The impact of intervention with relatives of treatment resistant drinkers: changes in relatives' psychological functioning and drinkers' behaviour.

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THE IMPACT OF INTERVENTION WITH RELATIVES OF TREATMENT RESISTANT DRINKERS: CHANGES IN RELATIVES' PSYCHOLOGICAL FUNCTIONING AND DRINKERS' BEHAVIOUR

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THESIS CERTIFICATION

I, Janis A Fairbairn, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy, in the Department of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Janis A Fairbairn

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ABSTRACT

Forty three research participants (40 female, 3 male) who were in ongoing contact with treatment resistant dependent drinkers, completed the 10 session FOCUS intervention at the Australian Institute of Alcohol and Addictions (Holyoake) in Perth, Western Australia. This Holyoake intervention focussed *exclusively* on the needs of relatives of excessive drinkers and did not teach relatives how to encourage their drinkers into treatment. The intervention aimed to minimise the harm experienced by relatives by improving their well being and coping, and assisting them to recognise behaviours which may *unwittingly* enable their drinkers' excessive consumption to continue.

Participants were allocated to one of 2 groups; viz. Immediate Entry to treatment or Waitlist. The Waitlist group commenced treatment at the completion of the waitlist period. Data were analysed quantitatively and qualitatively and there was a high level of consistency between the two analyses. The quantitative data were analysed by repeated measures MANOVA with treatment and time (pre, mid, end treatment and 3 months and 6 months post treatment) as the independent variables.

Given the quasi-experimental design, the results need to be viewed cautiously.

It appeared that the Holyoake intervention produced significant improvements in participants' mental health, coping, and relationship status which were sustained through 6 months post treatment. Moreover, as a "spin off" of treatment (according to participants' observations), a significant, sustained reduction in the amount of alcohol their drinkers consumed on any given drinking day was identified.

Twenty five participants did not complete the intervention and 13 of these (the Late Dropout group) were available for follow up 5 weeks after completing 5 treatment sessions. Despite the small sample size, a pattern of significant effect similar to the Full Treatment group was evident on participants' mental health and coping status. Moreover, it seemed that the "spin off" effect of treatment on drinkers' abusive behaviour and consumption patterns was more pervasive for the Late Dropout group. These data suggested that the Late Dropout group may have decided to terminate treatment because their situations had improved.

Participants' raw data (n=68), which included all participants who had *commenced* treatment, revealed that whilst 69% of their drinkers had either sought help

(n=13) or reduced their consumption *to some degree*, 50% had made *substantial* change. Given data was analysed wherever possible by the intention to treat principle, these figures were also expressed in terms of all participants who had been *allocated* to treatment (n=83). Thus, the least favourable "spin off" effect on drinkers' behaviour appeared to be that whilst 57% had made *some degree* of positive change, 41% had made *substantial* change.

Content analyses of the Full Treatment group's qualitative interviews (n=43) revealed that only 16% of participants predominantly used assertive coping strategies to deal with difficult situations with their drinkers prior to the Holyoake intervention. However, by the end of the intervention, participants' use of assertive behaviours had increased dramatically to 81%; e.g. clear messages, emotional control and confidence, improved boundaries and communication, and assertive confrontation. Sixty seven percent of participants identified their own personal empowerment (i.e. self responsibility and self efficacy) as the <u>most</u> important factor which had helped them deal more effectively with their situations.

This research in no way suggested that participants were in any way *responsible* for their drinkers' behaviour. It has merely highlighted the considerable *influence* one family member has on another. Therefore, this research seemed to debunk the widely held belief that dependent, treatment resistant drinkers cannot be helped until they admit their problem, and actively seek help.

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CHAPTER 1

Introduction: the nature of the problem

Heavy drinking results in significant harm to individuals, their families, and the community. Collins and Lapsley (1996) estimate that each year the misuse of alcohol costs the Australian community approximately $4.5 billion in health care, direct law enforcement, and lost productivity. However, this does not include the additional, unquantifiable pain and suffering associated with alcohol related family breakdown.

According to Crosbie, Drysdale, and Rodrigues (1997), one fifth of all deaths in Australia are related to alcohol or other drugs (including tobacco): nearly 27,000 die each year. Twenty five percent of these deaths are related to alcohol, and 3% to illicit drugs. Alcohol has an enormous impact on accidents and injuries; e.g. 34% of fall injuries, 44% of fire injuries, 34% of drownings, 30% of fatal motor vehicle accidents, and at least 20% of all hospital admissions are alcohol related.[1] Moreover, alcohol is associated with a great deal of violence and crime; e.g. 73% of all assaults, 84% of offensive acts, and 77% of all street offences. More than half the instances of domestic violence are alcohol related, and alcohol is a major contributor to child abuse and marital breakdown. At least 1% of the population have a family member with alcohol problems serious enough to come to the attention of health or welfare agencies (Mattick, 1993; Orford, 1988a & 1990).

A high proportion of Australians with alcohol problems are functioning members of the work force. The cost to industry caused by their lateness, absenteeism, damage to tools, accidents, poor work performance, erratic behaviour, unreliability and carelessness is enormous, and amounts to approximately $500,000,000 per year (Bryski, 1984). In an attempt to reduce this cost, workplace intervention programs have been implemented in the armed services, several major corporations (e.g. BHP, QANTAS), and some Federal Government departments.[2] These programs are generally very successful; e.g. the Mobil Corporation in the USA reported (Cannella, 1987) that 76%

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[1] Senate Standing Committee on Social Welfare. (1997). Drug problems in Australia - an intoxicated society. AGPS, Canberra

[2] e.g. The Department of Science & Technology

of individuals identified under this scheme completed alcohol rehabilitation and successfully returned to work.

Notwithstanding the success of some of these "early" intervention programs, by the time alcohol related problems are detected in the workplace, it is highly likely that a great deal of harm has already occurred - not only to individual drinkers, but also to their families. Clearly, it is in the best interests of the community to intervene at an *earlier* stage.

Despite improved understanding of alcohol dependency, other "excessive appetites" (Orford, 1985) and improvements in treatment efficacy (e.g. Jarvis, Tebbutt, & Mattick, 1995; Mattick, et al. 1993; Miller & Heather, 1986), clinicians are still grappling with the central problems of penetrating treatment resistant drinkers' denial, motivating them to reduce their consumption and/or seek treatment, and assisting them to sustain their treatment gains (Liese & Franz, 1996; McCrady, 1993).

Prochaska and DiClemente (1984; 1988), and Prochaska, Norcross, and DiClemente (1994) describe the process of firstly advancing precontemplators (heavy drinkers who deny a problem) to a point where they are willing to think about change, and secondly advancing contemplators (who are thinking about changing) towards action. Prochaska, Norcross, and DiClemente claim it is essential to raise precontemplators' consciousness regarding the impact of their drinking, and to provide helpful, constructive relationships. In addition to this, contemplators need considerable emotional arousal to give them the impetus and resolve to propel themselves towards action, and the opportunity to re-evaluate themselves, their goals, and their future. According to Prochaska, Norcross and DiClemente, no change will occur without some form of intervention.

This transtheoretical approach (Prochaska & Di Clemente, 1984) is extremely valuable in understanding the process of change, and assisting clinicians develop more effective motivation techniques (e.g. Miller & Heather, 1986; Miller & Rollnick, 1991) for those clients *who have already presented*. However, a major problem still remains; i.e. how to bring *resistant* drinkers to a point where they will even contemplate treatment *before* they present with serious health, legal, occupational, or relationship problems. Given the vast majority of dependent drinkers remain uninvolved in either treatment or self help groups (Garrett, et al. 1999), the longer it takes to get these

drinkers into treatment, the greater the damage accrues to themselves, their families, and the community.

1.1 The impact of excessive drinking on relatives

Relatives (especially partners) of excessive drinkers are a high risk group who suffer considerable psychological distress and marital hardship (e.g. Barber & Crisp, 1995; Collins, Leonard & Searles, 1990; Crisp & Barber, 1995; Meyers, Miller, Hill & Tonigan, 1999; Miller, Meyers & Tonigan, 1999; Orford, 1990, 1992, 1994, 1988b; Velleman et al. 1993). Moreover, relatives of excessive drinkers seem to experience similar patterns of disturbance regardless of culture (Holmila, 1997; Orford, et al. 1998a; 1998b) - even in Aboriginal Australia. (Kamien, 1975; Sigston, 1984). However, the extent of disturbance relatives experience is mitigated by individual circumstances including the duration, severity, and patterns of problematic drinking; the degree and duration of family conflict and other abusive behaviours; and the culture and structure of the family (Cooper, Peirce, & Tidwell, 1995; Orford, 1990; Tharinger & Koranek, 1988).

Each person faced with the dilemma of living with an excessive drinker has a unique set of life experiences which has contributed to the development of particular ways of coping with severe stress. Whilst it is not prudent to generalise (e.g. Havey, Boswell & Romans, 1995; Jacob, Windle & Bost, 1999; Lyon & Seegeldt, 1995; Orford, 1990; Orford & Velleman, 1995; Sher, 1997a; Serrins, Edmundson, & Laflin, 1995), relatives who grew up in problem drinking families (or in families with other chronic severe health problems) *may* react differently to finding themselves in another alcohol dependent environment to those who have not had such long term negative life experiences (e.g. Black, Bucky & Wilder-Padilla, 1986; Hart & McAleer, 1997; Moss, Mezzich et al., 1995).

However, the degree of psychological distress relatives of excessive drinkers experience is likely to be compounded by the complex, interdependent coping patterns which develop within the family system. According to Wilson (1983), and quoted by Orford (1990, p.95), “all members in the family system - including excessive drinkers - are struggling to cope with the stress to which they are exposed.” Moreover, each

individual's reactions are likely to have repercussions for the rest of the family, and influences each person's subsequent choice of coping strategies.

Woititz (1988) has claimed that certain patterns tend to dominate in problem drinking families; viz. emotional immaturity, low frustration tolerance, inability to express emotions, high levels of anxiety in interpersonal relationships, perfectionism, compulsiveness, low self esteem, feelings of guilt and isolation. Moos and Moos (undated, quoted in Orford, 1990, p.82) also found that families with more severely impaired alcoholics demonstrated less cohesion and expressiveness, and increased family arguments.

According to Williams (1987) relatives (particularly partners) expend increasing amounts of time and energy in preventing drinking episodes and trying to maintain some degree of homeostasis which results in a family system which is increasingly confused, painful and dysfunctional. According to Clair and Genest (1987), Fox (1968), and Wegscheider, (1981), relatives become so preoccupied with their drinkers' behaviour, that normal family activities are often disrupted or may even cease to exist. This "co-alcoholic" (Lindquist, 1986) or "codependent" response (Dittrich, 1993; Rothberg, 1986; Steinglass, 1987) is seen to contribute to the maintenance of family distress and enables the heavy drinking to continue.

Moreover, relatives' (especially partners') nagging and controlling behaviours (such as hiding or throwing alcohol away) have been found to cue or reinforce further drinking (e.g. Jarvinen, 1991; McCrady, 1986; Noel & McCrady, 1993; Orford, 1975), and sabotage the progress of drinkers in treatment (Yoshioka, Thomas & Ager, 1992). As a result, Kaufman (1980) claims the family is kept in a state of confusion and pain as the relative (typically the wife) becomes increasingly obsessed with controlling the behaviour of the alcoholic (Beattie, 1987), and the drinker becomes adept in his/her role in the "confrontation-denial trap" (Miller & Rollnick, 1991).

Whilst these concepts are often invoked when describing the experiences of partners of excessive drinkers, they are not well understood and may not have been subjected to empirical examination. Moreover, Orford (1975; 1990) and Jacob, Windle, and Bost (1999) warn against viewing relatives' chronic stress and behavioural patterns as a *unique* response to problems of alcohol-complicated families because this chronic

stress is shared by members of families exposed to other, seemingly quite different, sets of stressful events.

1.2 The impact of excessive parental drinking on children

Children raised in an excessive drinking environment generally lack the love, attention, stability and consistency so essential to healthy development. There is general agreement (e.g. Havey, Boswell & Romans, 1995; Henderson & Blume, 1985; Murray, 1989; Russell, Tharinger & Koranek, 1988; Sher, 1997b; Velleman & Orford, 1993; West & Prinz, 1987) that an environment where problem drinking parents behave irrationally and unpredictably, (and non problem drinking parents are increasingly absorbed with controlling the alcohol related problems), is a major source of stress for children.

Whilst not all children from problem drinking families exhibit disturbed psycho-social functioning (e.g. Jacob & Leonard, 1986; Segrin & Menees, 1996; Senchak, Leonard, Greene & Carroll, 1995; Serrins, Edmundson & Laflin, 1995; Sher, 1997b; Werner, 1986), many experience anxiety, depression and other psychiatric disorders (Lynskey, Fergusson & Horwood, 1994; Rolf, Johnson & Israel, 1988; Sher, 1997), personality disorders (Fitzgerald, 1995) cognitive difficulties (Pihl & Bruce, 1995); decreased self esteem (Clair & Genest, 1987; Howells, 1989), a wide range of health problems (Moos & Billings, 1982), and a propensity for guilt, self blame, and impulsive or disruptive behaviour (Sher 1997b).

According to Jacob, Windle, Seilhamer, and Bost (1999), Farrell, Barnes, and Banerjee (1995), Orford and Velleman (1991), and Tharinger and Koranek (1988), the deleterious impact of excessive parental drinking on children's psycho-social functioning is mitigated by various organisational and developmental factors. These mitigating factors may include the severity, duration and frequency of parental problem drinking; the gender of the problem drinking parent and his/her relationship with the children; parental mental and physical health, and coping strategies, work history and socio economic status; the quality, stability and cohesion of the family as a caregiving environment. Other important mitigating factors were children's age, gender,

intellectual and problem solving abilities, and the ability to secure emotional and social supports.

In the only non clinical Australian study in this area, Howells (1989)[3] found 30% of a Western Australian sample of 11-12 yr olds (n=243) answered "yes" to the question, "Have you ever *wished* your mother and/or father would drink less?" It was interesting to note that only one child answered in the affirmative for *both* parents. This child also identified both his parents as "alcoholics." DiCicco (1984) argued that children are not likely to wish their parents would drink less unless they have been exposed to something other than non-disruptive social drinking, particularly if a child "wishes" for one parent and not the other.[4] Moreover, 17% of the sample identified themselves as children of "problem drinkers" or "alcoholics." *All of these early adolescents had significantly lower self esteem* than their peers who did not wish their parent/s would drink less, or identify them as having a alcohol problems.

Beardslee, Son and Vaillant's (1986) longitudinal study identified the increased vulnerability of COAs to developing alcohol problems when compared to matched controls. This finding has been supported by others (Brown, Creamer & Stetson, 1987; Duncan, Jacob, Windle, Seilhamer & Bost, 1999; Duncan, Tildesley, Duncan & Hops, 1995; Schuckit & Smith, 1995; Sher, 1997b; Windle, 1996), particularly when families are chaotic, discordant, and unsupported (Cooper, Peirce & Tidwell, 1995; Phil & Bruce, 1995; Orford & Velleman, 1991). Moreover, adult children of alcoholics (ACAs) seem more vulnerable to psychopathology (Belliveau & Stoppard, 1995), tend to use dysfunctional communication patterns (Hart & McAleer, 1997), may experience problems with the management of anger (Potter-Efron & Potter-Efron, 1991) and are likely to form intimate relationships with alcoholics (Black, Bucky & Wilder-Padilla, 1986; Vaz-Serra, Canavarro & Ramahleira, 1998).

However, whilst negative early childhood experiences undoubtedly *influence* adult mental health status (long lasting in the case of early childhood abuse), Kagan (1998) claims these experiences are not fixed like a photograph. Rather, he emphasises the power of context, human malleability and variability to respond to different emotions and circumstances; i.e. the capacity for resilience.

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[3] The present author; i.e. Janis Fairbairn

[4] Di Cicco (1984) found the "wish" question to be "a fairly sensitive identifier of parental alcoholism."

1.3 The need to treat relatives of excessive drinkers in their own right

Despite the considerable level of chronic stress and associated health problems suffered by relatives (particularly partners) of excessive drinkers (and consequently their children), the main focus of the literature has generally been on how to successfully rehabilitate excessive drinkers. Partners have been variously co-opted to enhance their drinkers' treatment outcomes (e.g. McCrady, Stout, Noel, Abrams & Nelson, 1991; O'Farrell & Bayog, 1986; O'Farrell & Cowles, 1989) or to engage their resistant drinkers into treatment (e.g. Barber & Crisp, 1995; Barber, Gilberston & Crisp, 1997; Meyers, Miller, Hill & Tonigan, 1999; Miller, Meyers & Tonigan, 1999; Sisson & Azrin, 1986; Thomas & Agar, 1993; Thomas & Santa, 1982; Thomas, Santa, Bronson, & Oyserman, 1987). Unfortunately, most of these researchers paid scant attention to the needs of relatives in their own right.

Very few programs have been *primarily* aimed at improving relatives' (particularly partners') situations in their own right; (e.g. Binns, Dear, Knowles & Hall, 1989; Burnett, 1984; Dittrich, 1993; Honig & Spinner, 1986; Laundegan & Williams, 1993). However, Dittrich also aimed to teach partners intervention strategies to encourage their resistant drinkers into treatment. Although some of these drinkers subsequently entered treatment, Dittrich did not establish which was the active ingredient - partners' improved mental health and coping strategies, or the intervention strategies partners had learned.

Given Paolino and McCrady's (1977) assertion that for every excessive drinker there are likely to be at least 5 others who also suffer deleterious effects, it is of great concern that family distress has largely been overlooked in the race to get the drinkers into treatment. According to Mattick, et al. (1993), it is not only *ethically* important to treat relatives *in their own right,* it also makes good economic sense from a harm minimisation perspective.

Rehabilitation and treatment services have largely failed to motivate excessive drinkers into treatment early enough to minimise the harm to themselves and their families. Therefore, it is in the best interests of the community to reduce the chronic distress suffered by relatives and to empower them to improve their situations (and

perhaps reduce their children's vulnerability to developing future alcohol problems) - *whether their drinkers seek treatment or not.*

Given the important *contribution* (as distinct from blame) of relatives' distress and reactive behaviour in the maintenance of excessive drinking, and their subsequent entrapment within the drinking system, there *may be* an equal and opposite impact upon the drinking if relatives' issues were addressed in their own right. Perhaps Wright and Cross's (1978) assertion that "treating a partner is also treating an alcoholic" may be substantiated - *even if drinkers are initially resistant to change.* Therefore, it may be possible to effect positive change without waiting for excessive drinkers to eventually present for help due to serious alcohol related problems. Thus, working with relatives in their own right may indeed be a valuable approach to the secondary prevention of addiction (Orford, 1994),

The primary focus of this thesis has been to investigate both the outcome and process of a clinically derived intervention developed by the Australian Institute on Alcohol and Addictions (Holyoake) in Perth, Western Australia which aimed to improve the mental health and coping status of relatives of excessive drinkers in their own right, without involving their drinkers in any way. The secondary focus has explored whether improving the psychological functioning of relatives had a positive "spin off" effect of improving their relationships with their drinkers as well as encouraging and motivating their drinkers to seek help or reduce their consumption.

However, it is important to recognise that this research in no way suggests that relatives (and in particular partners) are ever *responsible* for their drinker's behaviour. It merely acknowledges the *influence* one family member has on another within the family system.

Whilst this thesis began from a clinical framework which reflected the best guesses of Australian addiction workers in the front line, it has moved beyond the testing of a single intervention by investigating the underlying principles on which that intervention appeared to be based. This thesis has taken the concepts of best guesses and clinical wisdom and moved them into a framework more clearly based within a conceptual and empirical framework. Thus, this thesis has compared the conceptual framework which *seemed* to be embedded within the Holyoake intervention to what the

empirical literature would identify as important elements to incorporate into an "ideal" intervention.

Chapter 2 has described the process by which relatives (particularly partners) of excessive drinkers inadvertently become an integral part of the process of alcohol dependency, and the impact of this on relatives' mental health, coping, and relationship status. Chapter 3 has explored how other researchers have variously co-opted relatives into the treatment process to enhance their drinkers' prognosis, and how relatives have been trained as intervention agents to motivate their *resistant* drinkers into seeking treatment. Chapter 4 has examined the nature of the few treatment programs specifically designed to address relatives' needs in their own right - without directly involving their drinkers. Given there may be a positive "spin off" of relative changes on treatment resistant drinkers' behaviour,

Chapter 5 has explored the process of change through which drinkers would be likely to progress, and how relatives' disengagement from the interdependent, stress, coping and transactional patterns within the family system may indeed motivate treatment resistant drinkers to seek help or reduce their consumption.

