J. Behav. Ther. & Exp. Psychiat. Vol. 17, No. 1, pp. 15-21, 1986.
Printed in Great Britain.

0005-7916/86 $3.00 + 0.00

FAMILY-MEMBER INVOLVEMENT TO INITIATE AND PROMOTE TREATMENT OF PROBLEM DRINKERS

ROBERT W. SISSON
Al-Care of Rockford, Illinois
and
NATHAN H. AZRIN
Nova University

Summary—The present study evaluated a method of teaching distressed family members of problem drinkers how to minimize their own distress, reduce the drinking, increase the motivation of the alcoholic to obtain formal treatment and assist in the treatment program. Twelve concerned family members were given either community-reinforcement counseling or a traditional type of counseling (control group). The reinforcement counseling resulted in more alcoholic persons obtaining treatment than did the traditional type and a greater reduction in drinking before the formal treatment was obtained; drinking was reduced further during the joint treatment of the family members and problem drinkers. These results suggest that the drinking of unmotivated alcoholic persons can be reduced by counseling concerned family members in the use of appropriate reinforcement procedures and can lead to the initiation of formal treatment.

The role of the spouse of the alcohol abuser has received much attention as a possible factor in drinking behavior. Studies have described the attitudes and feelings of spouses (Orford and Guthrie, 1968; Whalen, 1953) and examined correlations between the spouse's behavior and that of the alcoholic at various stages of alcoholism (Jackson, 1954), as well as the interactions between spouse and alcoholic (James and Goldman, 1971; Hersen, Miller and Eisler, 1973). Several programs have provided concurrent treatment for the distressed spouse while the alcohol abuser is in treatment (Ewing, Long and Wenzel, 1961; Gliedman, 1975; MacDonald, 1958; Pixley and Stiefel, 1963; Westfield, 1972). These needs have been further evidenced by the emergence of self-help groups for the spouse of alcoholics such as Al-Anon.

In spite of the recognition of the role of the spouse, experimental evaluation of spouse treatment methods has not been forthcoming.

Behavioral psychology has developed several methods for treating alcoholics (see review by Miller and Foy, 1981) using treatments such as aversion therapy (Vogler *et al.*, 1970; Miller, 1978), controlled drinking (Lovibond and Caddy, 1970; Sobell and Sobell, 1978) and covert sensitization (Hedberg and Campbell, 1974). In some of these behavioral treatments the spouse is included in the treatment, as in the community reinforcement treatment method (Hunt and Azrin, 1973; Azrin 1976; Azrin *et al.*, 1982), as a means of providing reinforcers for the absence of drinking. This suggests the possibility of treating the spouse, or other non-alcoholic family members, alone, as a means of decreasing the drinking of the alcoholic. This rationale is somewhat comparable to that of behavioral programs which teach reinforcement procedures to the parents (Hawkins *et al.*, 1966) or teachers (Besalel-Azrin, Azrin and Armstrong, 1977) as a means of remediation of problem behaviors in children. This approach would appear to have special value for the alcoholic who is unwilling

Request for reprints may be addressed to either R. W. Sisson, Al-Care of Rockford, 1055 E. State St., Rockford, IL 61108, U.S.A. or to N. H. Azrin, Nova University, 3301 College Avenue, Fort Lauderdale, FL 33314, U.S.A.

to seek treatment, but whose family member does desire treatment for the problems caused by the alcoholism. Many such persons, usually the wife, sought this assistance from the agency in which an alcoholic treatment study was being conducted (Azrin *et al.*, 1982). Also, recognizing the value of treating the spouse, Cheek *et al.*, (1971) reported a preliminary study of training the spouse in behavior modification techniques primarily using relaxation therapy, reinforcement and desensitization. No data on drinking were obtained, but the approach was judged to hold great promise.

The non-alcoholic members of a family might also influence the alcoholic to seek out professional treatment. According to a recent survey (U.S. Department of H.E.W., 1981) only 15% of alcoholics are in formal treatment. Greater success in reducing drinking would be possible if the alcoholic could be persuaded by other family members to obtain treatment and then be assisted in the treatment by them.

