGNETTE**

Pat is a 57-year-old Irish-born electrician who presented for treatment for alcohol problems following his third arrest for drunk driving. He was ordered by the court to participate in treatment, and failure to do so would result in a jail sentence.

Pat had immigrated to the United States 37 years before and still retained a distinctive Tipperary accent. He was driven to therapy by his wife of 25 years. “When the clinician asked Pat to describe his reason for coming to therapy he replied:

“A brat of a cop tried to tell me that I was drunk and shouldn’t be driving. You know these people [Americans] don’t know who we [the Irish] are at all. They don’t know when to mind their own business. By the way, the young lady you have in the office is doing you no good, you wouldn’t believe all the signing of papers I had to do.... You see, the judge sent me over to have a word with you for a few minutes and then everything would be the finest.”

It was clear to the clinician that Pat was putting him on notice that:

1. He had no problem with alcohol and it would be disrespectful to accuse him of having such a problem.
2. The clinician was likely not to understand the Irish drinking patterns and may therefore conclude that a problem existed when it was just “normal” drinking.

3. He had reinterpreted the judge's decision in a benign fashion.
4. He was offering advice to the clinician regarding his office staff to deflect discussion from himself.

The culturally aware clinician then casually asked, "Pat, tell me about your family," as though ignoring the alcohol problem. Midway through the session the clinician circled back to the drinking issue in a nonthreatening manner. Now that some level of comfort had developed in the relationship, the therapist asserted, "Well, I know, Pat, that if a problem existed with alcohol you would be the first to want to take care of it." This was followed by a short lecture from Pat on his belief about "doing what's right." This opened the door to explore the quantity and frequency of Pat's consumption of alcohol. This was a slow process due to Pat's stories. When the therapist indicated that he would like to speak with Pat's wife, he was quickly told "don't let on to herself about how much I have been drinking...this was just between me and you."

As the interview verified, Pat's wife had no knowledge of how much he drank but could identify the many hours he spent in the pub. Her primary concern was helping Pat "get out of the trouble with the judge—I would die if he had to go to jail. No one knows about this problem ... we have one kid in college and two kids graduated from college and they don't know a word about daddy's drinking problem." "It must be hard to deal with all that," said the clinician, showing great understanding. Mrs. B straightened up in her chair and said, "Well, that is a cross God sent us and we must accept it. Pat is a good man." She did not want to discuss her feelings about Pat's drinking.

At the conclusion of the first session the clinician saw both Mr. and Mrs. B together for a brief summary, taking time to assure both of confidentiality and of the main focus of doing what the judge wanted, and finally suggesting a willingness to join forces with Pat to see if in fact there may be a little problem with alcohol. A final handshake and a scheduled second appointment concluded the session. Meanwhile, Pat agreed to "stop drinking for the moment until we see what's what."

By the third session, Pat was willing to go to an AA meeting—"for educational purposes." Within a short time, Pat embraced recovery, not because he was "an alcoholic" but because he was "too old to be drinking like that." The therapeutic approach consisted of a brief, solution-focused therapy with strong didactic elements that did not focus on exploring Pat's feelings.

## **CONCLUSION**

Addiction to alcohol or drugs is a complex issue to treat in itself. It can be further complicated by cultural factors that may serve as a barrier between client and clinician. The Irish have more than their share of alcohol problems, but when handled with sensitivity they will embrace abstinence more easily than other ethnic groups. The key is to appreciate indirect language so that a therapeutic relationship can be established. A willingness to "talk around" an issue will usually be beneficial. Over time, the therapeutic process can become more direct, although increasing emotional awareness may be a slow process.

## **REFERENCES**

- Barnard, M. (1993). Needle sharing in context: Patterns of sharing among men and women injectors and HTV risks. *Addiction*, 88, 805-812.
- Bradley, F., Bury, G., O'Kelly, F., & Shannon, W. (1993). Irish general practice and the human immunodeficiency virus. *Irish Medical Journal*, 86(5), 152-153.
- Buckley, P. (1994). *A thorn in the side*. Dublin: O'Brien Press.
- Casolaro, V., & Smith, R. J. (1993). The process of intervention: Getting alcoholics and drug abusers-to treatment. In S. L. A. Straussner (Ed.), *Clinical work with substance-abusing clients* (pp. 105-118). New York: Guilford Press.