Chapter 6 has provided a *conceptual* rationale for the elements of an "ideal" intervention designed to assist relatives to improve their mental health, coping, and relationship status. The thesis has then moved into the development of research questions and hypotheses, an examination of the method, followed by results, discussion and conclusions.

CHAPTER 2

The stress and coping patterns of relatives of excessive drinkers

In their review of the literature pertaining to relatives (particularly partners) of excessive drinkers, Watts, Bush and Wilson, (1994) highlighted that the literature still carries a strong legacy of pathology from the past and is still burdened by the co-dependency movement. Hand and Dear (1994) also criticise this movement for the unvalidated, exhaustive array of definitions (as opposed to descriptions) ranging from a progressive and deteriorating disease resulting in death if not arrested (Young, 1987) to the more believable view of Smalley and Coleman (1994) that co-dependency is a set of learned behaviours, attitudes, and emotional patterns that frequently manifest into other addictive behaviours. However, despite their criticisms, Hand and Dear (1994) acknowledge the valuable contribution of the codependency movement in highlighting the need for clinicians to give more attention and status to the families of excessive drinkers.

It has increasingly been acknowledged (e.g. Hand & Dear, 1994; Orford, 1994; Orford, et al. 1998a & 1998b; Miller, et al., 1999; Troise, 1995; Velleman et al. 1993; Watts, Bush & Wilson, 1994) that the anxiety, depression, anger, unhelpful coping strategies, stress related health problems, and increased medical usage commonly detected in relatives of excessive drinkers are nothing more than a normal reaction to the compound chronic stress involved in trying to cope with the marital and family conflict generated by drinkers' disruptive behaviour. Troise (1995) supports this view and castigates the codependency movement for neuroticising partners and overlooking the evidence which has been building for decades; viz.

- There is no evidence for a unitary personality characteristic, normal or pathological, among wives of alcoholics as a group. Wives of alcoholics manifest a wide range of normal and neurotic personality traits (Kogan & Jackson, 1954).

- Psychological/physiological symptoms commonly observed in partners of alcoholics are primarily reactive to trauma induced or imposed by the alcoholic (Moos, Finney, & Cronkite, 1990).
- There is no statistically significant difference between partners of alcoholics and "normals" in their capacity to experience mature, emotional intimacy with "best friends" outside the marital dyad (Troise, 1992).

However, Moos et al.'s (1982) assertion that the trauma is *induced* or *imposed* by the alcoholic ignores the important *contribution* that partners may make to their own distress by their cognitive and behavioural *reactions* to their drinkers' behaviour. Even in the 1950s, Whalen (1953) acknowledged that excessive drinking becomes only "one of the factors within the family constellation which is productive of emotional problems" as partners get subtly and inexorably drawn into the family system of alcohol dependency.

2.1 The dependent use of alcohol

Despite the increasing problems caused by excessive consumption which seriously impact upon themselves and their families, dependent drinkers continue to drink *compulsively* in search of the magic, euphoric mood swing (much more elusive now) to avoid their emotional pain and withdrawal symptoms. Thus, dependent drinkers often lose control over their consumption and use increasing amounts over longer time periods than intended (DSMIV).

Given the considerable conflict between drinkers' powerful incentives to use and the many restraints against using, drinkers may repeatedly express a need to cut down or regulate their use, or make unsuccessful attempts to do so (Orford, 1985; 1988b), They become preoccupied with alcohol usually at the expense of their responsibilities, personal relationships, their partners, and their children. Increasingly, drinkers' daily activities revolve around drinking, securing supplies, or resisting the urge to drink. The dependency has become a chronic, relapsing disorder (Mattick et al. 1993).

Although dependent drinkers may recognise that their misuse of alcohol has contributed to existing psychological problems (e.g. severe depression), other health problems, as well as family distress, they continue to use. Alcohol has become an essential part of their emotional survival system, and they find it difficult to function

comfortably without it. Despite the considerable pressure (particularly from their families) to reduce their consumption, drinkers find the possibility of separation or "divorce" from their loved and trusted friend unthinkable (Orford, 1985; 1988b). Thus, relatives (particularly partners) may feel as though they are in competition with the bottle for their drinkers' attention and affection.

Despite putting forward a phoney front that identifies them as essentially OK, dependent drinkers increasingly experience feelings of guilt, remorse and self hatred due to their growing loss of control, unpredictable behaviour, and continued violation of their personal value systems and ethics. As a result, they experience considerable conflict due to the ongoing battle between the growing restraints against using (e.g. family complaints, finances, health, moral standards, work commitments, other leisure activities) and the usually overpowering incentive to drink (Orford, 1985; 1988b).

However, the full impact of this conflict may be blocked from conscious awareness by the developing psychological defence system of minimising, making excuses, and blaming others (usually their relatives) for their own unacceptable behaviour. The effect of these defences is to progressively and thoroughly draw drinkers (and eventually their families) out of touch with reality.

The more dependent drinkers use alcohol to relieve their increasing emotional pain, the more emotional pain they generate for themselves and their families. Moreover, drinkers' gradual breakdown is echoed and paralleled within their close, significant relationships.

Although these concepts which have described the characteristics of dependent drinkers are generally accepted within the addiction industry, and have indeed been *clinically* validated (e.g. Alcoholics Anonymous World Services, 1976; Orford, 1985), they are not well understood and their empirical evaluation is sparse.

2.2 The interdependent stress, coping and transactional patterns which develop between excessive drinkers and their relatives

According to Bryski, (1984), because alcohol dependency usually develops within a family milieu, problems first become evident "behind the bedroom door". As drinkers'

unacceptable behaviour impacts upon their partners, and partners' subsequent reactions reciprocally impact upon their drinkers, interdependent stress, coping, and transactional patterns develop between drinkers and their relatives. For example, partners may learn that the only time their drinkers will share at an emotional level is when they are drunk and/or feeling remorseful. Therefore, although partners may react negatively to their drinkers' unacceptable behaviour, the drinking behaviour often provides an essential prelude to intimacy.

As this process continues, relatives may become seduced and ensnared by their drinkers' survival system of defences. As a result, they may unwittingly (and with the best of intentions) co-operate with their drinkers' processes of self deception by shielding them from the full impact of the harmful consequences of their unacceptable behaviour. Therefore, drinkers lose the opportunity to gain what is needed most: significant insight regarding the severity of their dependency. Without this insight, drinkers remain a victim of their own defence system, and are unlikely to take any action to change their behaviour (Miller, Meyers & Tonigan, 1999; Maclaine, 1988; Wegscheider, 1981).

Although there are certain core issues which seem to transcend culture, the extent of the emotional distress relatives experience and how they cope with it depends upon the severity of the alcohol dependence, the culture and structure of the family (Cooper, Peirce, & Tidwell, 1995; Orford, 1990), relatives' previous life experiences, and their current situations. Each person faced with the dilemma of living with an alcohol dependent person has a unique set of life experiences which has contributed to the development of particular ways of coping with severe stress.

In the early stages of dependency, the unacceptable consequences of excessive use may only be episodic. When alcohol dependents are not using, their relationships with their relatives *may* be quite good. However, as relatives begin to express their concerns, suspicions, and fears that *something* is radically wrong, drinkers typically minimise the problems, and make excuses (often quite plausible) for their behaviour, and may express regret for having hurt their family.

According to Wegscheider (1981), because relatives are struggling to understand why their drinkers behaved in such an inappropriate manner, they may decide to accept their drinkers' excuses and explain away the unacceptable behaviour by seeing it as quite normal given the circumstances, or as a result of some other problem. Thus,

relatives may unwittingly collude with their drinkers' defence systems (Orford, 1992; Wegscheider, 1981). Figure 2.1 has attempted to illustrate the interdependent coping and relationship patterns which seem to develop between relatives and their drinkers in reaction to the increasing levels of stress within the family environment (Orford, 1988b; Orford et al. 1998a; 1998b).

In later stages of alcohol dependency, when the problems increase, it usually becomes quite obvious to the family (and usually to people outside the family) that the excessive use of alcohol is underpinning most of their family's problems. As their drinkers become increasingly more irresponsible and unreliable, the family face profound dilemmas about how they should respond and they usually try to compensate for their drinkers' behaviour; e.g. covering up, becoming more vigilant, and avoiding social events where alcohol is served (Orford, 1988b; Rychtarik, Carstensen, Alford, Schlundt & Scott, 1988; Thomas & Agar, 1993);

Relatives usually act in these ways out of a sincere (if misguided) sense of love and loyalty. However, relatives may also act out of shame to protect their own and their family's self respect. Certainly, they are motivated by fear that the consequences of the alcohol dependency will severely impact upon them and their children. This increased vigilance leads to emotional distress (e.g. anxiety, depression, stress, worry), and requires huge amounts of energy (Orford, 1985; Orford et al. 1998b). Eventually, relatives (particularly partners) become emotionally and physically drained as their repeated attempts to control the drinking related problems fail.

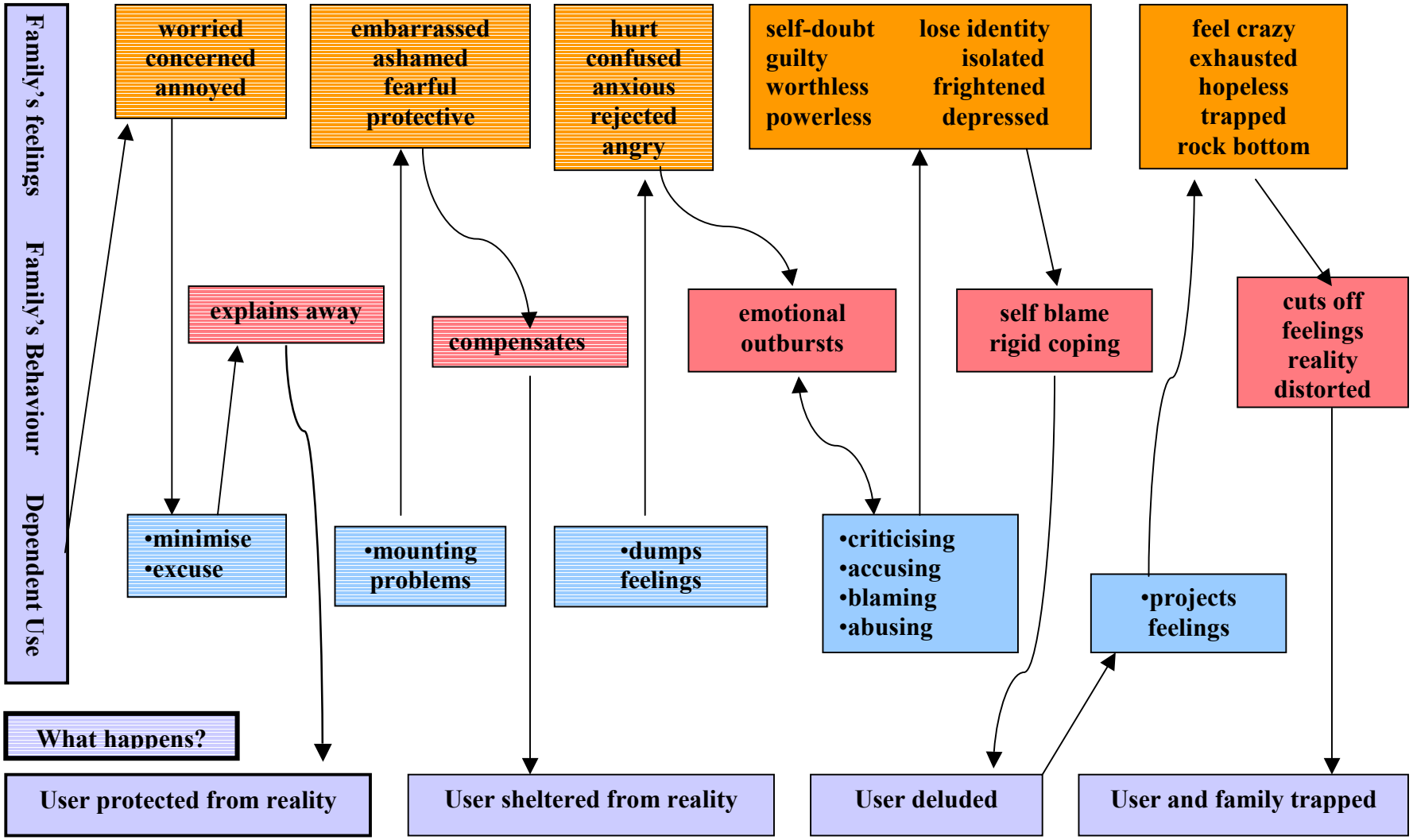

Figure 2.1 The interdependent stress, coping, and transactional patterns which seem to develop between excessive drinkers and their partners

As drinkers' consumption becomes more compulsive and out of control, their growing feelings of guilt, remorse, and self hatred become increasingly more uncomfortable and unbearable. Drinkers may attempt to cope with this emotional distress by more frequently trying to "dump" their negative feelings on their partners (or other close family members). This is usually achieved by blaming, accusing, or abusing partners in some other way. If an argument is provoked by this behaviour, and partners respond with emotional outbursts, drinkers have in effect "transferred" their emotional pain to their partners who accept it, and throw it back with all the anger they have been holding back for so long. Partners appear bitchy, nagging, sarcastic, and unpleasant - as do most people who are under almost unendurable stress. (Hand & Dear, 1994; Orford, 1995; Orford et al. 1998b; Wegscheider, 1981).

If partners do not respond in this way (perhaps they are trying to control their reactions), drinkers will often press other more vulnerable "emotional buttons" to provoke the argument they need to relieve their own emotional distress. This emotional ventilation temporarily relieves some of the drinkers' internal stress and allows them to survive within increasingly painful situations. However, not only do the arguments relieve drinkers' emotional pain, they also strengthen their defence systems by helping to justify their alcohol use, and attribute blame for their actions to their partners.

As the "dumping" of negative emotions continues, the family usually reacts by feeling more and more hurt, inadequate, and guilty (because some of the accusations may indeed hold a grain of truth). Drinkers often criticise their partners for their appearance, sexuality, disposition, parenting ability, household responsibilities, financial ineptitude, or their friends. Partners may even get blamed for problems which are a direct result of their drinkers' excessive consumption.

Drinkers' accusations are hurled at increasingly confused and exhausted relatives (particularly partners) who are already feeling a great deal of self doubt, guilt, and low self worth (Orford, 1988b). By this time, relatives are putting all their imagination, skills, time, and energy (more than they ever thought they had) into trying to make things right for their families. To cope with this level of emotional distress, relatives may do as their drinkers do: cut off their feelings and build walls of defences to shield themselves from the reality of their situations. They also may lose control of their behaviour; (shouting abuse when they meant to be calm and polite), their feelings

("It's like I'm on an emotional roller-coaster") and their thoughts ("I think I must be going crazy").

At an emotional level, relatives may believe that they are at least partly responsible for their drinkers' excessive consumption and therefore need to do something to fix it. Their coping patterns may become more rigid and compulsive as they try (usually unsuccessfully) to control the level of distress the family is experiencing. Wegscheider (1981) claims relatives usually present for help with time, money, energy, joy, and hope in chronically short supply. Not only are relatives distressed and confused, they are also likely to be grieving the loss of intimacy they once enjoyed with their drinkers (Coleman, 1987; Orford et al. 1998a).

Whilst these concepts which have described the interdependent stress, coping and transactional patterns which seem to develop between excessive drinkers and their relatives are widely accepted and have been *clinically* validated (e.g. Alcoholics Anonymous World Services, 1976; Beattie, 1989; Hand & Dear, 1994; Maclaine, 1988; Wegscheider, 1981), they are not well understood and their empirical evaluation is limited (See Table 6.1).

2.3 The stresses and strains of relatives of excessive drinkers

In the first explanation of relatives' "stresses and strains" from a qualitative perspective, Orford et al. (1998a) found both English and Mexican relatives faced similar core stressors. The most universal stressor relatives experienced was finding their drinkers unpleasant to live with. Relatives described their drinkers as angry, abusive, and threatening; critical and domineering; emotionally distant; possessive and jealous; and poor communicators. Moreover, relatives were concerned about their drinkers' health; financial difficulties; relationship/sexual problems; arguments; and the harmful effects upon the family unit.

As a result of these stressors, both English and Mexican relatives experienced similar strains due to their negative feelings, life style, and physical and general health. Orford et al. categorised relatives' "bad feelings" into 4 predominant areas; viz.

- Anxiety; i.e. general emotional upset and unease; worry and preoccupation; nervous and tense; irritable and quick tempered.

- Helplessness and despair; i.e. inability to cope, resigned and disillusioned; loss of trust, faith and hope in user.
- Depressed; i.e. miserable and unhappy; low energy and enthusiasm; suicidal thoughts.
- Guilty and devalued; i.e. guilt, remorse, failure, unconfident, devalued, used, and not in charge.

However, Crisp and Barber (1995) claimed that whilst the *range* of problems experienced by partners of excessive drinkers has been well documented in the literature, the *frequency* with which these problems occurred and the *degree of distress* they caused had been not been established. Therefore, Crisp and Barber developed the Drinkers' Partners' Distress Scale (DPDS) to target *both* interpersonal and intra-personal domains. Their study of Australian partners (Barber & Crisp, 1994; Crisp & Barber, 1995) identified two factors embedded within the DPDS which they labelled depression and marital discord.

The depression factor described partners' embarrassment, loneliness, neglect, lack of stimulating adult company, worry about leaving heavy drinkers in charge of household responsibilities, unsatisfactory sex, and insecurity about their relationship. The marital discord factor described partners' irritability and anger in reaction to their drinkers' behaviour, money shortages, and drinkers' verbal and physical abuse.

2.4 How relatives cope with their drinkers' unacceptable behaviour

According to Velleman et al. 1993 (p.1288), most relatives (particularly partners) of excessive drinkers "swing from one unsatisfactory coping position to the other." Relatives tend to try one method of coping with an intolerable situation, reject it (because it didn't work; i.e. the excessive drinking didn't stop), and replace it with another method. Although relatives may try to be more consistent, the problem is that they do not know *what to be more consistent about.*

The literature has identified the range of coping strategies predominantly used by partners to deal with their drinkers' excessive consumption and unacceptable behaviour (Holmila, 1997; Orford, 1992; Orford, 1994; Orford et al. 1992; Orford et al. 1998b). This research has led to greater confidence in the typology of relatives' coping strategies as described in Table 2.1.

Table 2.1
A typology of coping strategies commonly used by relatives of excessive drinkers (Orford et al. 1992; 1998b)

Coping strategies	Behavioural characteristics
Emotional	• Expression of strong emotion towards the drinker due to his/her excessive use.
Controlling	• Attempts to directly control use or directly related events.
Tolerant[1]	• Actions that support or aid use or which protect the drinker from the consequences of his/her use.
Inactive	• Responses indicating lack of action.
Avoidance	• Deliberately creating distance from drinker due to excessive use.
Assertive	• Calm open communication to the drinker about relative's feelings and needs.
Independent	• Actions indicating relative's independence or lack of dependence on the drinker.
Supportive	• Actions that directly support reduced consumption.

Further factor analyses by Orford et al. (1998b) combined these coping strategies into three major coping positions which they labelled as engaged, tolerant, and withdrawal. The engaged coping position described relatives' behaviours which attempt to change drinkers' unacceptable behaviour by actively confronting it in a manner which is more or less emotional, controlling, assertive, or supportive. Tolerant and withdrawal coping positions are the principal alternatives to the engaged position. The tolerant coping position is comprised of tolerant-accepting (i.e. resignation) and tolerant-sacrificing (i.e. self sacrifice) coping strategies: relatives tolerate their drinkers' behaviour in ways which are more or less inactive, accepting, or supportive. On the other hand, relatives who adopt a withdrawal coping position withdraw from interaction with their drinkers by utilising avoidance or independent coping strategies.

Many relatives (and indeed many therapists) perceive control, emotional, tolerant and withdrawal coping strategies as less unsuccessful, and assertive and supportive strategies as more successful. However, Orford et al.'s "central conclusion" (p.1809)

[1] Tolerant strategies were split into tolerant-sacrificing, and tolerant-accepting by Orford et al. (1998b).

was that "these distinctions are subtle and difficult to make, and in practice are lost within an undifferentiated combined form of engagement".

Holmila (1997) also found relatives used three predominant patterns of relating to their excessive drinkers. These patterns echoed Orford et al.'s (1998b) three coping positions, and supported their cross cultural application. Primarily, Holmila found both male and female partners' need for autonomy and integrity drove them to maintain distance from their drinkers so they could better manage their *own* lives: this is akin to Orford et al.'s withdrawal coping position. However, female partners in particular experienced considerable conflict whilst attempting to balance their primary need to detach from their drinkers with their secondary need (and perceived responsibility) to adopt a care-giving, counselling, and controlling role: this was akin to Orford et al.'s engaged position. The third, and least important way (Holmila, 1997), partners related to their drinkers was to resign themselves to their fate and maintain a facade that nothing special was going on. This pattern was generally favoured by male partners, who also tended to withdraw active support from their female drinkers. This pattern of relating mirrored Orford et al.'s tolerant-accepting and avoidance coping strategies.

