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# Unilateral Family Therapy with the Spouses of Alcoholics

Edwin J. Thomas  
Cathleen Santa  
Denise Bronson  
Daphna Oyserman

**SUMMARY.** The design and development of a unilateral family therapy for alcohol abuse is reported from a study of 25 spouses. Subjects were recruited from newspaper advertisements in which spouses of partners who had a drinking problem and refused to enter treatment were solicited to receive free professional assistance. Treatment embraced treatment orientation, clinical assessment, spouse role induction, abuser-directed interventions, spouse-directed interventions, and maintenance. Results indicated that the unilateral treatment program can be implemented, the spouses of uncooperative alcohol abusers can be assisted to function as a positive rehabilitative influence with their alcoholic mates, and that important positive gains for the abusers and spouses can be achieved. It is concluded that the unilateral approach should be experimentally evaluated and, if results are favorable, applied with other populations.

The consequences of excessive drinking are well known and have been amply documented. By consuming alcohol in excess, the alcohol abuser harms his or her health, incurs large costs for society through loss of work, loss of efficiency, and greater likelihood of being in traffic accidents. In addition, the alcohol

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Requests for reprints should be sent to Edwin J. Thomas, School of Social Work, the University of Michigan, Ann Arbor, Michigan 48109.

abuser increases the likelihood of distressed family relationships, violence in the family, reduced family stability, and marital dissolution. Alcohol abuse is clearly a difficult problem, but refusal of the abuser to enter treatment makes an already difficult problem worse. The alcohol abuser who refuses treatment poses troublesome and as yet unsolved problems concerning what the appropriate mode of treatment should be considering the needs of everyone involved.

There is an enormous population of individuals and families that potentially could benefit from intervention to reach the abuser. Writers have estimated that the combined remedial approaches to the alcohol problem reach no more than fifteen percent of the alcoholic population (Krimmel, 1971; Luks, 1983). This leaves an estimated 85 percent who are "hidden" and untreated excessive drinkers. If there are some ten million alcohol abusers (e.g., see Keller & Gurioli, 1976, and Steinglass 1976, for related estimates), there would be some 8.5 million who are thus "hidden." If one assumes further, as do Paolino and McCrady (1977), that for every alcohol abuser there are five other persons who suffer directly, this yields some 42.5 million individuals in the United States who could potentially benefit from improved or new methods of assistance that could reach them.

There is increasing evidence that the spouse, as a critical and sometimes sole point of leverage, may be used productively in rehabilitative efforts with alcohol-abusing partners. For example, the involvement of nonalcoholic wives in the treatment of their alcoholic husbands appears in some studies to be associated with relevant positive outcomes (e.g., Cadogan, 1973; Corder, Corder & Laidlaw, 1972; Ewing, Long & Wenzel, 1961; Gliedman, 1957; Hedberg & Campbell, 1974; McCrady, Paolino, Longabaugh & Rossi, 1979). Reports of efforts to work alone with the spouses of alcoholics indicate some benefits for the spouses (e.g., Cheek, Franks, Laucius & Burtle, 1971; Estes, 1977; Igersheimer, 1959). Some studies using selected confrontive tactics have described gains for the alcohol-abusing spouses as well (e.g., Hall, 1984; Howard & Howard, 1978; Johnson, 1973; Maxwell, 1976; Thorne, 1983; Zimberg, 1982). However,

to our knowledge, there has been no systematic evaluation of the effectiveness of these interventions. Particularly suggestive are analogous attempts to program wives to bring about changes for their spouses (e.g., Goldstein, 1971, as reported in Jacobson & Martin, 1976; Scheiderer & Bernstein, 1976; Szapocznik, Franks, Kurtines, Foote & Perez-Vidal, 1983), although the helping methodology in these efforts is not well developed for working with spouses in general nor was it used with spouses of alcohol abusers.