The present study developed and evaluated a behavioral treatment program for teaching the non-alcoholic family member (1) how to reduce physical abuse to herself; (2) how to encourage sobriety; (3) how to encourage seeking professional treatment; and (4) how to assist in that treatment. To reduce physical abuse, she was taught how to react at the earliest sign of impending violence, as well as to the violence itself. To encourage sobriety, she learned how to reinforce the alcoholic for periods of sobriety, and how to arrange negative consequences of drinking through requiring the drinker to take responsibility for correcting or overcorrecting (Azrin and Besalel, 1980a) the disruption caused by his drinking. To encourage him to seek treatment, the other family members learned to identify moments when the drinker was most motivated to do so. To assist in the treatment, the family members attended the professional sessions and helped the alcoholic to engage in the prescribed activities thereafter.

METHOD

Subjects and experimental design

The participants in the study were 12 adult women who had contacted a community alcoholism treatment program because a member of their family had a severe alcohol problem. Nine were concerned about their husbands, two about a male sibling and one about her father. The women participants will be designated as the non-alcoholic family member and the drinking family member (males) as the alcoholic person or drinker. All the alcoholic persons were reported as having several symptoms of alcholism, including loss of control and physical withdrawal symptoms. The ages of the women ranged from 28 to 62. All reported having been verbally abused and being embarrassed in public because of the alcoholic's drinking. Six women reported that they had been struck, three of them regularly. Seven were assigned to the Reinforcement Program and five of them to the Traditional Program. Assignment to the two groups was based on a coin flip.

Recording procedure

Each woman was instructed to record the progress of the drinker on a chart provided for her. She recorded each day, as best as she was able to determine, whether the drinker had had any alcohol that day, the approximate amount, whether intoxicated, went to work, or was arrested. She also provided an estimate of these problems for the preceding month at the time of intake.

TREATMENT

1. *Traditional Program*

The non-alcoholic women clients in the Traditional Program received a treatment program which was currently being administered by the treatment center; it emphasized education via discussion, movies and pamphlets about the disease concept of alcoholism. The counselor provided supportive counseling and sympathetic listening to the problems presented by the women and stressed that their family members were suffering from a disease which was also affecting them and their families. In addition a firm referral to a local Al-Anon self-help group was provided (Sisson and Mallams, 1981). After the first counseling session, each woman met with a member of that group who discussed the program and arranged to provide transportation for the first meeting. Clients in the Traditional Program were seen on a weekly basis for counseling in addition to any Al-Anon attendance. All the women were urged to continue weekly counseling and Al-Anon meetings. They were told that should their alcoholic family member request treatment, could be obtained at the counseling center or at a local detox and and residential rehabilitation program, or at a number of Alcoholics Anonymous groups.

2. *Reinforcement Training Program*

The non-alcoholic clients in the Reinforcement Training Program received the following procedures:

A. *Awareness of problem training.* At intake, the client (non-alcoholic) filled out an Inconvenience Review Checklist consisting of a listing of possible problems caused by her family member's drinking. The items included problems ranging from "embarrassing you in public" to "being slapped around or beaten by him". The counselor then discussed each client's answers to reveal the full extent of how the drinker's behaviors affected her life.

B. *Motivation training for the client.* To motivate her further to do something about the distress produced by the drinker's behavior the counselor discussed the potential benefits of participating in the program, namely to prevent physical abuse to herself, to reduce the alcoholic's drinking and to motivate him to obtain counseling. The program for the alcoholic himself, should he come in, was explained in detail and is described in Azrin *et al.*, (1982). Emphasis was given to the importance of the woman encouraging the alcoholic, once he was having counseling, to take disulfiram (Antibuse) and of having her involved in monitoring its intake. Common objections to disulfiram, which the alcoholic might raise, were also discussed. To increase the motivation for change, each woman client was asked to review at length what the person was like before he was drinking so heavily, and to highlight his current positive attributes when he did not drink.

C. *Positive consequences for not drinking.* Each client was taught to use positive reinforcers when the alcoholic was not drinking. The list of possible reinforcers usually included making favorite foods, talking about topics he enjoyed, providing preferred sexual activities, purchasing gifts and generally being pleasant. The women were also instructed in techniques of positive communication (Azrin *et al.*, 1982), to tell him that she was so pleasant because she enjoyed being with him when he was not drinking, to express her positive feelings for him, and request that he continue not to drink. She was instructed to pick a time for this discussion: when the drinker was sober, "in a good mood" and when both were generally feeling "close" to each other.

D. *Scheduling of competing activities.* Each client was instructed to schedule activities which the drinker would enjoy and at which it was very unlikely that heavy drinking would occur. Examples were taking their children on a picnic, going out to dinner, visiting non-alcoholic friends or relatives, and becoming active in organizations which were not settings for heavy drinking. The women were assisted in locating such organizations.