2.5 The stress/coping/transactional model

The considerable influence relatives (and particularly partners) and drinkers are capable of exerting *on each other* (either positive or negative) is explained by the stress/coping/transactional model described by Orford (1994). Whilst this model is "silent on the aetiology of drinking problems", it acknowledges that relatives living under conditions of chronic stress usually develop dysfunctional (i.e. rigid, extreme, and resistant to change) styles of relating and coping with their drinkers' unacceptable consumption and behaviour;

For instance, in any given interaction (e.g. Time 1) relatives and drinkers each bring their unique set of beliefs and assumptions, history of *previous* interactions and the success (or failure) of their efforts to cope. At Time 1, each person's relating style and choice of coping strategies directly impacts upon the other. For example, a partner may be met with aggression and accusation (e.g. "If you didn't nag so much I wouldn't drink so much") when s/he complains about the drinking. S/he may similarly react to these

accusations and give back as good as s/he gets (e.g. ”If you didn’t drink so much I wouldn’t have to nag so much”).

At the next interaction (e.g. Time 2), each person’s choice of relating style and coping strategies will not only be influenced by their unique history and experience but by three additional factors. Firstly, the success (or failure) of their *own* coping efforts (including the other’s reaction) at Time 1; secondly, their appraisals of the demands of the situation and available resources; and thirdly, each person’s reaction to the other’s coping style and strategies at Time 1 (see Figure 2.2).

Unfortunately, relatives who are enmeshed in the interdependent coping and relationship patterns with their drinkers usually react to the increasingly unacceptable drinking behaviour and their own emotional distress with generally ineffective and counterproductive coping strategies; viz. emotional (nagging, blaming, threatening), control (e.g. lecturing, criticising), tolerant (rescuing, self sacrificing, accepting), inactive (frozen), or avoidance (emotional/physical withdrawal). Moreover, emotional and control coping strategies may even exacerbate the level of discord in the family which may actually cue and facilitate further drinking episodes (Jarvinen, 1991; McCrady, 1986; Noel & McCrady, 1993).

Obviously, a loving, nurturing, intimate relationship cannot develop or survive within this destructive milieu. Given the destructive nature of these relationships, relatives’ distress and ineffective and counterproductive coping strategies, and the deleterious impact on their children, it is vital to intervene to reduce the significant level

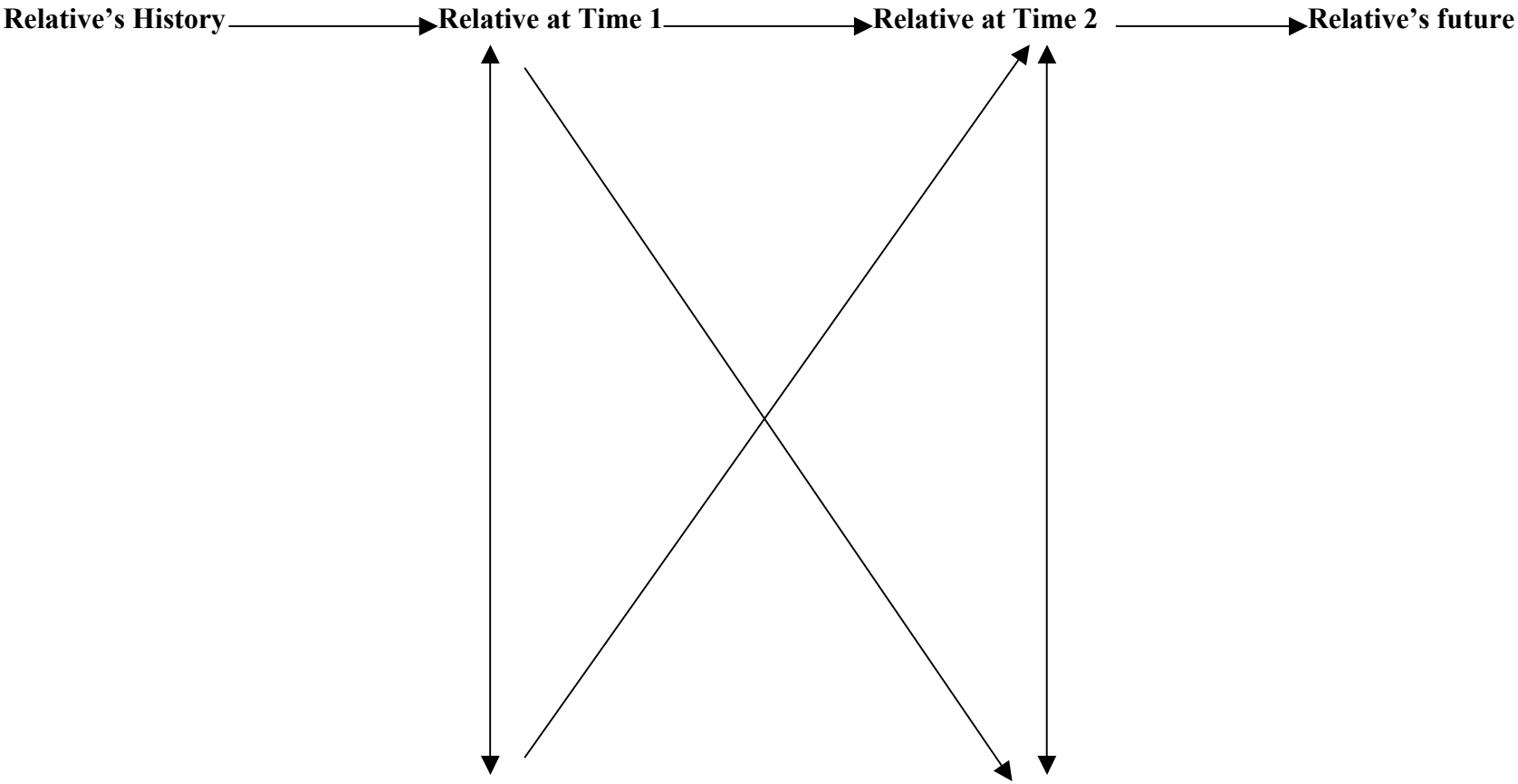

Figure 2.2 Transactional model of relative's coping with their drinker's excessive consumption (reproduced with permission from Orford, 1994)

of harm to the community - whether their drinkers seek help or not. Moreover, if relatives are empowered to disengage from these interdependent patterns of behaviour (which are likely to have become well entrenched), and learn more effective patterns of coping, the change in choreography is highly likely to throw drinkers off balance and leave them unsupported. This temporary period of instability may indeed provide drinkers with a priceless window of opportunity to more closely review their behaviour. Perhaps they might even decide to learn their relatives' new behavioural steps.

The stress/coping/transactional model (see Figure 2.2) has explained the potential for relatives to exert considerable influence over their drinkers. In fact, a significant change in one person's behaviour *in any relationship* is likely to prompt a reactive change in the other - for better or worse. For instance, Vaughan, Doyle and McConaghy (1991) clearly demonstrated the operation of this model in their randomised, controlled interventions with *families* of Australian schizophrenic patients. Without having any contact with patients or their clinical managers, Vaughan et al. educated families about schizophrenia, and improved their problem solving and communication skills. As a result, families' sense of mastery and self confidence increased, which reduced their anxiety and guilt. The positive changes in how these families related to their loved ones with schizophrenia as a result of the cognitive behavioural intervention, resulted in lower levels of expressed emotion (e.g. frustration, irritability, anger) within the family milieu, *which resulted in lower rates of relapse and suicide for patients with schizophrenia.*

This chapter has focussed on the interdependent coping and transactional patterns which seem to develop between relatives and their excessive drinkers. As relatives inadvertently become entrapped in this process, the reciprocal behaviour patterns create a situation which tends to support the status quo. The excessive drinking continues and relatives' stresses and strains are compounded. Thus, relatives' (particularly partners') mental health and coping status is compromised, and their relationships with their drinkers continue to deteriorate - with deleterious impact upon their children.

Although the crucial importance of marital and family therapy in the treatment of alcoholism was highlighted by the US Congress National Institute on Alcohol Abuse and Alcoholism over 20 years ago, evidence based interventions which improve the quality of family communication patterns were slow to be adopted (O'Farrell, 1993). However, given the reciprocity between marital disharmony and excessive drinking, it eventually became obvious that relatives (particularly partners) were indeed a valuable resource in

the treatment of alcohol problems. The next chapter will explore the various ways in which relatives have been co-opted into the treatment process to enhance their drinkers' recovery prospects and prevent relapse, and ultimately how relatives have been used as agents of change to encourage their treatment resistant drinkers to reduce their consumption and/or seek help.

CHAPTER 3

Relatives as agents of change

Given the deleterious impact of excessive drinking on the families of excessive drinkers, it is a serious oversight that the significant importance of empowering relatives (particularly partners) to improve their mental health and develop more effective and less harmful coping strategies *for their own benefit* has been largely neglected. Instead, the literature has generally been written from the focus of co-opting relatives as rehabilitative *influencers* (Yoshioka, 1992) to improve their drinkers' treatment prospects.

This neglect of relatives' (and in particular partners') needs may be underpinned by the belief that it is the excessive drinking which is the main pathological element within the family environment and once it is removed, relatives' distress will corresponding reduce. However, this belief has been challenged for decades (Bailey, 1967; Paolino & McCrady, 1977; Whalen, 1953), and more recently by Barber and Crisp (1995) who found no significant improvement in partners' well being, depression, or self esteem even though 60% of their drinkers had presented for treatment.

Historically, partners of excessive drinkers have been dismissed as "hysterical" and merely "reacting to the emptiness of earlier disappointments" because they complained bitterly about their "failure" husbands, (Israel, Couadau & Ritter, 1966). However, in an attempt to reduce their *own* failure rate when treating excessive drinkers, clinicians slowly began to acknowledge the important role of the relationship between partners and their drinkers (Dinaberg, 1977), and the need to improve the quality of their interactions through marital and family therapy (Shapiro, 1977).

3.1 Relatives as adjuncts to their drinkers' treatment

The identification of relatives (particularly partners) as a valuable resource in their drinkers' recovery began thirty years ago. For example, Smith (1969) found partners' involvement in treatment enhanced their drinkers' prognoses, and Orford et al. (1975) found partners' style of coping influenced their drinkers' treatment outcome.

Moreover, Wright and Scott (1978) found decreases in partners' dysfunctional behaviour (through attendance at Alanon) significantly enhanced drinkers' treatment outcome.

More recently, O'Farrell (1993); O'Farrell and Bayog (1986) and O'Farrell and Cowles (1989) attempted to reduce the considerable discord (usually about the drinking) between partners and their drinkers by attempting to improve partners' communication skills (listening and direct expression of feelings), and co-opting them to supervise disulfiram dosages. This resulted in increased disulfiram compliance, improved relationships, and reduced consumption with a small number of drinkers (who were under considerable threat of divorce). It was interesting to note that one of the partners in O'Farrell and Bayog's research did not want to "invest further in the marital relationship" (through couple's work) until her husband had maintained a longer period of abstinence, and their lives had stabilised. Moreover, she needed time to get over her bitterness regarding his destructive behaviour, and to develop trust that he wouldn't drink again.

Bowers and Al-Red (1990) and Moos, Finney, and Chronkite (1990) also found a direct relationship between improved marital and family adjustment and alcoholism treatment outcomes, particularly with high autonomy families (McKay, Longbraugh, Beattie, Maisto & Noes, 1993). Moreover, McCrady, Stout, Noel, Abrams and Nelson, (1991) found alcohol behavioural marital therapy (ABMT) was the most effective way to reduce the drinking *as well as* improving marital satisfaction.[1] Partners were included in the ABMT program and, while their drinkers learned behavioural self control and general skills training, partners learned how to most effectively support abstinence, decrease their involvement with their drinkers' consumption, and cope more effectively when their drinkers were drinking. Although not a primary aim of the ABMT program, subjective well being for both drinkers and partners also improved, which suggests this may have occurred as a "spin off" from their drinkers' reduced consumption and improved marital adjustment.

However, in their commentary on the value of marital therapy in the treatment of alcoholism, Mattick et al. (1993) caution that the evidence was mixed and indicated that marital therapy "has little additional impact on post treatment drinking behaviour"

[1] Marital satisfaction was not defined in this paper

(p.45). Moreover, Kaufman and Pattison (1981) highlighted the crucial need for balance between the advantages of partner involvement in their drinkers' treatment, against procedures which might "...reinforce [partners'] over-involvement with alcoholics' responsibility for their drinking decisions" (p.955).

3.2 Relatives as early intervention agents

The value of associates as aides to intervention began to be discussed in the literature in the 1960s. For example, Johnson, De Vries and Houghton (1966) recommended working with close associates of women alcoholics, whilst Dumont (1967) attempted to help homeless men by working with their bartenders. These early attempts have foreshadowed a small but growing body of research (see examples in Table 3.1). Despite generally small sample sizes; methodological limitations (Sisson & Azrin, 1986, 1993); long and complicated treatment programs which were difficult to replicate (Thomas & Agar, 1993; Thomas & Santa, 1982; Thomas, Santa, Bronson & Oyserman, 1987), these programs increasingly supported the value of working with *co-operative, motivated relatives* (and in particular partners*)* to influence the behaviour of their treatment resistant drinkers. For instance, relatives were taught how to extinguish their drinkers' excessive consumption, reinforce non-drinking behaviour, improve communication, reduce conflict and prepare for their drinkers' treatment initiation.

The important role of family coercion in encouraging excessive drinkers to present for treatment was identified by Polcin and Weisner (1999). From a sample of 927 individuals receiving treatment across a representative sample of alcohol agencies in the US, more than 40% of drinkers reported that they had entered treatment because of an ultimatum. The most common source of ultimatum (approximately 60%) came from

Table 3.1
Examples of treatment programs designed to train relatives of treatment resistant drinkers as change agents

Author/s	Methodology	Findings	Further Research Needed[2]
Thomas & Santa (1982) **Thomas, Santa, Bronson & Oyserman (1986)** USA *Aims:* Improved partner coping; (ii) improved family interactions; and (iii) drinker encouraged into treatment.	• n=23 wives • Random assignment of pairs to either 4-6 months experimental group or delayed treatment control. • Sample size too small for systematic statistical analysis so selected comparisons made.	Treatment associated with: (i) reduction in drinking behaviour; and (ii) improvement in coping and family functioning.	• Partner outcome data. • Larger sample. • Data on male partners of excessive drinkers.
Sisson & Azrin, 1986 USA *Aims*: (i) reduce physical abuse to partner from drinker; (ii) encourage sobriety; (iii) encourage drinker to seek treatment; and (iv) how partner can assist in treatment.	• N=12 wives • "coin flip" assignment to Reinforcement Training (RT) group (mean 7.2 sessions) or traditional disease concept education, supportive counselling and Alanon (12 Step support group): mean 3.2 sessions	• All but one of the drinkers in RT group presented for treatment, compared to none in Traditional group. • Methodological flaws associated with differential length of treatment groups.	• Partner outcome data. • More rigorous research design.
Barber & Crisp, 1995 Australia *Aim* Train partner in coping responses which both empower the partner and provide incentive for the drinker to change.	• Random allocation to one of three groups; viz. individual or group treatment (each n=8), or wait list control (n=7) • 1 male participant • 5 sessions • Pre/post treatment measures	• Almost 60% of drinkers made significant moves toward change. • No significant difference in intervention rate between individual and group treatment approach. • No significant improvement in partner wellbeing, self esteem, depression, or marital discord	• Replication with larger sample. • Sustainability of treatment gains. • Data on male partners of excessive drinkers. • Program which enhances partner well being.
Miller, Meyers & Tonigan (1999) *Aim* Engage treatment resistant drinkers, and improve family members' functioning and relationship quality.	• Randomised clinical trial • Concerned significant others (CSOs) allocated to 3 conditions; i.e. "benevolent confrontation" (n=40), Alanon facilitation (n=42); or Community Reinforcement and Family Training (CRAFT) (n=45). • 12 hour contact, manual guided, individual format	• Significant, sustained reduction in CSO's anger, depression, enabling behaviours & family conflict. • Significant, sustained improvement in family cohesion & relationship. • Significantly more drinkers engaged from CRAFT condition (64%) by 6 month's post CSO's intake.	• Qualitative data on family members' behaviour change. • Impact of drinkers' engagement on levels of consumption.

[2] Identified by researcher or current author

family members, followed by the legal system. Moreover, Polcin and Weisner found a strong correlation between severity of dependency and family and/or legal ultimatums.

However, long before drinkers are eventually coerced into treatment, a significant number of their partners (or other family members) are likely to have contacted an addiction treatment agency for help (Yates, 1988; Garrett, Stanton, et al. 1999). Tragically, a common response to these requests for help has been, "*You* can't do anything about it until *they* decide to contact us."

In an attempt to utilise the valuable resource of these motivated, co-operative "affected others", Yates formed a Co-operative Counselling Service to use them as intermediaries between the agency and resistant drinkers. Affected others were encouraged to identify the areas of interpersonal influence they had with their drinkers which could be used as sanctions and pressures to discourage unacceptable drinking and encourage non drinking behaviours. Yates reported that in 50% of cases (n=30), previously resistant drinkers decided to present for treatment.

Moreover, Garrett, Stanton, et al. devised another strategic method for utilising "concerned others" (COs) as leverage for the earlier identification of dependency problems and ultimately, the successful engagement of their drinkers into treatment (Garrett, Landau, et al. 1998). Initially, the Relational Interventional Sequence for Engagement (ARISE) method trained addiction therapists to sensitively collect background information from COs and assist them to decide how to go about convincing their drinkers to present for an assessment. If drinkers refused to cooperate, COs were offered support and information for themselves and others within their drinkers' close family/social network. At a later stage in the ARISE sequence, COs were assisted to design a strategy for engaging their drinkers in treatment. If necessary, the final ARISE sequence was a formal intervention (based on Johnson, 1973). According to Landau and Brinkman-Sull (1997), 90% of substance abusers who took part in the formal ARISE intervention decided to enter treatment.

Other planned, "benevolent confrontations" which harnessed the powerful influence of drinkers' families (Faber & Keating-O'Connor, 1991; Johnson, 1973, 1986; Liepman, 1993; Liepman, Nirenberg & Begin, 1989; Miller, Meyers & Tonigan, 1999) have also achieved excellent results, particularly when the level of stress in the intervention is low (Loneck et al. 1995). For instance, Liepman found 86% of treatment resistant drinkers so confronted decided to enter treatment, and Miller et al. (1999)

reported 70% of drinkers confronted in this manner presented for assessment plus one treatment interview. The family group received pre-intervention training in the form of education, communication skills, and the reduction of enabling behaviours.

A similar process was described by Lindquist (1986) to assist battered women to confront their estranged, excessively drinking husbands with the purpose of encouraging them into treatment. This approach involved co-opting the drinkers' children and other key people whom they respected. Lindquist attributed the success of this method to the expressions of warmth and affection which were not customarily shared with drinkers. Moreover, the potentially humiliating effects of the confrontation were mitigated by the overt expressions of care and concern.

However, the planned, benevolent confrontation approaches seem to have one major drawback. Despite the high proportion of drinkers who entered treatment as a direct result of these interventions, very few families groups (approximately 30%) decided to go through with it because they found it too threatening (Barber & Crisp, 1995; Liepman, 1993; Miller et al. 1999).

Barber and Crisp (1995), Barber and Gilberston (1994, 1995), and Barber, Gilberston, and Crisp (1997) have elegantly adapted, encapsulated, and improved the approaches by Azrin and Sisson (1986); Thomas et al. (1987), Thomas and Santa (1982), and Johnson (1973) into their Pressures to Change (PC) program. Based on learning and behaviour theory, the PC program was designed to teach relatives to advance their precontemplating drinkers through five sequential, increasing levels of pressure. Thus, drinkers were encouraged to contemplate the benefits of change (Prochaska & DiClemente, 1984) and make a decision to moderate their drinking and/or seek treatment.

The first level of pressure (feedback and information) provided partners with information and feedback on their test scores and aimed to maximise partners' motivation for change. The first level also prepared partners for frustrations and setbacks, and explained the principles of the PC approach. The second level of pressure (incompatible activities) advised partners to identify high risk drinking times and to plan incompatible activities to coincide with these times.

The third level of pressure (responding) advised partners how to vary their interactions according to whether their drinkers were drunk or sober, and how best to exploit a drinking related crisis. The fourth level (contracting) involved partners

negotiating contracts with their drinkers about reduced consumption. The fifth level (confrontation) was similar[3] to Liepman's (1993) "benevolent confrontation" approach as described in Section 3.2. Level 5 pressure also advised partners to write a personal statement to their drinkers outlining partners' love for their drinkers, feedback about the ways the drinking was diminishing the relationship, and a simple, unambiguous plea to change or seek help. The effectiveness of a simple letter asking drinkers to seek help had also been found by Batel, Pessione, Bouvier and Rueff (1995).