Up to this point, there has been no systematically developed and tested intervention methodology applicable to reaching cooperative spouses of uncooperative alcohol abusers. Al-Anon is a valuable alternative resource. However, by virtue of its lay and inspirational character and its requirement of anonymity, this self-help methodology cannot be adopted directly by alcohol counselors and other helping persons. Nor in the area of marital and family therapy is there a recognized unilateral approach to reach uncooperative members. The main emphasis in most family therapies is on the family as a system, in which treatment is best carried out with all or most family members. Treatment of the individual for marital and family distress is generally at best a minor variant, acknowledged by some writers as a particular format for marital and family therapy (e.g., Bennun, 1984; Carter & Orfanidis, 1976; Cookerly, 1976; Meeks & Kelly, 1970; Olson, 1975; Prochaska & Prochaska, 1978; Stahmann, 1977; Steinglass, 1978). There has been increasing emphasis upon family treatment approaches in the alcoholic marriage (e.g., Berenson, 1976; Bowen, 1974; Dulfano, 1978; Finlay, 1974; Jansen, 1977; Meeks & Kelly, 1970; Steinglass, 1976, 1978; Ward & Faillace, 1970), but there is no recognized unilateral family approach in the area of alcohol abuse. The use of family members in the alcohol area to confront the abuser to induce him to enter treatment is illustrated by the confrontive "intervention" of the Johnson approach (1973). It is valuable, but it represents only one of many alternatives that may be employed in a unilateral treatment with cooperative family members. Clearly, present intervention methods of alcohol counselors need to be augmented to reach and assist the uncooperative abuser and his or her spouse.

The purpose of this paper is to present an overview of a three-

year pilot project to develop a unilateral family therapy for alcohol abuse. The main emphasis in this report is upon the treatment program that was developed.

### **THE CONCEPTION OF UNILATERAL FAMILY THERAPY**

The design and development of the treatment program to reach the uncooperative alcohol abuser was guided by a working conception of unilateral family therapy (Thomas & Santa, 1982).

As a mode of family therapy, unilateral family therapy is intervention directed toward changing the behavior of an uncooperative family member through working with a cooperative member as mediator. As in family therapy in general, the unilateral approach also has the goals of altering individual difficulties that arise from family dynamics, improving interpersonal relationships in the family, and, in general, of enhancing family functioning. However, in the unilateral mode it is not possible to work with all or most members of the family as is usually the case in family therapy. Unilateral treatment is carried out with one or more cooperative family members without the direct involvement of one or more others who refuse to participate. This refusal to participate in treatment may be due to the family member's failure to recognize that a problem exists, lack of motivation to change, or both. Those family members who do participate may be clients in therapy as well as the mediators of change for the nonparticipating parties.

A major feature of the unilateral approach is a conception of the role of cooperative family member as client as well as mediator of change for the uncooperative family member. This emphasis does not assume that the cooperative member is to blame for the difficulties but rather that this person is a potentially crucial point of leverage whose strengths and influence may be productively employed in treatment to achieve change when other avenues of influence are limited or foreclosed. Thus, the spouse is viewed in the unilateral approach as a vital and potentially active agent of positive change who may be the main or only rehabilitative influence accessible to the practitioner.

There are three main foci of intervention in the unilateral ap-

proach. The first is the *individual focus* with emphasis on coping for the cooperative family member. When working with the spouse, such individual difficulties as stress, anxiety, lack of assertiveness, depression, anger, emotional overinvolvement, and failure to realize personal or career objectives could be the focus of intervention. The second is the *interactional focus* with emphasis predominantly upon family functioning. Among the areas of intervention for this focus are marital and family communication, decision making and conflict resolution, parent-child relationships, and sexual and affectional enhancement for the marital partners. The last is the *third party focus* which involves work with the spouse or other family member to bring about change for the uncooperative family member. Among the methods here are (a) inducing the uncooperative member to seek treatment or other assistance, (b) removing spouse, family or environmental conditions which serve to promote the problem behavior, and (c) providing support for non-problem behavior of the uncooperative member.

It is this combination of interventional foci along with working only with one or a few cooperative family members in a rehabilitative capacity that makes the unilateral approach a distinctive mode of therapy. Although considered here in terms of alcohol abuse, the unilateral approach has potential applicability to many other types of clientele not now accessible. Further details concerning the unilateral approach are to be found in Thomas and Santa (1982).

## **THE PROJECT**

### **Overview**

In keeping with the developmental objectives of the research, this pilot research placed primary emphasis on the design and development of a unilateral family therapy for alcohol abuse. Potential subjects were recruited from newspaper advertisements in which spouses of partners who had a drinking problem and refused to enter treatment were solicited to receive free professional assistance. Treatment was given by four clinician-researchers, consisting of the Project Director (E.J.T.), and three

advanced doctoral students in the Doctoral Program in Social Work and Psychology who had MSW degrees and relevant clinical experience. Clinical and developmental effort for each case was carefully assessed, planned, supervised and monitored. Staff consultation was used for all major decisions.