E. *Outside activities for the client.* Each client was guided in finding outside interests and activities for herself so her life would not be so dependent upon the alcoholic. Where appropriate, she also received job-finding assistance procedures to give her financial independence (Azrin and Besalel, 1980, 1982).

F. *Awareness of drinking.* Each client was counseled on how to behave when her family member was drinking. She was to try to be present at the time of drinking, during which she would then encourage eating, drinking non-alcoholic beverages, suggest other activities besides drinking, make the drinker aware of how much he was drinking and remind him of how pleasant it was when he was not.

G. *Negative consequences of intoxication.* If the drinker became intoxicated, or came home intoxicated, the client would ignore him as much as possible and provide none of the extra pleasantries which she provided when he was sober. She was to tell him in a neutral manner that she did not like the drinking and that she would rather not be around him when he was drunk.

H. *Accepting responsibility for self correction.* When the drinker became intoxicated, the family member was taught to hold him responsible for his actions. For example, she would not hold missed meals for him, nor make him comfortable when he fell asleep on the floor, nor hurry to bail him out of jail, nor call his employer with excuses for lateness or absence, nor would she clean him up if he vomited or became incontinent, but rather have him correct the situation himself when able. These guidelines were to be followed within the boundaries of common sense; if the drinker was in a life threatening situation or one that was potentially very damaging to his health (such as "passing out" on the lawn during a winter evening), the client would take prompt and appropriate action.

I. *Handling dangerous situations.* Many times the family member found herself in situations in which the alcoholic person, especially while intoxicated, became physically violent towards her, which was one reason she had contacted the counseling center. She learned to construct the sequence of events which typically led to violence, and to identify cues before the physical violence began, such as "the way he closed the car door", a "certain glint in his eye", as well as cues of intoxication itself.

At these cues, the wife would not argue or threaten, but calmly tell her husband he obviously had been drinking, and that she felt uncomfortable being around him, and would be leaving until he felt better and was sober. She would then leave (taking the children) to a nearby prearranged relative, friend, motel or Women's Center until the drinker was sober and there was no longer danger of violence. Typically, except in the case of very violent men, the wives told their husbands where they would be.

If the drinker did become violent, the client would call the police and file charges, thereby making the drinker aware that violent behavior would not be tolerated. She was to make clear to the police that she was serious, and encourage the police to respond when she called again. In some cases, the wife decided not to return to her husband unless he agreed to counseling.

J. *Suggesting counseling.* Alcoholics appear to be most motivated to stop drinking after specific occasions when their alcohol problem has become especially severe. Examples of such occasions are after a physically debilitating drinking episode, after spending much money unwisely, after a car accident or having some contact with the law or after the drinker did something while intoxicated which he would not do otherwise and felt embarrassed or ashamed. The family member was taught to recognize such moments of high motivation and to suggest counseling. If the drinker agreed, she was to call the counselor and bring the drinker in immediately, regardless of time of day, or day of week. The only exception was extemely late at night, in which case the appointment was made at 7 a.m. the next morning.

K. *General procedure.* All procedures were discussed and then role-played with each client. Whenever possible, activities were written down to remind her how to behave. The long-term effects of these procedures were discussed and compared to the short-term inconvenience they might cause. The procedures were done in a group when possible, so that past successful members could encourage the newcomers.

L. *Joint counseling.* Once the alcoholic person entered counseling, he and the family member (the client) were seen together. The alcoholic client was told about disulfiram and how it would help him with his particular problem. The family member, who already knew about disulfiram and its advantages, was present to encourage the drinker to take it. Once he agreed, he was immediately seen by the medical staff for the necessary physical exam, had the prescription filled,

and took the disulfiram in the presence of the family member and counselor. If it had not been 12 hr since he had consumed an alcoholic beverage, the necessary time was allowed to elapse so the disulfiram could be taken without having an adverse reaction, but the client remained in the counseling center.

Once he had taken the disulfiram, the behavior therapy program for the drinker was described and started the following day. The treatment is described elsewhere (Azrin *et al.*, 1982) and consisted of disulfiram, reciprocity marriage counseling, job finding, relaxation training and competing social activities. This outpatient counseling program with the drinker, together with his relatives, lasted approx. 6 weeks.