Barber and Crisp (1995) found almost 60% of partners using the Pressures to Change (PC) approach over a 5 week period reported their drinkers had made significant moves towards change; viz. drinkers had sought treatment, were abstinent for at least 2 weeks, or had reduced to a satisfactory level. However, despite this improvement in drinkers' behaviour, Barber and Crisp found no *significant* improvement in partners' subjective life satisfaction, nor significant reduction in partners' depression or marital discord.

Given the reluctance of most partners to apply the Level 5 confrontation approach, this was revised (Barber & Gilberston, 1995; Barber, Gilbertson & Crisp, 1997) and confrontation was renamed as "involving others." Partners were advised to enlist the support of their drinkers' close and trusted friends, and coach these friends in the application of each level of pressure, particularly Levels 2 and 3 (incompatible activities and responding). The personal statement partners were advised to write to their drinkers in the original Level 5 pressure was retained.

Whilst this revised procedure yielded similar results in terms of drinkers' reduced consumption or help seeking behaviour (Barber et al. 1997), significant improvements in partners' affective well being, and marital harmony were only achieved when the revised PC program was offered to partners *individually* rather than in a group format. Unfortunately, no follow up data was available to evaluate the durability of these improvements, and the authors did not report on the number of participants who dropped out, or failed to complete the intervention.

Miller, Meyers and Tonigan (1999), whilst working independently in the US, extended the work of Barber et al. (1997) in their randomised clinical trial which trained concerned significant others (CSOs) to "engage" their treatment resistant drinkers in 4

[3] Whilst Liepman thoroughly trained his partners, partners in Barber & Crisp's study were encouraged to apply the directions given in their manual. Barber & Crisp's partners were reluctant to use this approach

hours assessment plus at least 1 treatment session. Although Miller et al.'s primary goal was to engage treatment resistant drinkers, the interventions were also designed to benefit CSOs. Each of the three experimental conditions; i.e. Liepman's (1993) "benevolent confrontation", Alanon facilitation, and Community Reinforcement and Family Training (CRAFT) achieved significant, sustained improvements in CSO's psychological functioning.

However, the CRAFT intervention yielded substantially more treatment resistant drinkers being engaged than the other treatment groups (see Table 3.1). Whilst Miller et al. initially assessed CSO's "enabling behaviours", they did not report on the impact of treatment on these behaviours. Moreover, Miller et al. did not provide data regarding the impact of this engagement process on drinkers' consumption patterns. Interestingly, significant improvement in CSO's psychological functioning occurred regardless of drinkers' engagement. However, Miller et al. also did not report on the number of participants who dropped out, or failed to complete the intervention.

In a further, uncontrolled study, Meyers, Miller, Hill and Tonigan (1999), applied the CRAFT approach to CSOs (30% parents) of treatment resistant other drug users (e.g. marijuana, cocaine). This resulted in 74% of users (n=42) being engaged for an assessment. Moreover, 95% of these returned for their first treatment session, and continued on to complete an average of 8 (of the possible 12) treatment sessions. Over the 6 month follow up period, CSO's reports indicated that users who entered treatment showed significantly more abstinent days than users who did not enter treatment. According to Miller et al., the most important feature of the CRAFT intervention was the empowerment of CSOs with the *belief* that they could indeed make a difference to their loved one's drinking/other drug use. However, given Miller et al.'s study was uncontrolled these data must be viewed with caution.

Through incorporating a motivational style of interviewing, CSOs were made aware of the positive benefits of the CRAFT program, and were trained in (i) contingency management to extinguish their associates' drinking behaviour and reinforce non drinking behaviour; (ii) communication skills to improve relationships; (iii) strategies to interfere with their associates' drinking (e.g. competing activities); (iv) increasing their personal range of activities; (v) effectively handling dangerous situations; and (vi) suggesting counselling at appropriate times through positive expectations and reinforcement.

According to Miller et al. (1999) an important element which was missing in their research was the absence of qualitative data to describe *how* CSOs had *applied* the skills they had learned during the CRAFT program. The quantitative data did not answer the following vital questions:

- What were the qualitative changes in relatives' coping behaviour?
- What processes were underpinning these changes?
- What impact did "engagement" have on drinkers' levels of consumption?
- What was the impact of CRAFT on the consumption patterns of drinkers who were not "engaged"?

This deficiency in the literature has also been identified by Bogden and Bilken (1992) and Orford et al. (1998a). More particularly, they highlight the need to *combine* qualitative and quantitative information to answer the basic "hows" and "whys" of particular outcomes (Araya, 1995; Heath, 1995) to understand *what* research participants experienced, *how* they interpreted those experiences, and how they made sense of them (Ogborne, 1995). Clearly, the addition of qualitative information would considerably augment and enrich quantitative data. Moreover, this additional information would provide clinicians with valuable information to give to clients who are grappling with a treatment resistant drinker; viz. "There is research evidence that these program elements work, and this is how other relatives have used them to improve their situations."

Unfortunately, most researchers who have co-opted relatives of excessive drinkers as agents of change have paid scant attention to the separate needs of relatives. Only a few researchers have reported relatives' mental health and relationship status pre and post intervention (Barber & Crisp, 1995; Barber et al. 1997; Meyers et al. 1999; Miller et al. 1999), and very few (e.g. Dittrich, 1993) have provided data regarding relatives' pre and post intervention coping strategies. Moreover, according to Miller et al. (1999), interventions have typically lacked a theoretical base.

Notwithstanding these limitations, this chapter has traced the research evidence which suggests that relatives are indeed a valuable resource in enhancing their drinkers' treatment outcome and reducing drinkers' recidivism - at least in the short term. Whilst the durability of these positive effects is uncertain, the evidence is much more compelling (albeit limited) regarding the value of training relatives as *early intervention agents* to

strategically encourage their treatment resistant drinkers to reduce their consumption and/or seek help.

However, despite the growing evidence of the efficacy of this approach with relatives from both Australia and the US, the belief is still widely held (as evidenced by Australian governments' short term funding priorities) that working with the family is indeed a luxury, and efforts should only be directed towards drinkers who actually present for treatment. Given the resistance of the vast majority of drinkers to present for treatment until they experience serious health, legal, occupational, or relationship problems (and some do not even present then!), this approach has unwittingly enabled the relentless damage to drinkers, their families, and the community to continue. Moreover, when drinkers eventually *do* decide to present for treatment, their dependency is usually well entrenched and therefore more difficult to treat.

The evidence also seems clear that the interdependent coping and transactional patterns which develop between excessive drinkers and their relatives (particularly partners) are instrumental in the maintenance of drinkers' excessive consumption. Moreover, that children from these families are at elevated risk of developing alcohol related problems. Therefore, it is clearly in the best interests of the community, from a harm minimisation perspective, to intervene with relatives as early as possible, whether or not their drinkers reduce their consumption or seek help.

Because the focus of recent attention on relatives of excessive drinkers in the research literature has largely been within the context of engaging their resistant drinkers into treatment, there is a paucity of treatment programs specifically designed to address relatives' separate needs. The next chapter will explore the few programs described in the literature which have as their *primary* aim the improvement of relatives' mental health and coping status, without involving their drinkers in any way.

CHAPTER 4

Treatment for relatives in their own right

Until quite recently, the main emphasis in the literature has been how to successfully rehabilitate excessive drinkers. Moreover, when relatives (particularly partners) *were* included in the treatment process it was mainly to improve their drinkers' recovery prospects, or how to more effectively encourage their resistant drinkers into treatment.

However, many partners are much too exhausted to take even *more* responsibility for their drinkers' behaviour. They are primarily concerned about their *own* emotional survival (and that of their children) and many do not want to invest further in the marital relationship until their drinkers have maintained a longer period of abstinence. Moreover, they need time to get over their bitterness regarding their drinkers' destructive behaviour, and to rekindle some degree of trust (O'Farrell & Bayog, 1986).

The needs of families of excessive drinkers for "education, support, and therapy" were only *officially* acknowledged in the Australian *National Health Policy on Alcohol* in 1989. Since then, the National Drug Strategy's *Outlines for the Management of Alcohol Problems* (Mattick et al. 1993) advises, within a harm minimisation milieu, that it is a legitimate concern for addiction clinicians to work with families of excessive drinkers - if only to assist them to deal with their drinkers' behaviours.

Probably the first program which focussed primarily on the wellbeing of relatives of excessive drinkers began at Hazelden, Minnesota in 1972. This disease concept/family systems program was presented within a psycho-educational framework, with emphasis on active learning and mutual support (within the context of the Alanon program). The program aimed to improve knowledge of the effects of chemical dependency on the family, enhance self awareness and self worth, and improve relatives' confidence to change family dynamics. By 1986, Hazelden had extended the program and expanded their facilities to cater for an annual 1600 residents. According to Laundergan & Williams (1993) this treatment experience for relatives "served as a catalyst to bring about the beginnings of change" in their drinkers (see Table 4.2). However, no data was presented on this.

The first intervention program in Australia *primarily* oriented to the needs of families of excessive drinkers was begun in 1979 by the Australian Institute on Alcohol and Addictions in Perth, Western Australia (Binns, Dear, Knowles & Hall, 1989). Although originally modelled on the Hazelden family program (Laundergan & Williams, 1993), it rapidly developed in response to addiction research and particular community needs. According to Binns et al. (1989), their intervention was based on systems theory which placed thinking and behaviour within a social context, and emphasised personal responsibility and the principles of rational emotive therapy. This intervention produced significant, sustained improvements in participants' mental and physical health, as well as improved relationships between participants and their drinkers. However, Binns et al. did not obtain data regarding the impact of these changes on drinkers' consumption patterns, or changes in participants' coping strategies.

Another unpublished, uncontrolled Australian family program (Howells, 1981) which *primarily* targeted partners of treatment resistant drinkers was delivered by the present author in the Northern Territory of Australia. This program aimed to (i) increase partners' understanding of family dynamics; (ii) increase partners' awareness of their inadvertent contribution to the maintenance of these dynamics; (iii) to assist partners develop more effective and useful coping and problem solving skills; and (iv) to increase their drinkers' awareness of the serious impact their excessive consumption was having on the family.

A total of 60 women and 8 men (out of 86 starters) completed the program. Three months later, 63 were followed up by telephone. Not only did most participants report improvement in coping, problem solving, and self esteem, 20 also reported *positive outcomes for their drinkers*. Some had presented for counselling and/or alcohol dependence treatment, whilst others were attending AA or had stopped drinking on their own. Moreover, 8 of the remaining 35 participants who reported no reductions in drinking, said their relationship had improved, and the drinking was no longer disrupting the family.

Six months post program, 54 participants (75%) were followed up by telephone. They reported that the number of drinkers who had maintained their reduced consumption had halved (20 to 10), and the remaining 44 participants (81%) reported

no change in their drinkers' consumption. However, the number of participants from this "no reductions" group who had reported no deleterious impact of the drinking on family harmony had more than doubled between 3 and 6 months post treatment (see Table 4.1). Some participants also reported improvement in their children's behaviour at home and at school.

Despite the methodological limitations (including no follow up of people who did not complete the program), it seems reasonable to surmise that this program had considerable promise in facilitating improvement in relatives' problem solving/coping skills *as well as* being an effective early intervention tool.

Table 4.1
Unpublished results of an uncontrolled family program conducted by the current author in the Northern Territory of Australia (1981)

	Number of Participants	Drinking moderated or ceased	Drinking unchanged but family disruption reduced
Participants commencing program	86		
Participants completing program	68 (80%)		
Follow up at 3 months	63 (93%)	20 (32%)	8 (13%)
Follow up at 6 months	54 (75%)	10 (19%)	18 (33%)

One of the early models for addressing the special and separate concerns of wives of alcoholics from a feminist perspective was devised by Burnett (1984). Burnett castigated the earlier, sexist literature for blaming "wives as highly neurotic contributors to their husbands' illness" (p 51), and for continuing to utilise wives as mere adjuncts to their husband's treatment process, despite the deleterious impact of alcoholism on the family. Burnett's 8 steps of treatment aimed to widen wives' options by providing them with information, encouragement and support; viz.

- Information regarding the illness concept of alcoholism in the form of metaphors, examples, and anecdotes to encourage partners to "buy the idea without resistance" (p.59);

- The need for wives to disengage themselves from the struggle to control their husbands' drinking;
- The reduction of wives' frustration and anger, and the increase of wives' self esteem through giving up other "home remedies" such as rescuing their husbands and making excuses for them;
- The need for wives to pay attention to their own feelings, needs and goals;
- Assisting wives to become emancipated through becoming more financially independent;
- Assisting wives to increase their level of support through friends, Alanon, and parent groups, and assisting wives to emancipate their children by ensuring they do not assume inappropriate responsibilities for their excessively drinking fathers;
- Supporting wives if their drinkers remain resistant to treatment despite the changes wives have made; and
- Assisting wives who wish to extricate themselves from their marriages which can no longer provide the essential love, intimacy, trust, dependability, and emotional stability that wives deserve.

Honig and Spinner (1986) also viewed the treatment of partners in their own right as essential, and devised a four phase, group program (based on Jackson, 1954) which aimed to assist partners to "lead independent, productive and gratifying lives" (p.95). The four phases of treatment dealt with partners' attempts (due to the stigma of alcoholism) to deny the problems in their families; provided education to raise partners' awareness of alcoholism and the need to change certain aspects of their own behaviour; encouraged partners to express their feelings about the effects of alcoholism on their lives; and assisted partners to set goals for the future.

Although there is a paucity of research regarding the *intervention* value of working with partners of excessive drinkers in their own right, there is clear (albeit limited) evidence that this approach may indeed be useful (see Table 4.2). For instance, although Dittrich (1993) *primarily* worked with partners in their own right, she also provided them with information regarding effective strategies to encourage their treatment resistant drinkers into treatment. Dittrich's approach was psycho-educational, based on Alanon principles, and primarily tried to reduce partners' "enabling" behaviours" through (i) education regarding alcoholism, co-alcoholism, and family

dynamics; (ii) management of feelings and assertive communication; and (iii) goal setting, and planning for the future (including separation if drinkers did not enter treatment).

Dittrich achieved significant positive mental health gains for the wives, and 48% of their previously treatment resistant husbands had entered treatment during the 12 months following their wives' treatment (see Table 4.2). However, Dittrich did not clarify which was the active ingredient in her program's success in encouraging 48% of drinkers into treatment; partners' education, improved confidence, assertiveness, and reduced enabling behaviours; or the threat of divorce. Nor did she provide information regarding drinkers' consumption patterns.

All of the programs described in this chapter have been primarily designed to improve the mental health and coping status of relatives of excessive drinkers in their own right - whether or not their drinkers were in treatment. However, only Binns et al. 1989,[1] Howells, (1981)[2] and Dittrich (1993) provided pre and post intervention data on the effectiveness of their programs (see Table 4.2). Moreover, only Dittrich (whose secondary aim was to encourage treatment resistant drinkers into treatment) provided data on the impact of partners' treatment on their drinkers. However, none of these researchers provided data regarding the number of people who did not complete the intervention.

[1] An unpublished Master's dissertation
[2] An uncontrolled study

Table 4.2
Examples of programs focussing primarily on the needs of relatives of excessive drinkers

Programs	Methodology	Findings	Further research needed[3]
Hazelden Family Program 1977-1979 Laundergan & Williams (1993), US *Aims* (i) improve knowledge of the effects of chemical dependency on the family; (ii) enhance self awareness and self worth; and (iii) improve confidence to change family dynamics	• Sample of total participants from two 12 month periods • n=1068 • Self report inventory pre/post program & 6 month follow up	• Significant cognitive and attitudinal change (i.e. "correct" answers to inventory questions)	• Comprehensive outcome data for participants • Data regarding drinkers' consumption patterns or help seeking behaviour
Codependent's Program Binns, Dear, Knowles & Hall, 1989 AUSTRALIA *Aims:* (i) increase family member's understanding of family dynamics ; (ii) understanding role in maintaining these dynamics; (iii) develop appropriate coping & problem solving skills	• Quasi experimental design • 1 treatment group and control • 12 sessions • n= 172 completed program (from 287) • 20% male participants • Pre/post program and 9 month follow up	• Women presented with higher levels of ill health, depression, psychiatric disturbance than men • Significant improvement in self esteem • Significant reduction in ill health, depression and psychiatric disturbance • Both men and women made significant gains in quality of relationship with the problem drinker	• Data regarding participants' coping strategies • Data regarding participants' processes of change • Data regarding drinkers' consumption patterns or help seeking behaviour
Group Program for Wives of Alcoholics Dittrich, 1993, US *Aims* (i) increase understanding of alcoholism and family interactions; (ii) identify and decrease their own enabling behaviours; iii) develop more useful coping strategies; and (iv) positive plans for future	• Random assignment to experimental group (n=10) and wait list control (n=13) • 8 sessions • Pre/post measures • Telephone follow up at 12 months	• Significant improvement in self esteem • Significant reduction in anxiety, depression and enabling behaviours • "overwhelming" improvement in knowledge re alcoholism, ability to express feelings, assertiveness, and awareness of options • 48% of drinkers had entered treatment • 39% of partners had separated from their drinkers	• Qualitative data regarding participants' coping strategies • Data regarding participants' processes of change • Data regarding associates' consumption patterns • Data regarding relationship between participants and drinkers • More comprehensive follow up data

[3] According to researchers and/or current author

Despite the limited number of studies, small sample sizes, and methodological limitations, the positive "spin off" on drinkers as a result of improving their partners' mental health and coping status is indeed promising. However, it is important to note that even though positive changes in how partners handled their situations seem to have *facilitated* their drinkers' reduced consumption or engagement in treatment, this in no way suggests that partners are in any way *responsible* for their drinkers' behaviour. It merely highlights the importance of partners' contributions to the dependency syndrome (as distinct from blame), as well as the considerable *influence* partners can have within the family environment.

Given that one purpose of this thesis was to examine whether improving partners' mental health, coping, and relationship status (for their own benefit) had a positive "spin off" impact on their drinkers' consumption, the next chapter has outlined the nature of change (and in particular how this may apply to excessive drinkers) from the viewpoint of Prochaska and DiClemente's (1984, 1988) transtheoretical theory of change. This is perhaps the most influential and predominant theory of change in the literature which examines the stages through which people move as they begin to consider the *possibility* of changing their problematic behaviours. This theory describes how people prepare themselves to take action, and how their decisions to take action are most successfully maintained. The next chapter has also explored how the transtheoretical theory of change might apply to partners of excessive drinkers as they attempt to disengage themselves from the interdependent stress, coping and transactional patterns which seem to have developed between themselves and their drinkers.

CHAPTER 5

The process of change: moving from not thinking about it to taking action

In recent years, the psychological treatment of addictive behaviours has come to be dominated by the transtheoretical approach to change developed by Prochaska & DiClemente (1984; 1988), and Prochaska, Norcross and DiClemente (1994). Their three dimensional, transtheoretical model has emerged from painstaking follow-up research with self changers (DiClemente & Prochaska, 1982) and clients involved in various forms of psychotherapy (Prochaska, 1979; Prochaska & DiClemente, 1984). Prochaska and DiClemente attempted to integrate the stages, processes and levels involved in the process of change. Not only has this model been used to understand, describe and encourage change in alcohol addiction, it has also been used with heroin (e.g. Tejero, Trujols & Hernandez, 1997), tobacco (e.g. Ruggiero, Redding, Rossi & Prochaska, 1997), obesity (e.g. Suris, Trapp, DiClemente & Cousing, 1998), and even HIV/AIDS (e.g. DiClemente, 1993).

The transtheoretical model of change draws on the essential tenets of many diverse theories of psychotherapy. It has been tested, revised, and improved through scores of empirical studies, and is currently in use by professionals around the world (Prochaska, Norcross & Di Clemente, 1994). Under this model, people who successfully change their addictive behaviours generally pass through 6 stages of change. Prochaska, Norcross and DiClemente (1994) have termed these stages precontemplation, contemplation, preparation, action, maintenance, and termination.