### ***The D&D Perspective***

To meet objectives of design and development (D&D), cases were selected, as described below, to meet the criterion of developmental relevance; practice was conducted with D&D objectives as well as therapeutic aims; effort was evaluated at this early point in D&D largely in terms of the adequacy of the treatment methods being evolved; and the design for evaluation was selected to allow for D&D flexibility (for further details concerning developmental research and intervention design, see Thomas, 1984).

### ***Eligibility Criteria***

Cases were selected by criteria to assure their developmental relevance to the unilateral approach. Spouses making contact with the project were already solicited on the basis of their partner having a drinking problem and being unwilling to receive treatment for it. These were basic criteria for the abuser. Criteria for the spouse included recognition that the partner had a drinking problem, willingness to receive help to try to moderate the partner's drinking, and absence of a drinking problem for that spouse. Additional criteria for both marital partners were that there was no domestic violence, no other drug abuse, no history of severe emotional disorder, no immediate plans for marital dissolution, and that the partners were not then receiving professional counseling. These criteria served to keep the domain of D&D feasible and manageable.

Human subjects criteria for the abuser were provision of the abuser's consent to allow the spouse to disclose information about the abuser and to allow the spouse to try to facilitate the abuser's sobriety. For the non-alcohol abusing spouse, consent was obtained for the spouse to participate as a client in unilateral family therapy and to provide assessment information. These cri-

teria were required by federal regulations for research with human subjects.

### ***Subject Characteristics***

A total of 25 spouses participated to varying degrees as subjects. The mean age of the spouses was 43 years, with 85% of them having had at least some college education. All but one spouse were white and all but one were female. Spouses had been married to abusers 15 years, on the average, and this was the first marriage for the majority. The only noteworthy difference for abusers was that they tended to be somewhat more educated than their spouses. Most participants had children living at home, typically one to three offspring. The median household income was reported to be in the \$25,000 to \$29,000 bracket. Nineteen of the spouses and 21 of the alcohol abusing partners were employed at the time of the initial assessment.

Available evidence from subjects who participated in assessment shows that the abusers indeed had a drinking problem. For example, in completing a spouse version of the Michigan Alcohol Screening Test to measure drinking behavior of the abuser, spouses produced average scores of 23 for the abuser. Spouses also reported that abusers consumed an average of 81.1 ounces per week of alcohol equivalent to 86 proof, and that all abusers were problem drinkers. Spouses and abusers participating in assessment reported that the abusers had been drinking at their present level for a mean of about eight years. Thirteen abusers participated in assessment and they had a mean MAST score of 18.1, considerably higher than the cut-off score of 5 which indicates there is an alcohol problem (Selzer, 1971).

### ***Research Design***

In keeping with the developmental objectives, a research design was adopted that allowed for clinical and developmental flexibility while also providing a basis for evaluation. The basic unit in the design was each pair of spouses who entered the project. One spouse in each successive pair was assigned at random to receive unilateral family therapy for six months, and the other spouse was assigned to a condition of delayed treatment. When



therapy was terminated for the original unilateral therapy spouse, treatment was given to the delayed treatment spouse. D&D was conducted with four series, each having a relatively small number of spouses (Series I had 10 subjects and treatment lasted 6 months, Series II and III, both very brief special purpose series, had a total of 5 subjects, and Series IV had 10 subjects in which treatment lasted 4 months). A battery of some 20 assessment instruments was administered before and after treatment and at 6- and 12-month follow-ups. These included instruments to measure spouse coping (e.g., Life Distress Scale), family functioning (e.g., the Dyadic Adjustment Scale), and abuser drinking behavior (e.g., The Quantity-Frequency Schedule). Clinical assessment and monitoring were also carried out throughout treatment.

## **RESULTS**

Given the D&D objectives of the research, the treatment program that evolved is necessarily a principal product. The results relating to the evaluation of outcomes were relevant but were secondary at this stage of development. Accordingly, an overview of the treatment program is presented below along with a summary of some of the quantitative outcomes relating to effectiveness.