RESULTS

Although urged to do so, (Part B of Procedure) none of the five drinkers related to the clients in the Traditional Program came in for counseling, while six of the seven in the Reinforcement Training Program (Part J of Procedure) came in ($\chi^2 = 5.49$, $P < .02$). The mean number of sessions with the family member before the drinker himself entered counseling was 7.2 and the mean number of days was 58.2. The mean number of sessions for clients in the Traditional Program was 3.5. Three of the spouses in the Reinforcement Training condition temporarily left their husbands (following the recommended procedure) and refused to return until they agreed to counseling, which all three did.

As can be seen in Fig. 1, the alcoholic family members in the two treatment conditions were drinking and were intoxicated about the same number of days and consuming about the same amount of ethanol per drinking episode during the month preceding either program. The alcoholic persons in the Traditional Program continued to drink at about the same level throughout the 3 months that data were available. (After that time, the Traditional clients discontinued counseling since it was not helping their situation.)

During successive months the alcoholic persons in the Reinforcement Training Program drank on a decreasing number of days, were intoxicated on less days, drank less ethanol per drinking episode and took Antabuse more frequently than those in the Traditional Program. During the third month, the Reinforcement Training subjects were drinking or intoxicated on less than 2 days, were consuming about 1 oz. of ethanol per drinking episode and were taking disulfiram on about two-thirds of the days.

An analysis of variance for repeated measures yielded significant between-group differences for the measures of days drinking ($F\ 1, 10 = 57.19$, $P < .0001$), amount of ethanol ($F\ 1, 10 = 31.01$, $P < .001$), days intoxicated ($F\ 1, 10 = 18.75$) $P < .001$) and days of disulfiram ($F\ 1, 10 = 18.56$, $P < .001$).

To determine whether the reduction of drinking occurred before or only after the drinker entered treatment, the data of the Reinforcement Training condition were tabulated for each client separately for the period when the non-alcoholic client was treated alone and compared with the period when the client and drinker were counseled together.

Table 1 shows that during pre-treatment, the drinking averaged 24 days per month and was reduced to an average of 11 days per month when the non-drinking family member was treated alone. During the period when the drinker was also treated, drinking decreased further to an average of 0.40 days per month. A repeated measures ANOVA showed that the difference between treatment conditions was statistically significant ($F\ 2, 5 = 16.10$, $P < .001$. *Post hoc* comparisons showed (Table 1) that the drinking was significantly less during the period of counseling the client alone ($P < .01$), or together with the drinker ($P < .01$), compared to baseline. The difference in drinking between the alone and together conditions was statistically significant at the $P < .05$ level.

Visual inspection of the data for individual subjects showed that none of the clients in the Traditional Program appreciably changed their drinking pattern, while six of the seven clients in the Reinforcement Training did.