Although it is these stages of change which have predominantly caught the imagination (Davidson, 1992) and provided an understanding of the "how" of change (Miller, 1998), it is also important to note the nine major processes of change as described in *Changing for Good* (Prochaska, Norcross & DiClemente, 1994, p.33) and which processes of change are most useful within each stage of change (see Tables 5.1 and 5.2)

Table 5.1

Major processes and associated behavioural goals involved in changing addictive behaviours (Prochaska, Norcross, & DiClemente, 1994)

Processes of change	Behavioural goals
Consciousness raising	• Increasing information about problem and its impact upon self and others.
Helping relationships	• Enlisting the help of someone who cares.
Emotional arousal	• Experiencing and expressing feelings about one's problems and solutions.
Social liberation	• Increasing non-problematic social alternatives for problematic behaviours; e.g. societal change, self help groups, increased family activities.
Self re-evaluation	• Assessing feelings and thoughts about self with respect to a problem.
Commitment	• Choosing and committing to act, or belief in ability to change.
Countering	• Substituting alternatives for problem behaviours.
Environment control	• Avoiding stimuli that elicit problem behaviours.
Rewards	• Rewarding self, or being rewarded by others for making changes.

Table 5.2
Stages of change in which particular processes of change are most useful (adapted from Prochaska, Norcross & DiClemente, 1994, p.54

Precontemplation	Contemplation	Preparation	Action and Maintenance
• Consciousness raising • Constructively helpful relationships	• Consciousness raising • Constructively helpful relationships • Emotional arousal • Self re-evaluation	• Constructively helpful relationships • Emotional arousal • Commitment • Self re-evaluation • Social liberation	• Constructively helpful relationships • Commitment • Countering • Environment control • Reward • Social liberation

5.1 How do people move from precontemplation to thinking about the need for change?

According to Prochaska, Norcross and DiClemente (1994), excessive drinkers will not advance from precontemplation into the contemplation stage of change without some form of intervention. The goal of intervention is to assist people to *understand* what is happening to them, to *see* they have a problem they might *think* about changing. However, before an intervention can take place, at least two processes need to be operational; viz. (i) raised consciousness regarding how the excessive use is affecting them and those closest to them, and (ii) a constructively helpful, caring and supportive environment.

(i) Consciousness raising

People who are dependent upon alcohol seem to have constructed a double brick wall of defences which enables them to avoid their emotional pain and the full consequences of their behaviour by minimising, making excuses, blaming others, and often projecting their bad feelings onto others. When others (e.g. partners) behave in ways which reinforce the validity of these defences (e.g. accepting the blame for their drinkers' feelings and behaviour, and therefore accepting the responsibility for fixing them), they are in fact shielding drinkers from the truth. While excessive drinkers continue to successfully blame others for their plight, the reality of their situation will not become part of their conscious awareness. Therefore, without consciousness raising, there is no hope that they will even entertain the need to change their *own* behaviour (only the behaviour of others). On the other hand, relatives who take action by providing their drinkers with information about the problem, and establish contingencies that they seek help, are positively contributing to the consciousness raising process (McCrady, 1986).

Although some excessive drinkers have cited their families, deteriorating financial situations, changes in marriage or work situations, religion, or the intervention of their GPs as important elements in their decisions to reduce consumption (Orford & Edwards, 1977; Saunders & Kershaw, 1979; Tuchfeld, 1981), many continue to use excessively despite the accumulating evidence that they should do otherwise. Clearly, logic and reasoning are not always sufficient to facilitate change.

(ii) Constructively helpful, caring and supportive relationships

Typically, excessive drinkers feel under attack because they are constantly behaving in ways which result in considerable recriminations from their relatives (particularly partners) and demands for them to change. Therefore, not only do they *need* a strong wall of defences to protect themselves and their dependency from the reality of their situation, they also need to protect themselves when their relatives react with frustration, anger, verbal (and sometimes physical) abuse. There is not much hope drinkers will lower their defences and make themselves vulnerable when they are living in a milieu which closely resembles a war zone.

Excessive drinkers will only be able to divert their energy into thinking about the need for change when they do not have to protect their position from attack. The kind of relationship which will facilitate this process is one which is honest, caring, encouraging, *constructively* supportive and does not judge, blame, abuse, or "push drinkers too prematurely into action": action without sufficient insight is doomed to be temporary (Prochaska, Norcross & DiClemente, 1994).

5.2 How do people move from contemplation into the action stage of change?

The process of consciousness raising and the creation of honest, constructively supportive, helpful relationships is likely to encourage drinkers to talk more freely about themselves and their problems, and may even result in them being more open and willing to learn about dependency. However, although contemplators may often *want* to change their excessive consumption, alongside this desire is an equally strong resistance to taking the necessary action: this illustrates the compulsive nature of alcohol addiction.

Given the central importance of alcohol to drinkers' emotional survival and the maintenance of the defence system, many say they are terrified of not being able to function properly and comfortably without the support of their loyal and trusted friend – alcohol. However, if excessive drinkers are given the opportunity to confront their issues, and process the emotional pain which will undoubtedly emerge, they may gradually begin to understand their behaviour and why things are the way they are in their lives. Given this honest, constructive environment, drinkers have the best chance

of developing the crucial belief (and hope) that they can indeed face their fears and do something positive about resolving their problems.

This major shift in belief and hope enhances drinkers' abilities to re-evaluate themselves, confront their dilemmas and conflicts (Bandura, 1989; Janis & Mann, 1977) and make conscious decisions regarding the costs of continuing their excessive drinking. The combination of belief, hope, self efficacy (1977a; 1977b; 1986; 1991), and the emotional arousal achieved by confronting the painful, often humiliating reality (Tuchfeld, 1981) of their situations gives contemplators the necessary energy, resolve and commitment to propel themselves through the preparation stage of change into the action stage.

Moreover, the gradual emergence of *positive* emotions associated with a caring, supportive, encouraging environment are also important in generating and reinforcing drinkers' hopes and beliefs that change is indeed possible. Orford (1986) highlights the important moral and spiritual dimensions of change which are included in the "successful, widespread, and ever-growing" Alcoholics Anonymous program; e.g. self examination, acknowledgment of character defects, restitution for harm done to others, and sharing personal hope, strength, and experience with others. Continued enactment of these "recovery" behaviours, combined with vicarious experience and verbal persuasion are of vital importance in the development of self efficacy. Moreover, self monitoring, realistic appraisal of behavioural outcomes, modelling from others successfully applying the program for change; and the growing belief in one's ability to exercise control over events enhances and promotes motivation, self regulatory behaviour and commitment (Bandura, 1977a; 1977b; 1989; 1991; Miller, 1989; Miller, 1998; Miller, Benefield & Tonigan, 1993; Miller & Heather, 1996; Miller, Westerberg, Harris & Tonigan, 1998).

5.3 How do people maintain their decision to take action?

According to Prochaska, Norcross and DiClemente (1994), it is essential to maintain, reinforce, and expand the raised awareness, supportive relationships, emotional arousal, and self re-evaluation processes so important in creating a milieu for change. However, they caution people that thorough preparation is essential to successfully navigate the hazards lurking in the action stage of change. The role of the family during the

preparation stage is extremely important as it gives drinkers the opportunity to experience the many positive interpersonal rewards which result from their changed behaviour. This enables drinkers to experience an energising, motivating vision of the future which reinforces and increases their commitment to maintain their action plan - and also strengthens the self liberating belief that they can actually achieve it. Table 5.3 outlines the range of strategies identified by Prochaska, Norcross and DiClemente as being important in the maintenance of change.

The stages of change described by Prochaska, Norcross and Di Clemente (1994) illustrate *when* shifts in attitudes, intentions, and behaviours occur, and the processes of change describe *how* these shifts occur. On the other hand, Miller (1989; 1998), Miller & Rollnick (1991), and Miller, Westerberg, Harris & Tonigan (1996) have explained the "why" of change and *how* people develop a "state of readiness for change." This is crucially important because as Heather (1992) has pointed out, addictive problems are essentially motivational problems.

5.4 What motivates people to take action and maintain their changed behaviours?

Miller (1989) has highlighted the important correlation between motivation and *compliance*, and defines motivation as "not something one *has* but rather as something one *does."* Moreover, motivation involves "recognising a problem, searching for a way to change, and then beginning, continuing, and *complying* with that change strategy." It seems to be essential that individuals "*do something* to get better"

Table 5.3
Strategies for maintaining the action stage of change (adapted from Prochaska, Norcross & DiClemente, 1994)

Substitute healthy responses for problem behaviours	• Active diversion - refocus energy and keep busy • Exercise to improve body image, self image, and self esteem • Relaxation to increase energy, waves, decrease anxiety, and improve sleep, health, and concentration • Challenge the self talk which triggers problematic behaviours • Assertiveness to clearly communicate thoughts, feelings, wishes and intentions to counter helplessness
Nurture caring & supportive relationships	• Seek confidential, professional help • Nurture existing friendships, and create new ones

	• Share feelings, hopes, fears with trusted friends
Create a more personally helpful environment	• Take responsibility for personal feelings & needs • Take responsibility for the quality of personal life • Rekindle previous interests and begin new activities
Reward personal efforts to maintain change	• Reward personal efforts as goals are gradually achieved • Tell trusted friends of personal progress • Be pleased with personal progress
Continue to re-evaluate personal situation	• Be mindful of personal goals • Set additional goals as necessary • Maintain and sustain personal progress

Moreover, the "doing something" is a general predictor of change - particularly with resistant clients (e.g. Meyers, et al. 1999; Miller, 1989; Miller, et al. 1996). According to Miller (1989), it is no longer necessary to wait until resistant, drinkers hit a disastrous "rock bottom" which may motivate them to do something about their situations. Instead, motivational interviewing principles have been found to be most effective and efficient in raising that rock bottom to a "high bottom" (Miller, 1983; Miller & Rollnick, 1993; Noonan & Moyers, 1997; Rollnick & Miller, 1995).

Miller (1998) highlights the crucial role of the therapist in creating a therapeutic milieu in which clients' motivation to change can emerge and develop. For instance, a confrontational therapist style is closely associated with problem drinkers' increased denial and resistance (Miller, Benefield & Tonigan, 1993) and actually impedes change.

On the other hand, a more empathic style results in less resistance and accelerated change. Prochaska, Norcross & DiClemente (1994, p.94) have also stressed the danger of relatives trying to push their precontemplators into action too prematurely by nagging, enabling, or just giving up on them. These reactions significantly damage the relationship and thus reduce the likelihood of change. It is indeed crucial that individuals are confronted by their *problems* and not by confrontational relatives.

Miller (1998) has embodied in the acronym **FRAMES** the important elements of brief "motivational intervention" which are important when working with clients who are "not ready" to change; viz. **F**eedback of personal status; emphasis on personal **R**esponsibility for change; **A**dvice to change; offering a **M**enu of approaches by which change might be achieved; an **E**mpathic counselling style; and messages supporting client **S**elf-efficacy for change. According to Miller, an individual's belief in his/her

ability to change is an essential prerequisite for change, and self monitoring is also an important element. Moreover, enhanced self efficacy (e.g. by training in effective coping strategies) seems a promising place to look in trying to understand what triggers change. In support of this, Satir (1988) claimed that people make changes and allow themselves to grow according to how they accept and value themselves.

However, before motivational intervention, or motivational interviewing can be utilised, clients must be at least prepared to present for their "Drinkers' Check-up" (Miller, 1989), be willing to discuss their issues face to face, and have some degree of ambivalence for the clinician to target and exploit.

Although the literature is replete with information about treatment and relapse prevention methods using motivational interviewing in tandem with Prochaska & DiClemente's (1984; 1986) model of change, the central problem still remains: how to bring *resistant* drinkers to a point where they will be prepared to even contemplate change let alone expose themselves to the benefits of motivational interviewing.

As pointed out by Barber & Crisp (1995), a recent and influential book on the treatment of addictions (Miller & Heather, 1986) based entirely on Prochaska & DiClemente's (1984; 1986) change model contained not one chapter on working with precontemplators. Similarly, motivation is not even listed in the index of "Changing for Good" (Prochaska, Norcross, & DiClemente, 1994).

5.5 The relevance of these models of change and motivation to relatives of excessive drinkers

Given that these theories of change and motivation previously discussed have been found to apply across many addictive behaviours, it is likely that the same principles will also apply to relatives of excessive drinkers as they progress through their own processes of change. It is reasonable to assume that as relatives learn about their contribution to the maintenance of dependency, gradually replace their ineffective coping strategies with more effective ones, the level of discord between themselves and their drinkers is likely to reduce. Moreover, as relatives continue to focus on their *own* needs and issues, and gain more control over their *own* behaviour (as opposed to trying to control their drinkers' behaviour), their sense of self efficacy and personal empowerment is likely to increase.

Moreover, the second order change involved in this process of de-enmeshment would result in relatives changing their expectations, perceptions, and feelings (Satir, Banmen, Gerber & Gomori, 1991). To make this transformation process possible, relatives may need to validate and return to their own basic yearnings or longings to be loved, accepted, validated and confirmed - not only by others but also by themselves. Relatives who actively pursue this goal, create a personal milieu which promotes enhanced self esteem, congruence as a way of being, healthy patterns of coping, and the ability to love self and others.

In view of the evidence which suggests that a non confrontational therapist style is associated with lowered resistance and improved motivation to at least exploring the need for change, it is likely that a non confrontational relationship between resistant drinkers and their relatives may produce the same result. Moreover, if the relationship between drinkers and their relatives was so improved, some of the **FRAMES** elements in motivational intervention may also be activated; e.g. **F**eedback of personal status (relatives' assertive coping style); emphasis on personal **R**esponsibility for change (relatives' relinquishing inappropriate responsibility for drinkers); **E**mpathic relationship style; and messages supporting **S**elf-efficacy for change (relatives' encouragement and supportive coping strategies).

It seems reasonable to assume that if relatives of excessive drinkers maintained their sense of empowerment and self efficacy, that the altered dynamics would produce a milieu much more conducive to change. Without relatives enabling the interdependent coping patterns to continue, drinkers' systems of defences would be much less effective in protecting and shielding them from the reality of their situations. Moreover, it would be far more difficult for them to successfully blame their relatives' nagging and controlling behaviours for their parlous plights, and the controlling/denial trap (Miller & Rollnick, 1991) would be likely to be dismantled.

Therefore, this period of instability is likely to provide a valuable opportunity for drinkers to confront the severity of their situations. Perhaps, as drinkers notice their relatives' ability to change their own reactive behaviours, a belief (and indeed a hope) may be fostered in drinkers that too may be able to successfully tackle their own difficulties. Thus, the processes of change and motivational milieu which are most effective in encouraging precontemplators to consider the need for change, as well as progressing contemplators towards making a decision to change, are likely to be

unintentionally created and facilitated by relatives who are focussing on their *own* needs, feelings, and responsibilities.

This chapter has outlined the stages and processes of change which seem to be operational as excessive drinkers move from being oblivious to the need to change (precontemplation) through maintaining their decisions to take action. However, these stages and processes of change only explain the *when* and *how* of shifts in drinkers' attitudes, intentions, and behaviours. Given this study was interested in the possible "spin off" impact on treatment resistant drinkers as a *consequence* of their relatives' improved mental health, coping, and relationship status, motivational aspects of change were also explored. This highlighted the central difficulty of how to stimulate, motivate, and encourage precontemplating drinkers who refuse to present for a motivational interviewing session.

Therefore, the change processes which are likely to be operational as relatives disengage from the interdependent stress, coping and transactional patterns have been explored, as well as the motivational impact of this disengagement on their drinkers. It was proposed that subsequent improvements in relatives' mental health, coping, and relationship status may indeed create the necessary processes of change and motivational milieu crucial to the movement of drinkers out of the precontemplation and contemplation stages of change.

The next chapter will examine the conceptual framework from which various therapeutic elements can be derived to empower relatives to improve their mental health, coping and relationship status. However, given the transactional nature of their relationships with their drinkers, the empowerment process is likely to facilitate a positive "spin off" impact upon their drinkers' behaviour.

CHAPTER 6

The empowerment process for relatives of excessive drinkers

Relatives (particularly partners) of excessive drinkers suffer considerable stresses and strains which have deleterious impact upon their mental health and coping status, and marital relationships (e.g. Barber & Crisp, 1995; Collins, Leonard & Searles, 1990; Crisp & Barber, 1995; Meyers, Miller, Hill & Tonigan, 1999; Miller, Meyers & Tonigan, 1999; Orford, 1990, 1992, 1994, 1988b, 1998a, 1998b; Velleman et al. 1993). However, whilst drinkers' consumption and unacceptable behaviour *per se* are undoubtedly major contributors, relatives also make a considerable contribution as they become entangled in the stress, coping and transactional patterns which develop within the family system.

Given the reluctance of many drinkers to reduce their consumption and/or seek help, it is likely that many relatives will remain in this chronically stressful environment, hoping that one day their drinkers will "see the light" and do something which will "fix" the family problems. Therefore, to reduce the level of community harm, it is vital to intervene with relatives in their own right, whether or not their drinkers decide to take action.

The purpose of this chapter has been to:

- Present the conceptual framework underpinning these psychological sequelae (derived from the general literature);
- Summarise the empirical evidence regarding the pre-intervention mental health status, marital discord, and ineffective coping patterns besetting relatives of excessive drinkers;
- Outline the range of therapeutic interventions suggested by the general literature;
- Select the most appropriate interventions to improve the mental health, coping and relationship status of relatives of excessive drinkers in particular;

- Construct an "ideal" program from the range of interventions suggested by the literature which would empower relatives of excessive drinkers to disengage from the stress, coping and transactional patterns which develop between themselves and their drinkers; and
- Explore the likely impact of relatives' empowerment process on their treatment resistant drinkers.

6.1 The mental health status of relatives of excessive drinkers prior to intervention: the empirical evidence

Relatives (particularly partners) of excessive drinkers enter into their relationships with excessive drinkers with a variety of experiences gained throughout their childhood and adult lives. Depending upon the nature of those experiences (and their reactions to them), relatives are equipped with various degrees of emotional resilience or vulnerability. Moreover, they have developed a variety of skills (emotional, cognitive and behavioural) to assist them to deal with the stresses and strains of Life. However, the experience of living with an excessive drinker is extremely harrowing, and seriously challenges the mental health and equilibrium of even the most resilient individuals.

6.1.1 Relatives' experiences prior to their current relationship with their drinkers

Some relatives, particularly those who were raised in problem drinking families or families which were chaotic, unsupported, and/or abusive, are likely to carry a legacy of emotional and social problems into later life (e.g. Beardslee, Son, & Vaillant, 1986; Black, Bucky, & Wilder-Padilla, 1986; Hart & McAleer, 1997; Orford & Velleman; 1991). However, the majority of children of alcoholics (Werner, 1986) seem to develop considerable resilience, adaptiveness, and coping strengths *despite* their distressing childhoods. Whilst Kagan (1998) has acknowledged the *influence* of negative early childhood experiences on current mental health status he emphasised the power of context, human malleability and variability to respond to different emotions and circumstances"; i.e. the capacity for resilience.

During adult life, this capacity for resilience may be further challenged and honed by various other negative events (as well as positive ones); e.g. physical or mental illness, problematic partners, and abusive experiences. However, due to the dynamic operation of the stress/coping/transactional model (see Chapter 2.6), each interaction presents an opportunity for individuals to modify their unique set of beliefs and assumptions, and adjust their coping skills and strategies - more or less adaptively.

Thus, relatives (particularly partners) enter into their relationships with problematic drinkers variously equipped with a mental health status which is more or less resilient or vulnerable. When they eventually present for help (usually some years later), they have been described by the empirical evidence (e.g. Barber & Crisp, 1995; Hand & Dear, 1994; Holmila, 1994; Orford, 1990; Orford, 1994; Orford et al. 1998a; Watts, Bush & Wilson, 1994) as a high risk, chronically stressed group who are exposed to a wide range of negative experiences. These stresses and strains have been summarised in Figure 6.1 and have been grouped together in five general areas; viz. (i) stress/anxiety; (ii) depression; (iii) low self esteem[1] & guilt; (iv) marital discord and disturbance; and (v) ineffective coping.