### ***The Treatment Program***

Intervention in the unilateral mode, as described earlier, entails one or more of three possible foci. As applied to alcohol abuse, the individual focus involves the coping behavior of the cooperative nonalcohol abusing spouse, the interactional focus entails the marital and family functioning of that spouse, and the third-party focus emphasizes the drinking behavior of the uncooperative alcohol abuser. In the treatment program that evolved, the third-party focus was paramount, and the primary goal was to have the uncooperative abuser enter treatment for the alcohol abuse, or reduce the drinking through abstinence or (if failing) controlled drinking. To accomplish these objectives, abuser-directed interventions were carried out by the spouse serving as

mediator of change for the abuser. The individual and interactional foci involved largely working with the spouse as mediator, where treatment was first directed toward induction of the spouse into the role of a positive rehabilitative agent as preparation for undertaking abuser-directed interventions mediated by the spouse.

Treatment embraced the following six areas: treatment orientation, clinical assessment, spouse role induction, abuser-directed interventions, spouse-directed interventions, and maintenance. Each of these is summarized below.

### ***Treatment Orientation***

Because the treatment program was new and differed considerably from most others, the treatment orientation was directed toward informing the spouse as fully as possible concerning what was in store for him or her. The spouse was prepared by explaining a number of points, such as the following: (a) the three foci of intervention, i.e., spouse coping, family functioning and sobriety facilitation; (b) the rights of the spouse to receive treatment and likewise the right of the abuser to refuse treatment; (c) the importance of keeping in confidence the matters discussed in the treatment; (d) the relationship between drinking behavior and family dynamics, with emphasis on the role of family factors in drinking behavior, the assumption that the spouse was not to be blamed for the excessive drinking of a partner, and the potential of the spouse to become a positive rehabilitative influence with the alcohol abuser; (e) the treatment regimen, including an overview of the main phases and an explanation of the importance of maintaining spouse input and cooperation in gathering data and formulating the intervention plan, not carrying out premature or ad hoc change efforts with the abuser, intervening only as planned with the therapist at the agreed upon time, and following the agreed upon plan as stipulated; and (f) the assurance that although some of the treatment methods were new and experimental and further research was needed to validate the approach, results to date had indicated that the approach could be implemented successfully in the majority of cases.

### ***Clinical Assessment***

Following the orientation, clinical assessment was conducted to obtain data from the spouse in areas such as the following: (a) factors affecting applicability and appropriateness of the unilateral approach, (b) abuser drinking patterns and history, (c) willingness of the abuser to seek treatment, (d) the abuser's capability to stop or reduce drinking, (e) increasers and decreasers of the abuser's drinking, (f) alternatives to drinking for the abuser, (g) the abuser's propensity toward physical violence, (h) interventional possibilities with the abuser, (i) spouse mediator capabilities, (j) areas in which the spouse may exercise influence and control with the abuser, (k) spouse conceptions of alcohol and alcohol abuse rehabilitation, (l) patterns of spouse enabling of the abuser's drinking, (m) possibilities to enhance the marital relationship, and (n) the characteristic ways in which the spouse has endeavored to change the abuser as part of the "old influence system." The information was obtained through interviews with the spouse and, where appropriate, by obtaining spouse recording of events outside the interview. Data such as these were then used to prepare an intervention plan.

### ***Spouse Role Induction***

Spouses were typically not ready at the beginning of treatment to serve as mediators of change for the abuser and to assume a positive rehabilitative role. Before abuser-directed interventions could be introduced, it was necessary to help the spouse adopt a positive rehabilitative role. Induction to change the role of the spouse was carried out independently from, and in advance of, endeavoring directly to alter the drinking behavior of the abuser. There were four modules involved in the role induction, each of which is briefly described below. Intervention in each of these areas was given, as needed, on an individual basis and not necessarily in the order indicated.