Fig.
amo
poin

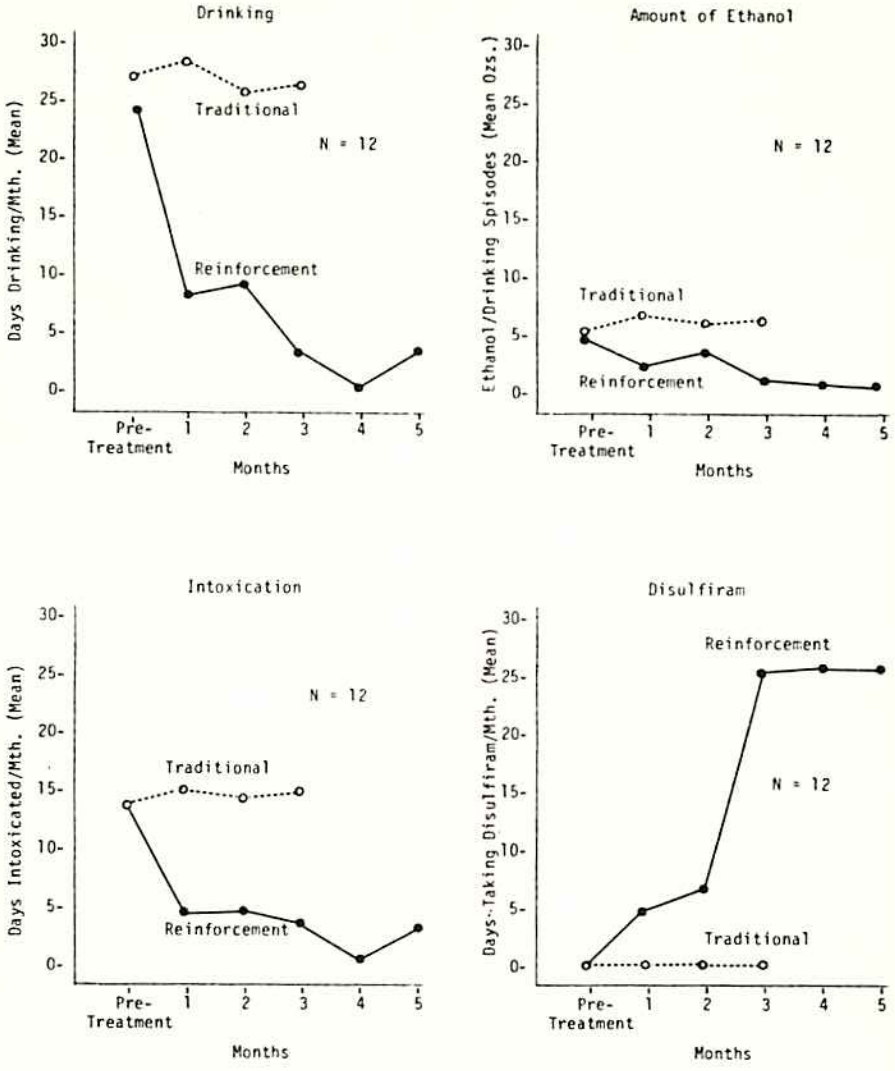

Fig. 1. Mean scores for the number of days drinking, number of days intoxicated, number of days taking disulfiram and amount of alcohol per drinking episode for the alcoholic family member for two different treatment conditions. Each data point is the mean during successive months of treatment.

Table 1. Number of days drinking per month for the Reinforcement Training drinkers including *post hoc t* tests between each treatment and the pre-treatment period

Condition	*N*	No. of days drinking per month (mean)	(S.D.)	*t*	*P*
Pre-treatment	7	24.43	8.20		
Non-drinker treated	6	11.08	8.25	11.91	< .01
Non-drinker and drinker treated	6	0.40	0.71	30.88	< .01

DISCUSSION

The results showed that the drinkers in the Traditional and Reinforcement groups were comparable in the terms of their frequency of drinking and intoxication prior to treatment. The reinforcement training of the non-alcoholic client alone was found to result in a reduction of drinking in the alcoholic before he was counseled directly, the extent of the reduction being about 50%. Additionally, the Reinforcement Training of the non-alcoholic client resulted in the initiation of treatment for the alcoholic in six of the seven cases, in contrast to none of the traditionally treated control clients. Once the drinker entered counseling, drinking was reduced further, thereby replicating the effectiveness of the community-reinforcement treatment seen previously (Azrin *et al.*, 1982).

The results of this study suggest that the training of spouses and other family members in reinforcement procedures is a feasible method of persuading an alcoholic to obtain treatment, decreasing drinking and assisting in a further decrease in drinking by participating jointly in the treatment. This training program appears more effective than traditional type programs which emphasize discussion and education about alcoholism.

Conclusions from the result of this study, however, should be tempered by the following considerations. The Reinforcement Training Program was a more intensive and time-involved program since the clients in it had an average of 7.2 rather than 3.5 training sessions as in the Traditional Program. It should be recognized, however, that intensity is a defining characteristic of the procedure and seven is not an excessive number of sessions. Furthermore, the limited number of subjects suggest that additional study is needed to assess the generalizability of these results.

The present study may have implications for theories of causation of the behavior pattern of the wives of alcoholics. A prevailing theory is that the wife has some psychological need which the drinking alcoholic fulfills (Whalen, 1953) thereby implicating her as the source of the problem. The present study suggests that blame can be attributed to her only in the sense that she has not acquired the skills to modify the behavior of the drinker. A more functional perspective of her behavior suggested by this study is that her response to the alcoholic is governed by principles of learning and can be reversed. Out of her concern for him, the wife may indeed inadvertently reinforce his drinking behavior but desires to do otherwise and succeeds when shown how to do so. The results of this study suggest that the family members of alcoholic persons can use reinforcement procedures to reduce the drinking and to motivate the drinker to obtain counseling. The present Reinforcement Training Program offers a specific set of procedures for accomplishing both objectives.

REFERENCES

Azrin N. H. (1976) Improvements in the community-reinforcement approach to alcoholism. *Behav. Res. Ther.* **14**, 339–348.

Azrin N. H. and Besalel V. A. (1980a) *How to Use Overcorrection.* H & H Enterprises, Lawrence, Kansas.