6.2 The conceptual framework underpinning relatives' stresses and strains

As illustrated in Figure 6.1, recent empirical and qualitative evidence has confirmed that relatives (particularly partners) of excessive drinkers experience considerable stress/anxiety, depression, low self esteem and guilt, marital disturbance, and usually employ ineffective coping strategies. This section will explore the general psychological literature relative to each of these disturbances. It will then present a derived,

[1] Given the good correlation between self esteem and depression (Barber & Crisp, Binns, Dear, Knowles, & Hall, 1989), self esteem was not measured separately. This was to keep the questionnaire package as brief as possible to improve participants' compliance

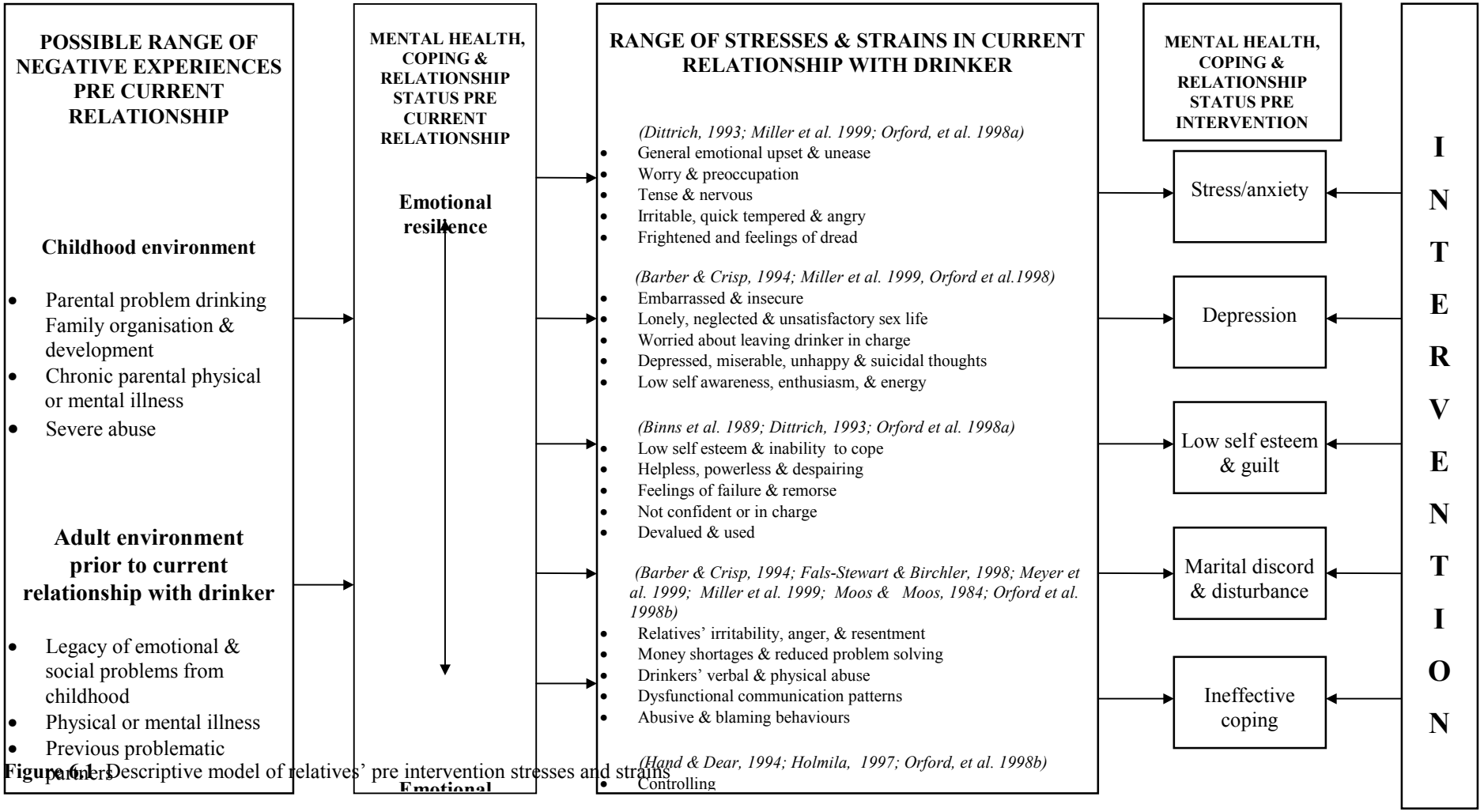

Figure 6.1 Descriptive model of relatives' pre intervention stresses and strains

conceptual framework which has been used to identify the nature of intervention elements deemed by the literature to be appropriate to assist relatives to improve their mental health, coping, and relationship status.

Each of the five stress and strain induced factors identified in Figure 6.1 have been discussed in relation to the treatment implications derived from the examination of the general literature.

6.2.1 Stress/anxiety

According to Allen (1998) and Rice (1992), stress needs to be described in at least three ways Firstly, stress may refer to any noxious external event or environmental stimulus (or stressor) which causes people to feel tense or aroused; i.e. out of homeostatic balance. Secondly, Cannon (1932), Rice (1992) and Allen (1998) have described stress as the body's physical reaction to demand, damaging, or dangerous situations. Thirdly, Allen (1998), Lazarus, (1984; 1993), & Rice (1992) described stress as the internal, mental state of tension, arousal, or response due to individuals' *interpretive, emotive and defensive* coping processes when faced with external stressors within a certain context (Rahe, 1995). These responses include feelings, thoughts, beliefs, attitudes; expectations of coping ability, and the likely consequences.

It is clearly possible to apply these findings to the situations of relatives of excessive drinkers (e.g. Barber & Crisp, 1995; Miller, Meyers & Tonigan, 1999; Maclaine, 1988; Orford et al. 1998a; Wegscheider, 1981). Relatives living in chronically stressful environments become adept at regulating their own behaviour (often neglecting their own needs in the process) to prevent critical comments from their drinkers which inevitably result in arguments. For example, partners may decide not to see certain friends because their drinkers do not like them, or may keep their houses spotlessly clean to avoid criticism from their drinkers.

According to Orford et al. (1998b) and Holmila (1997), relatives of excessive drinkers typically deal with their situations by employing 3 major coping positions; viz, engaged, tolerant, or withdrawal. An engaged coping position describes behaviours which directly confront drinkers' unacceptable behaviour in ways which are more or

less controlling, emotional, assertive, or supportive. Thus, when relatives are engaged, they "fight" more or less assertively. On the other hand, relatives who adopt the tolerant or withdrawal coping positions tolerate their drinkers' behaviour in ways which are more or less inactive, accepting, sacrificing, supportive, or withdrawing (see Table 2.1).

According to Lazarus (1993) and Rice (1992), when cognitive, physical and behavioural coping resources have been "taxed to the limit", people usually say things like, "I just can't take this pressure any more", or "I just feel like giving up". These are the signs of cracks in the defensive armour and reflect the strain that accumulates whilst enduring chronic stress. It is likely to be at this point that people decide to present for help.

Thus, stress is an interactive, transactional process (Folkman & Lazarus, 1980; Lazarus, 1993; Lazarus & Folkman, 1984; Newton, 1995) between the person and their environment. Just as the term stressor refers to forces bearing down on a person, stresses and strains (or wear and tear) refer to the combined psychological and physiological effect of that pressure within the person. Whether stresses and strains are detrimental to physical and/or mental health or foster growth through challenge, depends on the individual's appraisals and interpretations of the demands of the situation and also his/her available resources.

It is virtually impossible to distinguish stress from anxiety because both refer to the *subjective psychological result* from environmental pressure which involves a primary appraisal of the potential threat and a secondary appraisal of the adequacy of the available resources (Allen, 1998; Folkman & Lazarus, 1980; Lazarus, 1993; Lazarus & Folkman, 1984; Rice, 1992). If the individual concludes his/her resources are insufficient to overcome the threat, avoidant physiological and behavioural reactions will be triggered. On the other hand, if the individual perceives the "threat" as irrelevant and benign, anxiety/distress reactions will not be triggered. The central notion of this cognitive model is that it is not the negative event *per se* which *causes* anxiety or stress, but rather the appraisals, expectations, interpretations, and meanings which individuals assign to problematic situations (Andrews, Crino, Hunt, Lampe & Page, 1994; Clark & Steer, 1996; Salkovskis, 1996).

The stress/anxiety experienced by relatives of excessive drinkers (see Figure 6.1)

It has been generally acknowledged (e.g. Hand & Dear, 1994; Orford, 1994; Orford, 1988b; Orford et al. 1988a & 1998b; Troise, 1995; Watts, Bush & Wilson, 1994) that the stress related health problems detected in relatives of excessive drinkers are nothing more than a normal reaction to the compound, chronic stress involved in trying to cope with the family conflict generated by their drinkers' disruptive behaviour. As relatives' general emotional unease becomes more pronounced, they become worried and preoccupied about how to solve their family problems (Barber & Crisp, 1995; Orford et al. 1998a). Relatives attempt to prevent further drinking episodes, or compensate for them when they do occur (Rychtarik, Carstensen, Alford, Schlundt & Scott, 1988; Thomas & Agar, 1993).

As a result, relatives (particularly partners) tend to become entangled in the interdependent stress, coping and transactional patterns which seem to develop between themselves and their drinkers (see Chapter 2.2), and they become taxed to the very limit. Eventually, this emotional load becomes too great and relatives react with irritability and anger. Moreover, given they perceive their situation to be uncontrollable, they become frightened of the consequences and face the future with helplessness and dread (Orford et al. 1998a).

6.2.2 Depression

Depression is a common result of chronic, unresolved distress/anxiety and associated frustrations, conflicts, and hassles. The cognitive model of depression originally conceptualised by Beck (1967; 1976) and developed further by others (e.g. Beck, 1996; Blackburn, 1996; Clark & Steer, 1996; Hollon, DeRubeis & Evans, 1996; Weissenburger & Rush, 1996; Young, Beck & Weinberger, 1993), acknowledged the importance of negative childhood experiences in the development of assumptions or schemata which are dysfunctional; i.e. rigid, extreme and resistant to change.

Moreover, when negative life events (e.g. rejection or failure) are repeatedly evaluated in terms of these unrealistic, perfectionistic assumptions (e.g. LeBoeuf, 1979; Vitousek, 1996) negative automatic thought patterns develop which revalidate and reinforce these assumptions and thus depression is triggered. As depressed mood deepens, negative automatic thoughts become more intense and tend to over-ride more

rational interpretations. Thus, individuals become somewhat imprisoned by their "deep blue" interpretations, and the risk of suicide is heightened.

Thus, depression is an interactive process between adverse life circumstances and the way individuals have learned to cope. People who experience prolonged feelings of sadness, dejection, loneliness, misery, and guilt (exacerbated by a tendency to blame themselves) may ultimately feel powerless to overcome the overwhelming and insurmountable demands the world has placed upon them. Once they develop this negative view of themselves, the world, and their future, it may make perfectly good sense to give up the "futile" fight to change their situation. This is reinforced by the strengthening belief that they do not possess the necessary personal skills and competencies to act successfully in given situations; i.e. their sense of self efficacy is compromised.

The depression experienced by relatives of excessive drinkers (see Figure 6.1)

Given the accumulated stress/anxiety, frustrations, inner conflicts, and hassles of the excessive drinking milieu, it is not surprising that relatives eventually succumb to depression (Barber & Crisp, 1994; Orford et al. 1998a; Watts, Bush & Wilson, 1994; Wegscheider, 1988). Although the degree and severity of this depression depends upon individual circumstances (Tharinger & Koranek, 1988), the emotional load becomes too great for even the most resilient relatives. As the old adage[2] says, "If you sit in a barbers' chair long enough, you'll get a haircut".

Therefore, relatives are likely to develop the dysfunctional schemata and pessimistic explanatory styles characteristic of depression (Beck, 1967 & 1976; Blackburn, 1996; Clark & Steer, 1996; Young, Beck & Weinberger, 1993). Moreover, relatives who have been exposed to severely negative or abusive experiences in their childhoods are likely be more vulnerable to depression and suicidal thoughts than those who have not had this range of experiences (Cooper, Peirce & Tidwell, 1995; Kagan, 1998; Phil & Bruce, 1995; Orford & Velleman, 1991; Rolf, Johnson & Israel, 1988).

According to Barber & Crisp (1994) and Orford et al. (1998a), partners of excessive drinkers become embarrassed by their drinkers' behaviour and insecure about the future of their relationships. Because of their drinkers' emotional remoteness and

deteriorating communication patterns, partners feel increasingly lonely and neglected, and their sex lives become more and more unsatisfactory. Due to their drinkers' irresponsibility and unreliability, partners usually worry about leaving them in charge of the children or other family responsibilities. Given their chronic, relentless stressful situations, and their futile efforts to control their circumstances, partners are usually bereft of energy and enthusiasm, and may become so unhappy and depressed that they may even think about suicide.

Given the relationship between unrealistic, assumptions and beliefs regarding their situations (e.g. "If he cared about me he wouldn't drink so much!"), negative automatic thought patterns (e.g. "It's my fault - if I hadn't blown up at him AGAIN, he wouldn't be drinking now!"), and depressed mood, relatives tend to remain cognitively and emotionally trapped. Moreover, given their attention and energy are so relentlessly focussed on trying to solve and survive the consequences of the excessive drinking, perception often becomes distorted (Montgomery & Evans, 1984) and thus relatives' self awareness is usually compromised.

6.2.3 Low self esteem and guilt

Depression is the most frequently cited connection between low self esteem (i.e. a sense of negative self regard) and psychopathology (Harter, 1993). According to Mruk (1995), one line of evidence for this connection is that there appear to be certain cognitive similarities between people who are depressed and those with low self esteem. Given depressed people engage in irrational thinking patterns, or hold beliefs about themselves or situations which do not correspond to reality; e.g. labelling themselves "stupid" for making a simple mistake, the relationship between depression and self esteem is obvious.

After reviewing the self esteem literature, Mruk (1995) defined self esteem more widely as "dealing with the ongoing challenges of life with competence and worthiness." He described competence as learning skills which increase ability to deal more effectively with these challenges, and worthiness as living according to personal beliefs and values (and feeling good about that).

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[2] Author unknown

It has been acknowledged for decades (Kelly, 1955) that guilt is produced when people transgress against deeply held values and core constructs, either in thought or action. For example, relatives of excessive drinkers who see themselves as kind, loving, law abiding people are devastated when they find themselves thinking about how to hurt their drinkers (or even murder them), or when they react with uncharacteristic violence towards their drinkers or their children. Moreover, guilt is also associated with damaged personal boundaries and is induced when individuals take inappropriate responsibility for the behaviour of others (Mellody, 1989).

The low self esteem and guilt experienced by relatives of excessive drinkers (see Figure 6.1)

The low self esteem and guilt experienced by relatives of excessive drinkers are natural outcomes of chronic stress/anxiety and depression. According to Orford et al. (1998a), guilt is associated with low self esteem through feelings of remorse and uncertainty about whether right actions have been taken, not being confident or in charge, and/or feeling used and devalued. Moreover, it is often guilt inducing for people to reflect upon their past and conclude they have actually made *decisions* to act in one way rather than another, according to how they construed their situations. They usually feel devastated when they realise there were indeed other possibilities to deal with these situations in more effective ways - even though they were not aware of them at the time (Leitner & Dunnett, 1993).

In reaction to the increasing emotional "dumping", blaming, and accusatory behaviour from their drinkers, relatives often retaliate with similar angry outbursts (Barber & Crisp, 1994; Dittrich, 1993; Fals-Stewart & Birchler, 1998; Miller et al., 1999; Moos & Moos, 1984; Orford, 1988b; Orford et al. 1998b). Many relatives (particularly partners) have revealed in clinical situations that they are aware that their reactive behaviour actually cues further drinking episodes, may emotionally wound their drinkers, and deleteriously impacts upon their children, they feel increasingly guilty and incompetent because they believe they *should* be able to control themselves and solve their problems.

Moreover, due to the relentless build up of stress/anxiety, relatives (particularly partners) sometimes inappropriately "dump" their own feelings on their children.

Because this may violate their value systems, and beliefs about what kind of human beings they are, their guilt increases (Dittrich, 1993; Orford et al. 1998a). Thus, their sense of worthiness and competence is compromised; i.e. their self esteem is likely to become ravaged (Mruk, 1995).

6.2.4 Marital discord and disturbance

According to Rust, Golombok & Pickard (1987), 20% of marriages *without alcohol-complications* have some degree of discord and dissatisfaction surrounding various problematic areas. Moreover, these problematic areas are further complicated by feelings, beliefs, attitudes, and behaviour within the relationship, and motivation for change. According to Cordova & Jacobson (1993) and Schmaling, Fruzetti & Jacobson, (1989), distressed couples experience very few pleasant and rewarding interactions. Moreover, their interactions are often characterised by reciprocated negative behaviours where each person reacts in kind to the other's negative behaviour.

The resulting chain of hostile interactions is fuelled by expectations of criticism, and aggressive reactions are likely to erupt whenever criticism is perceived (even if not intended). Given the need to maintain defensive positions against perceived (and expected) attack, distressed couples are usually highly reactive. This compromises communication and increases the likelihood of misunderstandings. Therefore, unresolved conflicts tend to build up and fuel the couple's negative expectations about future conflicts, and their ability to constructively deal with them. Thus, they may decide that attempts to engage in problem solving are futile, and they may slip into destructive patterns of neglect, criticism, arguments, negative expectations and beliefs regarding each other, their relationship, and the future.

The marital discord and disturbance experienced by partners of excessive drinkers (see Figure 6.1)

According to Barber & Crisp (1994), Miller et al. (1999), Orford (1988b), and Orford et al. (1998a), the marital discord and disturbance partners experience is related to their own irritability, anger and resentment due to their drinkers' consumption and unacceptable behaviour. Moreover, due to drinkers' excessive consumption and

irresponsible behaviour, financial resources become stretched, and drinkers are usually verbally (and sometimes physically) abusive. Thus, the quality of the marital relationship become seriously compromised, communication patterns between the couple become more blaming and abusive, and problem solving is compromised (Fals-Stewart & Birchler, 1998; Hands & Dear, 1994; Orford, 1995; Orford, 1988b; Orford et al. 1998b; Wegscheider, 1981).

6.2.5 Ineffective coping

Coping has been defined as all cognitive and behavioural efforts to master, reduce, or tolerate internal (cognitive appraisals or conflict) or external demands (Folkman & Lazarus, 1980; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986; Lazarus, 1993). Matheny, Aycock, Pugh, Curlette & Silva-Cannella (1986) have extended this definition to any effort, healthy or unhealthy, conscious or unconscious, to prevent, eliminate, or weaken stressors, or to tolerate their effects in the least hurtful manner. Thus, coping behaviour may be positive or negative, active or avoidant, direct or indirect (Moos, Finney & Cronkite, 1990; Suls & Fletcher, 1985). Moreover, successful coping is dependent upon the direct relationship between coping effectiveness and coping effort.

Matheny et al. (1986) and Steptoe (1991) claim the nature of coping can be viewed as preventive (e.g. avoiding stressors through life adjustment), or combative. Whereas preventive coping may involve the avoidance of stressors, combative coping is more proactive and involves increasing awareness and monitoring of stress, marshalling resources, and/or tolerating stressors if they can't be eliminated. Moreover, it is important for people to guard against self limiting assumptions and self defeating thoughts, and remain open to suitable options.

The ineffective coping patterns of relatives of excessive drinkers
(see Figure 6.1)

The basic preventative or combative nature of coping as described by Matheny et al. (1986) and Steptoe (1991) is largely consistent with the major coping positions

demonstrated by relatives of excessive drinkers found by Orford et al. (1998b) and Homila (1997) as described in Chapter 2.4. Although relatives' withdrawal (independent, avoidance) and engaged (emotional, controlling, assertive, supportive) coping positions are consistent with Matheny et al., Orford et al. found relatives of excessive drinkers demonstrated a third major coping position; i.e. tolerant. When relatives utilise this coping position, they tend to adopt strategies which are self sacrificing ("My needs aren't important"); accepting ("This is a cross I have to bear"); and/or inactive ("I don't know what to do any more - I just feel frozen!").

6.3 Effective therapeutic approaches to reduce emotional distress, marital discord, and ineffective coping in the general population

The conceptual framework which explored and explained the nature of stress/anxiety; depression; low self esteem and guilt; marital discord; and ineffective coping revealed the pervasive influence of unrealistic patterns of thinking, beliefs, and assumptions. Therefore, from the range of available therapeutic interventions, a cognitive behaviour (CB) approach was selected by the present author because (i) CB methods are directly concerned with the thoughts, feelings, and dysfunctional schemata so obviously important in the maintenance and exacerbation of most psychological disturbances; (ii) CB therapy fills the gap between the purely behavioural methods and psychodynamic psychotherapies; and (iii) CB therapy is evidence based, more amenable to evaluation than the psychodynamic therapies, and more cost effective.

Moreover, CB therapy is effective for a wide range of psychological disturbances most notably stress/anxiety, depression and low self esteem (e.g. Andrews et al., 1994; Barlow, 1993; Beck, 1996; Blackburn, 1996; Clark, 1996; Clark & Steer, 1996; Gelder, 1989; Hawton et al. 1989; Hollon, De Rubeis & Evans, 1996; Montgomery & Evans, 1984; Salkovskis, 1996; Weissenburger & Rush, 1996). It has also been successfully used to treat marital problems and dysfunctional coping (e.g. Cordova & Jacobson, 1993; Matheney et al., 1986; Montgomery & Evans, 1995; Mruk, 1995; Rahe, 1995; Schmaling, Fruzzetti & Jacobson, 1989; Seligman, 1990).

6.3.1 The treatment of stress/anxiety

The CB approach to stress/anxiety (e.g. Andrews et al. 1994; Brown, O'Leary & Barlow, 1993; Clark, 1996; Clark & Steer, 1996; Craske & Barlow, 1993; Hope & Heimberg, 1993; Salkovskis, 1996) involves teaching individuals about the intimate relationship between their thoughts, feelings and behaviour.