- Cheung, Y. W. (1993). Approaches to ethnicity: Cleaning roadblocks in the study of ethnicity and substance abuse. *International Journal of the Addictions*, 28(12), 1209-1226.
- Corrigan, E. M., & Butler, S. (1991). Irish alcoholic women in treatment: Early findings. *International Journal of the Addictions*, 26(3), 281-292.
- Cusack, J. (1996, May 22). Heroin worth 1 million pounds seized as big drug link cut. *The Irish Times*, p. 1.
- Desmond, N., Murphy, M., Plunkett, P., & Mulcahy, F. (1993). Use of a Dublin inner city hospital A & E department by patients with known HIV-1 infection. *International Journal of Studies on AIDS*, 4(4), 222-225.
- Ewing, J. A. (1984). Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association*, 252, 1905-1907.
- Fallows, M. (1979). *Irish Americans: Identity and assimilation*. Englewood Cliffs, NJ: Prentice-Hall.
- Greeley, A. (1981). *The Irish Americans*. New York: Harper & Row.
- Griffin, W. (1992). This distant land: The Irish in America. *Ireland of the Welcomes*, 41 (4), 26-31.
- Grube, J., Morgan, M., & Kearney, K. (1989). Using self-generated identification codes to match questionnaires in panel studies of adolescent substance use. *Addictive Behaviors*, 14(2) 159-171.
- Harrison, L., Carrhill, TR., & Sutton, M. (1993). Consumption and harm: Drinking patterns of the Irish, the English and the Irish in England. *Alcohol and Alcoholism*, 28(6), 715-723.
- Henderson, C. (1994, April 11). Dublin AIDS groups call for government funding. *Ireland: AIDS Weekly*, p. 23.
- Hines, P., Garcia-Preto, N., McGoldrick, M., Almeida, R., & Weltmann, S. (1992). Intergenerational relationships across cultures. *Families in Society*, 76(6), 323-339.
- Johnson, V. (1986). *Intervention*. Minneapolis, MN: Johnson Institute Books.
- Johnson, Z., O'Connor, M., Pomeroy, L., Barry, J., Scully, M., & Fitzpatrick, E. (1994). Prevalence of HIV and associated risk behaviour in attendees at a Dublin needle exchange. *Addiction*, 89(5), 603-607.
- Lender, M., & Martin, J. (1982). *Drinking in America*. London: Macmillan.
- Malcolm, E. (1986). *Ireland sober, Ireland free*. Dublin: Gill & Macmillan.
- McGoldrick, M. (1982). *Irish families*. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 310-339). New York: Guilford Press.
- McGoldrick, M. (1996). *Irish families*. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 544-566). New York: Guilford Press.
- Morion, H. V. (1978). *The magic of Ireland*. London: Arrow Books.
- Muhlin, G. (1985). Ethnic differences in alcohol misuse: A striking reaffirmation. • *Journal of Alcohol Studies*, 46, 172-173.
- National Opinion Research Center. (1997). *Understanding alcohol and other drugs: A multimedia resource*. New York: Facts on File.
- Neill, K. (1979). *An illustrated history of the Irish people*. Dublin: Gill and Macmillan.
- O'Faolain, N. (1996, January 15). Opinion. *The Irish Times*, p. 6.
- O'hEithir, B. (1987). *This is Ireland*. Dublin: O'Brien Press.
- Schofield, A. (1991). The prevalence of alcoholism in an Irish general hospital. *Irish Journal of Psychological Medicine*, 8(1), 33-36.
- Smyth, B., Keenan, E., Dorman, A., & O'Connor, J. (1994). Gender differences in needle sharing behaviour patterns. *Addiction*, 89(1), 96-97.
- Stivers, R. (1976). *A hair of the dog: Irish drinking and American stereotype*. University Park: Pennsylvania State University Press.

- Straussner, S. L. A. (1993). Assessment and treatment of clients with alcohol and other drug abuse problems: An overview. In S. L. A. Straussner (Ed.), *Clinical work with substance-abusing clients* (pp. 3-30). New York: Guilford Press.
- Teehan, J. (1988). Alcohol expectancies of Irish and Canadian alcoholics. *International Journal of the Addictions*, 23(10), 1057-1070.
- Valliant, G. D. (1983). *The natural history of alcoholism*. Cambridge, MA: Harvard University Press.
- Walsh, D. (1987). Alcohol and alcohol problems: Research 15. Ireland. *British Journal of Addiction*, 82, 747-751.
- Wilson, R.W., & Williams, G. D. (1989). Alcohol use and abuse among U.S. minority groups: Results from the 1983 National Health Interview Study. In D. L. Spiegler, D. A. Tate, S. A. Aitken, & C. M. Christian (Eds.), *Alcohol use among U.S. ethnic minorities* (pp. 399-410). Rockville, MD: U.S. Department of Health and Human Services.
- Woodham-Smith, C. (1963). *The great hunger*. New York: Harper & Row.