1. *Alcohol Education.* To counter misconceptions and misinformation concerning alcohol and its effects, alcohol education was given as necessary in such areas as: the nature and promise of contemporary treatment for alcohol abuse; the

- characteristic behavior of alcohol abusers; the effects of alcohol; the seriousness of alcohol abuse for health, work performance, and family and psychological functioning; and the role of learning and family factors in excessive drinking.
2. *Facilitation of the Marital Relationship*. Since discordant marital relationships may impede efforts of the spouse to serve as the mediator of change, relationship enhancement was introduced to reduce the discord and conflict, to facilitate more harmonious marital relationships, and to potentiate the ability of the spouse to influence the abuser. Relationship enhancement consisted of interventions directed toward having the spouse carry out behaviors when the abuser was sober that the abuser would find enjoyable and that the spouse was willing and able to carry out. The objective was to improve marital relationships above current levels, given the motivation and capability of the spouse at that time.
  3. *Disenabling*. To counter the ways in which the spouse enabled the abuser's drinking, a tailor-made program to reduce the enabling was introduced, with emphasis placed on the major areas in which the spouse had been enabling the abuser's drinking.
  4. *Neutralizing the Old Influence System*. To diminish dysfunctional aspects of the "old influence system," such as nagging, complaining, and threatening, focus in this module was placed on neutralizing the customary and generally ineffective ways in which the spouse had endeavored to control the drinking of the abuser.

### ***Abuser-Directed Intervention***

The purpose of abuser-directed interventions was to induce the abuser to enter treatment for his or her alcohol abuse or to reduce the drinking, or both. The reduced drinking would ideally take the form of abstinence, but, in some cases, moderated drinking short of abstinence was the best outcome that could be achieved on a temporary basis, with abstinence being the final goal. Two intervention methods particularly appropriate for getting the abuser to enter treatment are given below:

1. *Programmed Confrontation of the Abuser.* The aim of programmed confrontation was to confront the abuser so that he or she would be induced to enter treatment for the alcohol abuse and/or to decrease or stop drinking. Programmed confrontations entailed training the spouse to confront the abuser firmly but compassionately in the presence of the therapist concerning the particulars and adverse effects of the abuser's drinking; to present the abuser with specific directives to enter treatment and/or to decrease or stop drinking; and to present the consequences that the spouse planned to carry out if the abuser failed to take the specified action. What distinguishes programmed confrontation from most confrontive interventions, including the Johnson (1973) approach, to which it bears some similarities, is that programmed confrontation involves systematic assessment, intervention planning, implementation, and follow-up. Programmed confrontation is a powerful induction that can be very successful providing that it is used with great care and when selected conditions are met. Among the important preconditions for using this intervention are that other interventional alternatives are not feasible and that the spouse is willing to follow through with a strong consequence if the recommended action is not taken.
2. *Programmed Request.* The programmed request consisted of a carefully timed, staged and delivered request to have the abuser carry out a recommended action, usually to enter treatment for excessive drinking. The programmed request requires as much planning and rehearsal as programmed confrontation and, when appropriate, can be strong enough to accomplish its objective. Among the conditions that need to be met to implement a programmed request are some readiness on the part of the abuser to respond favorably to the request and unwillingness of the spouse to carry out a strong consequence if the abuser fails to comply with the request.

Additional abuser-directed interventions are particularly appropriate for endeavoring to achieve the goal of reduced

drinking, whether or not the interventions above are employed or the abuser enters treatment. In each of these interventions, as with those described above, the spouse served as a mediator to carry out the intervention with the abuser, doing so on the basis of a treatment plan found to be feasible and appropriate in work with the therapist. There were four such interventions as follows:

3. *Spouse-Mediated Sobriety Facilitation*, which consisted of spouse behaviors that served to strengthen nondrinking alternatives for the abuser and to weaken abuser inducements to drinking;
4. *Programmed Self-Control*, which was directed toward helping the abuser achieve self-control of his or her own drinking behavior through mediation of the spouse;
5. *Programmed Decision Making*, which was decision making, instigated by the therapist through the spouse, directed toward having the marital partners reach a mutually satisfactory decision regarding the reduction of the abuser's drinking or of the conditions relating to such drinking; and
6. *Programmed Contingency Contracting*, which consisted of contingency contracts established between the spouse and the abuser directed toward achieving moderated drinking and/or entry into treatment for alcohol abuse. Each of these four interventions, like the programmed confrontation and programmed request, has particular conditions that make them the appropriate course of treatment.

### ***Spouse-Directed Interventions***

Although the main efforts of the unilateral approach are directed toward inducing the spouse to assume a positive rehabilitative role and on instigating abuser-directed interventions as described above, there are conditions under which interventions are directed expressly toward the spouse. One of these conditions is when an abuser-directed intervention has been employed without success, and it is no longer appropriate to try to change the abuser's drinking through the spouse or to get the abuser into treatment. Rather, the primary objective at this point is to improve the well being of the spouse.