When chronic anxiety/stress manifests itself in obsessive or compulsive behaviour, Schwartz (1996) recommends four basic steps; i.e. the 4 Rs. The first **R** is to **R**elabel unwanted thoughts, urges and behaviours as merely habitual responses to stressful situations. The second **R** is to **R**eattribute why these habitual thoughts, urges, and behaviours persist as merely rigid, habitual responses springing from a brain which is "stuck in gear" (p.39) due to stress induced chemical imbalances. The third is to **R**efocus attention by working around the troublesome thoughts and urges by becoming involved in another useful, constructive, enjoyable activity. The fourth **R** (**R**evalue) is the natural outcome of diligent practice of the first three which results in the realisation that obsessive thoughts and compulsive behaviours are worthless distractions to be ignored. According to Schwartz, the outcome of this process is a brain no longer "stuck in gear" and beginning to function in a more normal, automatic way.

6.3.2 The treatment of depression

Similarly, the CB approach to depression (e.g. Beck, 1967, 1976 & 1996; Blackburn, 1996; Clark & Steer, 1996; Fennell, 1989; Hollon, De Rubeis & Evans, 1996; Weissenburger & Rush, 1996; Young, Beck & Weinberger, 1993) aims to assist individuals to find solutions to their problems using cognitive behavioural strategies such as distraction, behavioural monitoring, pleasant even scheduling, and the disputation of unhelpful thinking processes.

6.3.3 The treatment of low self esteem and guilt

Based on his review of the empirical literature, Mruk (1995) has developed a six session group program aimed to encourage and nurture self esteem. This psycho-educational program involved education and self awareness, sharing experiences, monitoring dysfunctional thoughts and beliefs, cognitive restructuring, assertiveness, problem solving, and planning an ongoing course of action. Participants in Mruk's program appraised their self esteem (pre and post treatment) with O'Brien and Epstein's (1983, 1987, 1988) Multidimensional Self Esteem Inventory (MSEI), which measures 8 dimensions; viz. competence, lovability, likeability, personal power, self control, moral self approval, body appearance, and body functioning. In addition, it provides a measure of global self esteem, self identity, and defensiveness.

6.3.4 The treatment of marital discord and disturbance

Given the importance of negative perceptions, expectations, beliefs and attitudes in the maintenance of marital discord, a cognitive behavioural approach seems most appropriate (e.g. Cordova & Jacobson, 1993; Montgomery & Evans, 1995; Schmaling, Fruzzetti & Jacobson, 1989). For instance, the following treatment techniques are effective in reducing marital discord; e.g. behaviour exchange, cognitive interventions, communication training, problem solving, reducing conflict, and identifying and altering negative patterns of communication (see Table 6.1 for objectives).

6.3.5 The treatment of ineffective coping

Successful coping primarily involves contending realistically with the problem by engaging in all possible efforts to reduce harm and enhance prospects for survival and recovery (e.g. Cohen & Lazarus, 1979; Folkman & Lazarus, 1980; Folkman et al. 1986; Matheny et al. 1986; Moos et al. 1990; Roger, Jarvis & Najarian, 1993). Essential concomitants to this process are the toleration of (or adjustment to) the emotional response; maintenance of self image, and emotional equilibrium; and the maintenance of satisfying relationships with others. Moreover, according to Montgomery and Morris (1989), it is important not to dwell on bad feelings, to do something constructive

to improve the stressful situation, or undertake a pleasant or constructive distracting task.

Table 6.1
Effective treatment techniques for marital discord (Cordova & Jacobson, 1993; Montgomery & Evans, 1995; Schmaling et al. 1989).

Technique	**Objectives**
Behaviour exchange	• Counteract selective focus on negative behaviours • Alleviate helplessness • Reverse blaming stance • Foster closeness and increase affection
Cognitive interventions	• Understand relationship between feelings, thoughts and behaviour • Identify personal feelings, thoughts and beliefs • Identify dysfunctional beliefs and their likely origin • Explore impact upon behaviour
Communication training	• Identify feelings, needs and concerns • Express clearly and specifically • Improve non verbal and attending skills
Problem solving	• Specific description of problem and its emotional impact • Explore possible solutions • Selection of acceptable solution/s • Explore implementation difficulties
Reducing conflict:	• Conflict de-escalation • Identify thoughts, feelings and assumptions • Explore behavioural options
Identifying and altering negative patterns of interaction	• Identify particular themes of conflict • Identify particular patterns of conflict

This has illustrated the important feedback loop involved in Ellis' (1988) Rational Emotive Therapy (RET) between thoughts, feelings, and emotional and behavioural consequences to an unpleasant event. Not only do thoughts have a powerful impact upon feelings and behaviour, behavioural reactions (such as doing something constructive or distracting oneself) have a powerful, reciprocal influence on thoughts and feelings. According to Ellis (p.108), "thoughts, feelings and behaviour interact and circularly affect each other".

Moreover, the theory of cognitive dissonance (Festinger, 1957; Festinger & Carlsmith, 1959) and the influence of counter-attitudinal behaviour (where behaviour is inconsistent with true feelings) has clearly revealed that changes in behaviour actually precipitate changes in attitudes. For instance, legislation outlawing sexual harassment in the workplace has resulted in many workers changing their attitudes in tandem with their new behaviours – even when they initially did not agree with the changed policy.

Matheny et al. found four coping strategies had the strongest effect upon coping outcome; viz. tension reduction (via relaxation), cognitive restructuring (to avoid unhelpful ruminations), problem solving, and social skills (i.e. communication and assertiveness). Other effective strategies were filling time constructively to divert attention from painful stimuli, sharing thoughts and feelings with others, expressing repressed emotions, seeking information, and organising resources to improve future coping as a means of stress inoculation.

6.4 Appropriate interventions to empower relatives of excessive drinkers to improve their mental health, coping, and relationship status

The range of appropriate interventions for relatives of excessive drinkers have been developed as a result of examining the literature to firstly identify and describe the psychological impact of living with an excessive drinker, and secondly, to provide a conceptual framework for intervention with this particular psychological sequelae.

However, although alcohol treatment outcome studies have been published for more than half a century, little evaluation research has been devoted to the problem of helping those who are concerned about a loved one's excessive drinking (Liepman, Nirenberg & Begin, 1989; Miller et al. 1999). Whilst there is a large literature on family therapy involving partners as adjuncts to their drinkers' treatment (e.g. Bowers & Al-Redha, 1990; McKay, Longbraugh, Beattie, Maisto & Noes, 1993; Moos, Finney, and Chronkite, 1990; O'Farrell, 1993; O'Farrell & Bayog, 1986; O'Farrell & Cowles, 1989; Orford et al. 1975; Smith, 1969; Wright & Scott, 1978), the well being of these partners has rarely been reported upon or even considered (e.g. McCrady, Stout, Noel, Abrams & Nelson, 1991).

There is much less evaluative research on intervention with treatment resistant drinkers through training their partners as early intervention agents (e.g. Barber & Crisp, 1995; Barber, Gilberston & Crisp, 1997; Garrett, Landau, et al. 1998; Garrett, Stanton, et al. 1999; Landau & Brinkman-Sull, 1997; Liepman, 1993; Miller et al. 1999; Sisson & Azrin, 1986; Thomas & Agar, 1993). Moreover, the *primary* focus of all these researchers has been the engagement of unmotivated drinkers into treatment.

With the exception of Barber and Crisp (1995), Barber, Gilberston and Crisp (1997) and Miller et al. (1999), no researchers have provided data regarding relatives' psychological functioning. Barber et al. reported significant improvements in partners' well being, family cohesion and relationship happiness only occurred when the intervention was delivered in individual (as opposed to group) format. However, Barber et al. did not provide data regarding the durability of these improvements or drinkers' consumption patterns following their engagement.

Miller et al.'s (1999) CRAFT intervention has further developed the research of Barber and Crisp (1995) and Barber, Gilberston and Crisp (1997) which resulted in sustained improvements in partners' mental health, coping, and relationship status - regardless of whether their drinkers were subsequently "engaged" (4 hours assessment plus one treatment session). However, no data was provided on the subsequent impact of this engagement process on drinkers' consumption patterns. Miller et al. highlighted the need for qualitative data to determine *how* relatives undertaking the CRAFT intervention had *applied* the skills they had learned. This neglect of qualitative data in the literature has also been identified by others (Bogden & Bilken, 1992; Orford et al. 1998a).

Evaluative research which has *primarily* focussed upon improving the mental health, coping, and relationship status of relatives of treatment resistant drinkers is even more sparse (Binns et al. 1989; Dittrich, 1993). Whilst Binns et al. (an unpublished study) reported significant, sustained improvements in partners' mental health and relationship status, their sample was not *totally* comprised of partners of treatment resistant drinkers, and no data was provided regarding participants' coping patterns.

Although Dittrich (1993) found significant improvements in partners' coping patterns as well as mental health, the secondary aim of this intervention was to teach partners strategies to encourage their drinkers into treatment (including separation).

Therefore, Dittrich was unable to clarify which was the active ingredient which facilitated the presentation of 48% of drinkers into treatment. Was this engagement facilitated by partners' improved psychological functioning, to the intervention strategies they had learned, or the threat of divorce? Moreover, Dittrich did not provide empirical evidence of the durability of treatment gains for both partners and their drinkers.

Table 6.2 has summarised the intervention aims, therapeutic elements and outcomes from those programs which have attempted to improve the psychological functioning of relatives of treatment resistant drinkers (whether as a primary or secondary aim), and has identified areas which seem to need further research.

Thus, the literature is not fully developed in this field. Moreover, interventions have typically lacked a theoretical base (Meyers et al. 1999). For instance, whilst Binns et al. (p.87) claim their intervention "exhibits similarities to many therapeutic approaches that are based on systems theory, in that it places behaviour and thinking within an interactive social context...and makes much use of Rational Emotive Therapy", Dittrich (1993) based her intervention on Alanon principles.

Given empowering relatives through improving their psychological functioning (without involving their treatment resistant drinkers in any way) may be a valuable approach to the secondary prevention of addiction (Orford, 1994), it has been the business of this thesis to help redress these gaps in the literature by testing an intervention which, though *clinically* developed by the Australian Institute on Alcohol and Addictions (Holyoake) in Perth Western Australia, seemed to be consistent with the conceptual underpinnings presented in this chapter.

Table 6.2
Intervention aims, therapeutic elements, and results of interventions designed to improve the psychological functioning of relatives of treatment resistant drinkers

Intervention aims	Intervention elements	Intervention outcomes for relatives	Further research needed[3]
Codependents' Group Program Binns, Dear, Knowles & Hall (1989) AUSTRALIA *Aims:* • Understanding of family dynamics • Understanding of role in maintaining these dynamics • Development of appropriate coping & problem solving skills	• Process of dependency and codependency • Family roles in the maintenance of dependency • Patterns of family denial • Impact of dependency upon children • Self responsibility • Relationship between thoughts, feelings and behaviour • Self esteem and grief • Letting go and detachment • Family relationships and intimacy	• Significant, sustained improvement in self esteem • Significant, sustained reduction in ill health, depression, and psychiatric disturbance • Significant, sustained gains in quality of relationship between participants and their drinkers	• Data regarding participants' coping strategies • Data regarding participants' process of change • Data regarding drinkers' consumption patterns and help seeking behaviour
Group Program for Wives of Alcoholics Dittrich (1993) US *Aims* • Increase understanding of alcoholism and family interactions • Identify and decrease enabling behaviour • Develop more useful coping strategies • Make positive plans for future • Encourage resistant drinkers into treatment.	• Process of dependency, "co-alcoholism" and family roles • Family enabling patterns • Identification and sharing of feelings • Assertive communication of feelings • Intervention strategies • Life style options and goal setting	• Significant improvement in self esteem • Significant reduction in anxiety, depression, and enabling behaviours • 48% of drinkers entered treatment • 39% participants separated from their drinkers	• Qualitative data regarding participants' coping strategies • Data regarding participants' process of change • Data regarding relationship between participants and drinkers • Data regarding drinkers' consumption patterns • More comprehensive follow up data
Community Reinforcement and Family Training (CRAFT) Miller, Meyers & Tonigan (1999) US *Aims* • Engage treatment resistant drinkers • Improve family members' functioning and relationship quality.	• One to one counselling • Understanding of triggers and restraints for drinking • Belief in ability to make a difference to the drinking • Assertive communication to improve relationships • Increased personal activities	• Significant, sustained reductions in depression, anger, and family conflict • Significant, sustained improvements in family cohesion and relationship happiness • 64% drinkers engaged	• Qualitative data regarding participants' coping strategies • Data regarding participants' process of change • Data regarding drinkers' consumption patterns

[3] Either in the opinion of researchers or current author

Given their enmeshment in the interdependent stress, coping and transactional patterns which have developed between relatives and their drinkers, and relatives' depressed and anxious state, they tend to not be aware of the *extent* to which they have inadvertently become part of the problem (see Figure 2.1). Nor do they realise how much power they really *do* have to improve their situations (Wegscheider, 1981; Meyers et al. 1999; Miller et al. 1999). However, by presenting for help, they are demonstrating a need for guidance, and a commitment to solve their problems.

According to Prochaska, Norcross and DiClemente (1994) and Miller (1989), the motivation and decision to take action is nurtured and strengthened by the maintenance, reinforcement, and expansion of raised awareness, supportive relationships and emotional arousal. Moreover, given relatives' loneliness, isolation, and loss of trust, it is crucial to provide a supportive, safe therapeutic milieu which will facilitate ongoing emotional arousal and expression, as well as an opportunity to re-evaluate themselves, their drinkers, and their situations (see Table 5.2).

This process of consciousness raising, emotional arousal, and self re-evaluation strengthens and maintains the commitment to navigate the often hazardous action stage of change. It is here that relatives need to counter their problematic behaviours with more effective strategies, build in reward systems to encourage themselves, and gain more control over their personal environments - both internal and external. Thus, therapeutic elements for relatives of excessive drinkers need to involve three basic foci; viz. consciousness raising, supportive relationships to facilitate the process of self re-evaluation, and the development of skills and strategies (Prochaska, Norcross & DiClemente, 1994) to counter their ineffective coping behaviours

6.4.1 Consciousness raising

Unrealistic patterns of thinking, beliefs and assumptions have a pervasive influence in maintaining and exacerbating the emotional distress, marital discord, and ineffective coping of relatives of excessive drinkers. Therefore, it is essential that treatment facilitates the process of consciousness raising, cognitive restructuring, and increased focus on what actually *is* possible for them to control and change. Up to date, evidence-based information regarding (i) the process of dependency and its impact upon their drinkers; (ii) the normal stress and coping patterns of relatives; and (iii) the need to

relinquish their *inordinate* attention on their drinkers' feelings and needs, and increased focus on their own.

However, given relatives' often chronic focus on their drinkers' situations (usually to the detriment of their own), and the relentless stress involved in trying to control the drinking related problems, relatives tend to suppress their own feelings as a survival mechanism, and as a result, their self awareness is often compromised (Montgomery & Evans, 1984; Orford et al. 1998b). Therefore, whilst up-to-date information is indeed of prime importance, it is important to maximise relatives' emotional connection and response to the material.

Satir, Banmen, Gerber & Gomoti (1994) in their conception of second order change (or de-enmeshment), highlight the need for the "healing additive" (p.163) of raised awareness to assist relatives to go beyond the content of the problem and the behaviour of their drinkers towards the need to change their own expectations, perceptions, and feelings. Through the process of raised awareness, relatives are given the opportunity to move from the automatic to the conscious level of responding, by "tapping" their anger and the associated hurt and fear (Barber & Crisp, 1995; Meyers et al. 1999; Miller et al. 1999; Orford, 1988b; Orford et al. 1998a) and giving themselves choices and new possibilities for change. According to Satir et al. (1994), "replacing survival patterns with coping patterns, and coping patterns with self care patterns, brings about major transformations."

6.4.2 Supportive relationships

Ideally, a group setting with support not only from staff but from other participants in the same situation would be likely to provide relatives with a safe, supportive, accepting, and validating environment. Given this milieu, relatives would have a good opportunity to confront their issues, share their experiences; and encourage each other through the often scary and threatening process of countering ineffective behaviours (Fuhriman & Burlingame, 1994; Wessler, R.L. & Hankin-Wessler, 1989; Yalom, 1995). Moreover, relatives would be likely to experience major shifts in understanding and hope which would facilitate, encourage, and strengthen their belief that they could indeed face their anger, hurt, and fears and do something positive about resolving their problems - whether their drinkers decide to take action or not.

6.4.3 Skills & strategies

According to Prochaska, Norcross and DiClemente (1994) and Satir et al. 1994, the goal of intervention is to assist people to *understand* what is happening to them, to *identify* what problems they *can* change, within an honest, caring, encouraging milieu which does not blame, judge, or push too prematurely into action. Once this has been achieved, the time is right to develop skills and strategies to counter old, ineffective behaviours.

Whilst some of the stresses and strains to which relatives are subjected are not under their direct control (e.g. drinkers' abusive and blaming behaviours), it is indeed possible for them to control others (e.g. their own emotional outbursts). These controllable stressors have been presented in Table 6.3 under four major dimensions; viz. (i) stress/anxiety; (ii) depression, low self esteem & guilt; (iii) marital discord and disturbance; and (iv) ineffective coping.

The conceptual framework underpinning these psychological disturbances and effective therapeutic approaches presented in Sections 6.2 and 6.3, gives clear direction regarding the range of interventions which would be likely to empower relatives of excessive drinkers to improve their functioning, and disengage from the interdependent stress, coping and transactional patterns which have developed between themselves and their drinkers. The range of interventions suggested by the literature have also been listed in Table 6.3 within each dimension of psychological disturbance, and categorised according to their focus on consciousness raising, or skills and strategies. Table 6.3 has also presented the range of appropriate outcome measures (both quantitative and qualitative) which would be suitable to test the efficacy of these interventions.

6.5 The construction of an intervention program to empower relatives of excessive drinkers to improve their mental health, coping and relationship status

Previous group interventions which have significantly improved the psychological functioning of relatives of excessive drinkers in their own right have ranged in length between 16 and 30 hours (Dittrich, 1993 & Binns et al. 1989 respectively). On the other

hand, individual therapy (focussed on training relatives as intervention agents) has resulted in significant improvement in relatives' well-being after 5 hours (Barber & Crisp, 1994) and *sustained* improvements across a much broader range of psychological variables after 12 hours (Miller et al. 1999).

Given the present research has been concerned with improving relatives' psychological functioning in their own right in perhaps a more cost effective group format, the range of interventions suggested by the literature have been collated and constructed into an 8 session, 20 hour group program (an approximate average of Dittrich and Binns et al.). Session topics, aims, learning objectives and associated skills and strategies for this "ideal' conceptually derived intervention have been presented in Table 6.4.

Other researchers who primarily aimed to improve the functioning of relatives of excessive drinkers (Binns et al. 1989; Dittrich, 1993) also included some aspects of these intervention elements in their programs (see Table 6.2); e.g.

- Education regarding the process of dependency;
- Education regarding relatives' stress and coping patterns;
- The need to increase self responsibility and decrease inappropriate responsibilities
- The need to set more effective personal boundaries;
- The relationship between thoughts, feelings and behaviour; and
- The need for more effective communication and problem solving strategies.

Table 6.3
Stresses and strains which are possible for relatives of excessive drinkers to control, range of effective interventions, and outcome measures

Stresses and strains which are possible for relatives to control	Range of effective interventions identified by the research literature	Measures to test the efficacy of interventions
Stress/anxiety • General emotional upset and unease • Worry & preoccupation • Tense & nervous • Irritable & quick tempered • Frightened & feelings of dread	*Consciousness raising* • Process of dependency • Relative stress & coping patterns • Relationship between feelings, thoughts & behaviour • Self responsibility *Skills & strategies* • Relaxation • Monitor and challenge unhelpful thoughts & beliefs • Trial alternative behaviours	• Crown-Crisp Experiential Index (CCEI) (4 subscales; i.e) Free floating anxiety Somatic anxiety Phobic anxiety Obsessionality • Overall emotional resilience/vulnerability measured by the sum of the 5 CCEI subscales (including depression)
Depression, low self esteem & guilt • Embarrassed, insecure, & lonely • Sad, miserable & unhappy • Low energy & enthusiasm • Low self awareness • Suicidal thoughts • Helpless, powerless & despairing • Low self esteem & inability to cope • Not confident & not in charge • Feelings of failure & remorse • Devalued & used	*Consciousness raising* • Process of dependency • Relative stress & coping patterns • Relationship between thoughts, feelings & beliefs • Self responsibility *Skills & strategies* • Explore and express feelings within a supportive, validating environment • Identify and challenge negative automatic thoughts and assumptions • Focus on own needs and increase pleasant events • Establish more effective personal boundaries • Relinquish inappropriate responsibilities • Ongoing action plan	• CCEI depression subscale • Drinkers' Partners' Distress Scale (DPDS) (depression subscale)

cont...