Azrin and Besalel (1980b) *Job Club Counselor's Manual.* University Park Press, Baltimore.

Azrin and Besalel (1982) *Finding a Job.* Ten-Speed Press, Berkeley, California.

Azrin N. H., Sisson R. W., Meyers R. and Godley M. (1982) Alcoholism treatment by disulfiram and community reinforcement therapy. *J. Behav. Ther. & Exp. Psychiat.* **13**, 105–112.

Besalel-Azrin V., Azrin N. H. and Armstrong P. M. (1977) The student-oriented classroom: A method of improving student conduct and satisfaction. *Behav. Ther.* **8**, 193–204.

Cheek F. E., Franks C. M., Laucius J. and Burtle V. (1971) Behavior modification for wives of alcoholics. *Q. Jl Stud. Alcohol* **32**, 456–461.

Ewing J. A., Long V. and Wenzel G. G. (1961) Concurrent group psychotherapy of alcoholic patients and their wives. *Int. J. Group Psychother.* **11**, 329–338.

Gliedman L. H. (1975) Concurrent and combined group treatment of chronic alcoholics and their wives. *Int. J. Group Psychother.* **7**, 414–424.

Hawkins R. P., Peterson R. F., Schweid E. and Bijou S. W. (1966) Behavior therapy in the home: amelioration of problem parent-child relations with the parent in a therapeutic role. *J. exp. child Psychol.* **4**, 99–107.

Hedberg A. G. and Campbell L. III (1974) A comparison of four behavioral treatments of alcoholism. *J. Behav. Ther. & Exp. Psychiat.* **5**, 251–256.

Hersen M., Miller P. M. and Eisler R. M. (1973) Interactions between alcholics and their wives: a descriptive analysis of verbal and non-verbal behavior. *Q. Jl Stud. Alcohol* **34**, 516–520.

Hunt G. M. and Azrin N. H. (1973) The community reinforcement approach to alcoholism. *Behav. Res. Ther.* **11**, 91–104.

Jackson J. K. (1954) The adjustment of the family to the crisis of alcoholism. *Q. Jl Stud. Alcohol* **15**, 562–586.

James J. J. and Goldman M. (1971) Behavior trends of wives of alcoholics. *Q. Jl Stud. Alcohol* **32**, 373–381.

Lovibond S. H. and Caddy G. (1970) Discriminated aversion control in the moderation of alcoholics' drinking behavior. *Behav. Ther.* **1**, 437–444.

MacDonald D. E. (1958) Group psychotherapy with wives of alcoholics. *Q. Jl Stud. Alcohol* **19**, 125–132.

Miller P. M. and Foy D. W. (1981) Substance abuse. In *Handbook of Clinical Behavior Therapy* (Ed. by Turner S.M., Calhoun K. S. and Adams H. E.). John Wiley, New York.

Miller W. R. (1978) Behavioral treatment of problem drinkers: A comparative outcome study of three controlled drinking therapies. *J. consult. clin. Psychol.* **46**, 74–86.

Orford J. and Guthrie S. (1968) Coping behavior used by wives of alcoholics; a preliminary investigation. (Abst.) *Int. Congr. Alc. Alcsm. Proc.* 28*th*, p. 97.

Pixley J. M. and Stiefel J. R. (1963) Group therapy designed to meet the needs of the alcoholic's wife. *Q. Jl Stud. Alcohol* **24**, 304–314.

Sisson R. W. and Mallams J. H. (1981) The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous and Al-Anon meetings. *Am. J. Drug Alcohol Abuse* **8**, 371–376.

Sobell M. B. and Sobell L. C. (1978) *Behavioral Treatment of Alcohol Problems. Individualized Therapy and Controlled Drinking.* Plenum Press, New York.

U.S. Dep. of H.E.W. (1981) Fourth Special report to the U.S. Congress on Alcohol & Health. DHHS Pub. No. (ADM) 81-1080. Wash., D.C. Supt. of Docs., U.S. Govt. Print. Off.

Vogler R. E., Lunde S. E., Johnson G. A. and Martin P. L. (1970) Electrical aversion conditioning with chronic alcoholics. *J. consult. clin. Psychol.* **34**, 302–307.

Westfield D. R. (1972) Two years' experience of group methods in the treatment of male alcoholics in a Scottish mental hospital. *Br. J. Addict.* **67**, 267–276.

Whalen T. (1953) Wives of alcoholics; four types observed in a family service agency. *Q. Jl Stud. Alcohol* **14**, 632–641.