In such instances, treatment may be oriented toward *disengaging*, which is focused on increasing the spouse's independence from the abuser and reducing his or her emotional involvement in the abuser's drinking problem. In addition to being something of a last resort, disengaging may sometimes be appropriate to combine with abuser-directed interventions, whether the abuser has entered treatment or has made improvement in reducing the drinking.

In addition to disengaging, *other interventions* used to assist the spouse to cope more effectively included working with such emotional problems and reactions of the spouse as stress, anxiety, lack of assertiveness, depression, and anger. These are addressed when removal of such difficulties may facilitate the therapist's work toward helping the spouse to bring about positive changes in the abuser's drinking behavior and improve his or her personal functioning.

### ***Maintenance***

Two additional interventions served to foster maintenance and generalization of the positive changes achieved and to help prevent relapse into excessive drinking. The first was *spouse support* to enable the spouse to continue to engage in the new behaviors after she or he had completed treatment and to help prevent the spouse from returning to previously maladaptive ways of behaving that might lessen her or his satisfaction with the marriage or threaten the abuser's sobriety.

The second intervention, *spouse-mediated relapse prevention training*, included the following areas as applied to the abuser: (a) identification of high risk situations for drinking, (b) temptation resistance training, (c) acceleration of nondrinking behaviors, (d) handling of relapses, (e) education concerning the nature of relapses and how they may be prevented, and (f) restoration of balance in life style, (e.g., see Gordon & Marlatt, 1981; Marlatt, 1982).

Each of the interventions described above was applied on an individual basis after assessment had been completed and the intervention in question had been found to be appropriate and feasible. The duration of treatment was generally four to six months

(depending upon the series the spouse was in), sometimes less if the treatment goals for the abuser had been achieved.

### **OUTCOME RESULTS**

The effects of treatment were analyzed within the limitations of the number of subjects. There was a maximum of 25 spouses available for analysis, 15 of whom received treatment in either Series I or Series IV for a period of 4 to 6 months. Of these 15, 9 received immediate treatment and 6 received delayed treatment. Of the 10 subjects who were classified in the nontreatment category, 3 had no contact with the project for purposes of treatment, 2 had limited contact and an additional 5 (from Series II and III) also had limited contact. Although the number of subjects in the categories was too small for conducting systematic statistical analysis, selected comparisons were made between the immediate and delayed treatment subjects and between all those who received treatment and those who did not.

There was a 53% reduction in alcohol consumption from before to after treatment for the abusers of spouses who received treatment, with a slight increase for the abusers of spouses who did not receive treatment. In a related analysis, all 13 subjects who received immediate or delayed treatment, for whom the relevant data were available, were classified in terms of whether there was improvement; the criterion for improvement was set at a reduction in drinking of 53% or more or entry into treatment, or both. Eight or 61% of the 13 abusers of spouses who had received treatment improved, whereas none of the 6 abusers of spouses improved who did not receive treatment ( $p = .02$  by Fisher's Exact Test).

Repeated measures analyses of variance were also conducted in which the effects of immediate treatment were contrasted with those of delayed treatment and the combined treatment subjects were contrasted with those for nontreatment. It was found that treatment was clearly associated with a reduction in drinking behavior and a diminution of general life distress. Some positive gains were also evident for affectional expression and sexual satisfaction for the marital partners. These areas of positive change tended to be those that were targeted in treatment, particularly



the drinking behavior. There were no other positive changes for other areas, and there were no statistically significant negative changes for any of the variables analyzed. A detailed report of the quantitative results will be presented elsewhere.

## CONCLUSION

Considered altogether, the results of the research indicate that the unilateral treatment program can be implemented, the spouses of uncooperative alcohol abusers can be assisted to function as a positive rehabilitative influence with their alcohol abusing mates, and that important positive gains for the abusers and spouses can be achieved. Positive changes were found in the analyses of outcomes in spite of the small number of subjects and the fact that the treatment program was in the process of development. These results confirm the promise of the unilateral approach and highlight the importance of conducting systematic experimental evaluation. If such inquiry yields additional favorable findings, the unilateral approach should be applied with other populations of alcohol abusers and other types of uncooperative and hard-to-reach family members.

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