Table 6.3 cont....

Stresses and strains which are possible for relatives to control	Range of effective interventions identified by the general research literature	Appropriate measures to test the efficacy of interventions
Marital discord & disturbance • Irritability, anger, & resentment • Dysfunctional communication patterns • Overly caregiving, counselling • Abusive & blaming behaviours • Reduced problem solving	*Consciousness raising* • Process of dependency • Relative stress & coping patterns • Relationship between thoughts, feelings & behaviour • Self responsibility • Awareness of personal communication style under stress *Skills & strategies* • Relaxation • Conflict de-escalation (get out of the "boxing ring") • Reverse blaming stance • Identify & challenge unhelpful beliefs & assumptions • Identify & express feelings, thoughts, needs & concerns assertively • Increase affectionate behaviour (if possible) • Problem solving	• Golombok Rust Inventory of Marital State (GRIMS) • Drinkers' Partners' Distress Scale (DPDS) (marital discord subscale) • Self report question regarding quality of interactions whilst drinker is drinking as opposed to not drinking • Qualitative interview question regarding relationship status
Ineffective coping • Controlling (emotional; overly responsible) • Tolerant (self sacrificing & accepting) • Withdrawing (emotional & physical) • Avoidant and inactive	*Consciousness raising* • Process of dependency • Relative stress & coping patterns • Relationship between thoughts, feelings & behaviour • Self responsibility *Skills & strategies* • Relinquish inappropriate responsibilities • Establish effective personal boundaries • Focus on own needs & increase pleasant events • Assertive communication • Identify & challenge unhelpful beliefs & assumptions • Problem solving	• Drinkers' Partners' Coping Questionnaire (DPCQ)[4] (control, tolerant & assertive subscales) • Qualitative interview question regarding most difficult situation, coping method, and outcome • Qualitative interview question regarding overall coping strategy

[4] Constructed by the present author

Table 6.4
Intervention elements, aims, learning objectives, and associated skills & strategies designed to empower relatives of excessive drinkers

Intervention elements	Aims and learning objectives	Associated skills and strategies
Understanding dependency	*Aim* To assist relatives understand the process of dependency and its impact upon drinkers *Objectives* Increase awareness & understanding of: • The features of dependency and the way it develops • Drinkers' stresses and strains and their coping strategies • The responsibility of drinkers (and not relatives) for their excessive consumption and behaviour	• Identify the process of dependency in personal situations with drinkers • Identify most common coping strategies used in personal situation • Focus on own feelings, needs, and concerns
Understanding relatives' stress & coping patterns	*Aim* To assist relatives identify, explain, and normalise their own reactions to the drinking, and how relatives have unwittingly become part of the problem. *Objectives* Increase awareness & understanding of: • The impact of drinkers' behaviour on their levels of stress • The coping behaviours relatives develop in reaction to chronic stress • How these coping behaviours impact upon relatives, drinkers, and the process of dependency	• Identify main situational source of stress and usual coping strategy (e.g. control, emotional, tolerant, withdrawal, assertive, inactive) and usual outcome • Relaxation practice • Identify which more effective coping strategy could be used in this situation and likely outcome
Changing focus	*Aim* To assist relatives modify entrenched patterns of ineffective coping *Objectives* Increase awareness & understanding regarding the need to: • Relinquish efforts to directly change *another's* behaviour • Focus efforts on changing what is possible to change • Replace counterproductive reactive behaviour with more effective coping strategies	• Explore process of countering inappropriate coping strategies • Effectively respond to drinkers' attempt to restore status quo

cont...

Table 6.4 cont...

Intervention elements	Aims and learning objectives	Associated skills and strategies
Increasing self care and responsibility	*Aim* To assist relatives to assume more responsibility for their *own* wellbeing *Objectives* Increase awareness & understanding of the need to: • Assume responsibility for personal feelings, thoughts, needs, and behaviour • Identify personal needs which have been neglected • Increase self care and control • Relinquish inappropriate responsibilities	• Identify what behavioural change is needed to improve personal well-being • Identify inappropriate responsibilities currently being assumed for drinkers • Surviving drinkers' attempts to restore status quo
Setting personal limits	*Aim* To assist relatives establish appropriate personal boundaries. *Objectives* Increase clients' awareness and understanding of : • How inordinate focus has been given to users' feelings, needs and behaviour to the detriment of their own • The need to establish more effective, self affirming personal boundaries	• Identify problematic situations and preferred outcome • Saying "no" assertively and maintaining action plan • Dealing with drinkers' attempts to restore the status quo
Challenging beliefs	*Aim* To assist clients to monitor and change unhelpful thinking patterns *Objectives* To increase clients' awareness and understanding of • The relationship between thoughts, feelings and behaviour; • How unhelpful belief systems have developed • How to change unhelpful thought patterns and beliefs to more realistic, helpful ones.	• Identify feelings • Identify and challenge unhelpful thoughts, beliefs, and assumptions • Replace unhelpful thought patterns with more realistic, self affirming ones • Monitor effectiveness in controlling emotional upset

cont...

Table 6.4 cont...

Intervention elements	Aims and learning objectives	Associated skills and strategies
Effective communication	*Aim* To assist clients to improve their assertive communication strategies *Objectives* To increase clients' awareness, understanding, and ability to: • Control and replace reactive behaviour with more considered, effective responses • Assertively express feelings, concerns, and needs to drinkers • Effectively deal with drinkers' "push back" reactions	• Reverse blaming stance and de-escalate conflict • "I" statements rather than "you' statements • Respond calmly to drinkers' negative statements/reactions • Deal with drinkers' attempts to restore the status quo
Problem solving: handling a crisis	*Aim* To assist relatives respond more effectively to a substance related crisis *Objectives* Improve ability to • Intervene effectively in a substance related crisis • Encourage drinkers to seek help.	• Choose appropriate time to level with drinker • Express feelings and needs with the 4 part assertive response • Calmly & firmly deal with drinkers' resistance and attempts to restore the status quo

Given Miller et al.'s secondary goal was to reduce relatives' psychological distress, some aspects of the intervention elements presented in Table 6.3 were included in their CRAFT program (e.g. increasing self care and responsibility, communication to improve relationships and problem solving). However, most intervention elements presented in Table 6.4 were superfluous to the needs of those researchers (e.g. Barber & Crisp, 1995; Barber, Gilberston & Crisp, 1997; Sisson & Azrin, 1986) who merely aimed to trained relatives as intervention agents.

6.6 The likely impact of relatives' process of empowerment on their treatment resistant drinkers

The evidence appears quite strong to suggest that relatives of excessive drinkers are capable of exerting great influence over their drinkers' behaviour - for better or for

worse (e.g. Barber & Crisp, 1994; Liepman, 1993; Meyers et al. 1999; Miller et al. 1999; Noel & McCrady, 1993; Orford et al. 1975). As early as 1984, Moos & Moos claimed that the most critical variable in deteriorating problem drinking families, was the "personal functioning and degree of life stress of the non alcoholic partner, particularly if the s/he exhibited high anxiety, depression, and physical symptoms."

Moreover, Steinglass (1982) claimed that the degree of psychological distress in these families is compounded by the complex, interdependent coping patterns which have developed within the family system. As illustrated in Figure 2.1, these coping patterns assist the maintenance of the status quo by reinforcing drinkers' excuses, rationalisations, and blaming behaviours. Thus, drinkers are protected from the consequences of their behaviour, and shielded from reality.

If this is true, when relatives significantly improve their mental health and coping patterns, refocus attention onto their *own* feelings, needs, and responsibilities (instead of their drinkers'), and disengage from these interdependent coping patterns, the status quo may begin to collapse. Consequently, drinkers (as well as other members of the family - including their relatives) are likely to be temporarily thrown off balance and left unsupported and unfettered. Whilst this period of instability is undoubtedly uncomfortable, it would provide drinkers with a priceless window of opportunity to more closely review their own behaviour: they may even decide to try out their relatives' new ways of coping.

Moreover, if relatives reduced their nagging and controlling behaviours, some of the "cues" for their drinkers' consumption would be removed (e.g. McCrady, 1988; Noel & McCrady, 1993), and the "confrontation-denial trap" (Miller & Rollnick, 1991) would be much less likely to occur and may become redundant. Subsequently, with marital discord and disturbance reduced, relationships between participants and their drinkers would be given an opportunity to improve. Thus, within a more honest, unprotected, constructively caring environment, it is likely that drinkers' awareness of the seriousness of their behaviour would be increased. As a consequence, they would be more likely to feel considerable emotional arousal (usually painful), coupled with some degree of pleasant emotional arousal due to their improved relationships.

These interactive changes which may occur between relatives and their drinkers are consistent with the processes of change identified by Prochaska, Norcross, and DiClemente (1994, & Chapter 5.1 and 5.2) as being crucial in the movement of

treatment resistant drinkers from precontemplation towards action; viz. raised consciousness, constructively helpful relationships and emotional arousal. Therefore, assuming the Holyoake intervention does indeed empower relatives to take charge of their *own* lives by improving their mental health and coping status, and reducing *their contribution* to marital discord and disturbance, it is highly likely (through the operation of the stress/coping/transactional model: Orford, 1994) that this will have a positive "spin off" on their drinkers' consumption - and *perhaps* even encourage and motivate drinkers to seek help (see Figure 6.2).

This chapter has presented the empirical evidence regarding the pre-intervention emotional distress, marital discord, and coping patterns characteristic of relatives of excessive drinkers. Through exploring the conceptual underpinnings of these psychological disturbances as well as evidence based interventions, an "ideal" program has been designed (as distinct from the *clinically* derived Holyoake program being tested) to assist relatives improve their situations and disengage from the interdependent stress, coping and transactional patterns which have developed within their family systems. Moreover, the likely impact of this changed milieu on treatment resistant drinkers has been explored. The following chapter has presented the development of the experimental hypotheses before the thesis moved into an examination of the method, followed by the results, discussion, and conclusions.

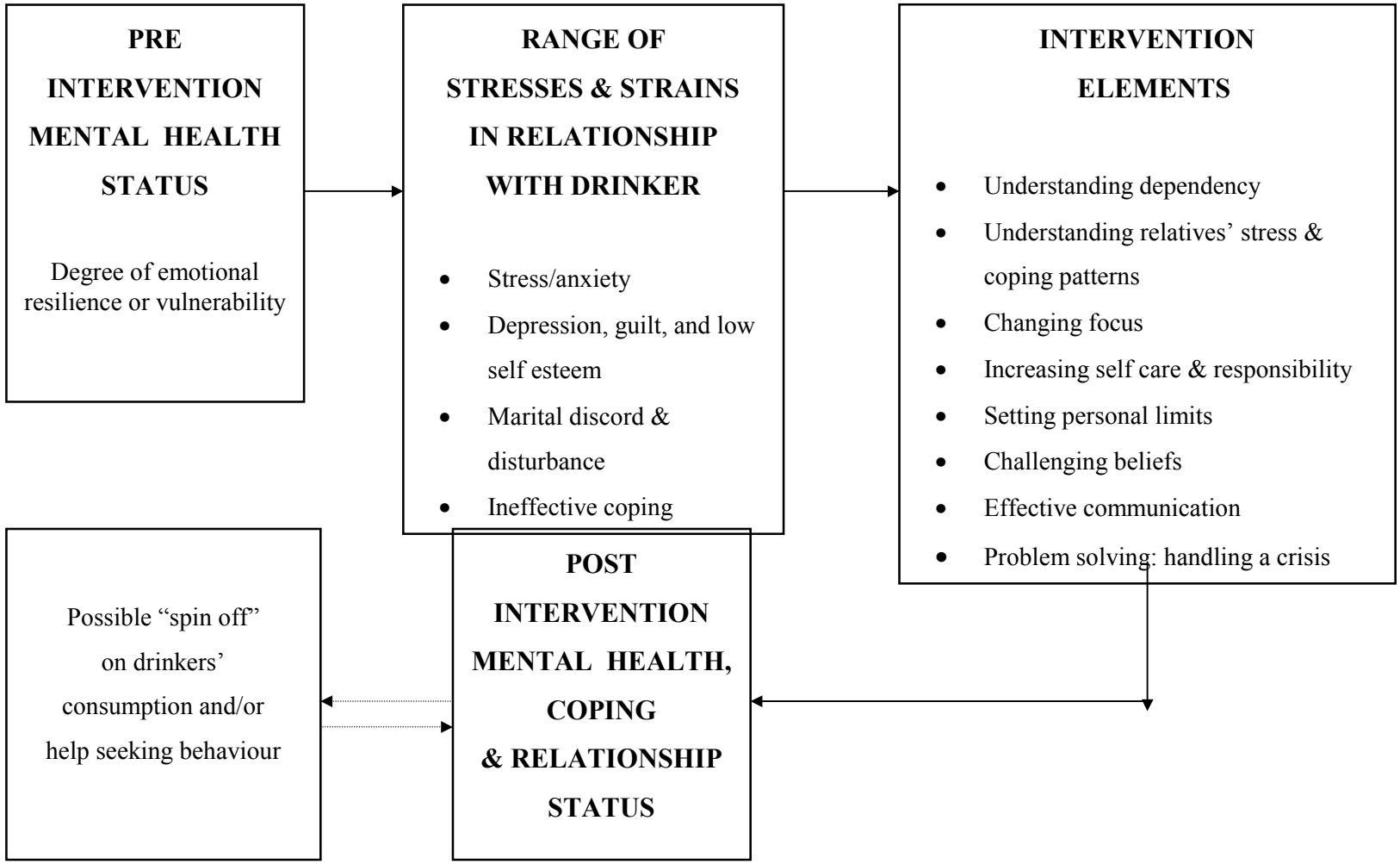

Figure 6.2 The process of empowerment for relatives of excessive drinkers

CHAPTER 7

Formulation of research questions and hypotheses

Before introducing the hypotheses which have guided this thesis, it is important to consider the *nature* of this research. Assuming the Holyoake FOCUS intervention does indeed improve relatives' psychological functioning and also facilitates a reduction in their treatment resistant drinkers' consumption, it is vitally important to understand the "hows" and "whys" of such an outcome. For instance, given the operation of the stress/coping/transactional model (Orford, 1994 & outlined in Chapter 2.6), it is vitally important to understand *how* and *why* the interdependent coping patterns which support the status quo of relatives' distress and drinkers' excessive consumption were dismantled. It is also of vital importance to understand relatives' *perceptions* of the "hows" and "whys" underpinning their drinkers' decisions to reduce their consumption and/or seek help.

The paucity of qualitative information to augment and enrich outcome data has already been highlighted by others (e.g. Araya, 1995; Bodgen & Bilken, 1992; Heath, 1995; Miller, Meyers, & Tonigan, 1999; Ogborne, 1995; Orford et al. 1998a). Therefore, this research has attempted to evaluate the intervention program in question in terms of *both* outcome *and* process. Not only will this help to fill the gap in the literature, it will also provide practical assistance to clinicians working with relatives of resistant drinkers; e.g. "There is good evidence that these program elements are effective, and this is how other relatives have successfully used them."

7.1 Summary of the thesis argument thus far

The initial focus of this thesis has been to examine and evaluate the Holyoake intervention program on a number of levels. Firstly, the *impact* the program appeared to have on relatives' mental health and coping status, and their relationships with their

treatment resistant drinkers. Secondly, the specific *outcomes* associated with the program in terms of possible improvements in relatives' mental health, coping, and relationship status, and thirdly, the process by which the intervention appeared to operate. The process of evaluation has drawn largely on the qualitative nature of the research in terms of relatives' statements and perceptions about the processes of change they were experiencing, and how they were applying the various ideas and strategies they had learned from the program.

Whilst the Holyoake intervention was *essentially* concerned with relatives' issues, the focus of this thesis has extended beyond this into exploring whether improvements in relatives' mental health, coping, and relationships with their treatment resistant drinkers would have a positive, "spin off" effect of motivating those drinkers to reduce their consumption and/or seek help. Thus, the intervention has also been examined and evaluated in terms of its impact on treatment resistant drinkers.

Examination of the empirical literature has revealed that relatives of excessive drinkers are indeed a high risk group who experience considerable stress/anxiety, depression, low self esteem and guilt, marital discord and disturbance, and ineffective coping patterns (see Figure 6.1). Given relatives' motivation to improve their circumstances and to do something positive about their drinkers' consumption, they have variously been co-opted into the treatment process to enhance their drinkers' prognoses (with mixed results), and more recently, successfully trained as agents of change to motivate their treatment resistant drinkers to seek help.

The few programs (e.g. Binns, Dear, Knowles & Hall, 1989) which focussed *primarily* on the needs of relatives in their own right (without involving drinkers in any way), reported significant improvements in relatives' psychological status and relationships with their drinkers. However, no evidence was provided regarding the impact of these improvements on drinkers' consumption or help seeking behaviour.

On the other hand, whilst Dittrich (1993) *primarily* aimed to reduce partners' enabling behaviours in her randomised study (based on Alanon principles), she *also* informed partners about effective intervention strategies, and encouraged them to prepare goals for the future (including a separation/divorce option if their drinkers did not enter treatment). Twelve months post treatment, 39% (n=9) of partners reported they had separated from their husbands, and 48% (n=11) reported their drinkers had entered treatment or AA (a third of these engagements occurred after separation).

However, Dittrich did not clarify which aspects of partners' changed behaviour had encouraged their drinkers to present for treatment: significant reductions in enabling behaviours, significantly improved confidence and assertiveness, the threat of separation/divorce, or the intervention strategies partners were taught.

Miller et al. (1999) improved on Dittrich's (1993) rate of engagement of treatment resistant drinkers and other drug users by training concerned significant others (CSOs) as intervention agents. Their Community Reinforcement and Family Training (CRAFT) resulted in 64% of treatment resistant drinkers being engaged (i.e. 4 hours assessment and at least 1 treatment session). In a further, uncontrolled study, Meyers, Miller, Hill & Tonigan (1999) applied the CRAFT approach with a group of CSOs (56% parents) who were concerned about their loved ones' other drug use (e.g. marijuana and cocaine). As a result, 74% of these drug users were engaged in assessment, and 95% of these completed an average of 8 treatment sessions. Moreover, CSO's reports indicated that the users who completed treatment showed a significantly higher number of abstinent days than those who did not enter treatment. An unanticipated finding was that CSOs *who were parents* were significantly more successful in engaging their treatment resistant drug users to enter treatment than non parents.

The CRAFT approach (see Chapter 3.2) also produced reductions in CSOs depression, anger, family conflict, as well as improved relationship happiness and relationship cohesion - whether their drinkers or other drug users had been engaged or not! According to Miller et al . (1999), an important element in the success of the CRAFT approach was empowering CSOs with the *belief* that they could indeed make a difference to their loved ones' alcohol or other drug use.

Whilst the evidence seems clear that relatives are capable of exerting great influence over their drinkers' behaviour (for better or worse!), several unanswered questions have arisen from the research of Binns et al. (1989), Dittrich (1993), Miller et al. (1999) and Meyers et al. (1999); viz.

- What was the nature of relatives' experiences with their treatment resistant drinkers?
- How did relatives interpret and make sense of those experiences?
- What was the nature of relatives' intervention experiences?
- *How* and *why* did relatives' change their coping behaviours?

- *How* did relatives apply what they had learned?
- What processes underpinned relatives' changed behaviour?
- What impact did drinkers' engagement have on their levels of consumption?
- What was the impact of relatives' improved functioning on the consumption patterns of drinkers who were not "engaged"?
- Would a conceptually based intervention, derived from an understanding of the empirical literature, which *specifically* aimed to improve relatives' mental health, coping, and relationship status, and encourage relatives to focus on their *own* feelings and needs rather than those of their drinkers, also result in drinkers reducing their consumption and/or seeking help?

This thesis has selected as its primary focus the needs of relatives of treatment resistant drinkers. Firstly, it has described the conceptual underpinnings of anxiety/stress, depression, low self esteem and guilt, marital disturbance, and ineffective coping (i.e. the psychological sequelae of living with a treatment resistant drinker). Secondly, it has examined the literature in order to establish a framework from which to develop an "ideal" conceptually derived intervention. Thus, the intervention program described in Table 6.3 has been operationalised from a conceptual model and derived from an understanding of the literature. Moreover, it has aimed to assist relatives to improve their psychological functioning by disengaging from the unhelpful, interdependent coping and relationship patterns which have developed between themselves and their drinkers - without overtly involving their drinkers in this process.

This was precisely what the Holyoake intervention for families of excessive drinkers in Perth, Western Australia has aimed to do over the past 20 years, and there was abundant *anecdotal* evidence that these aims were achieved.

However, the Holyoake intervention had developed in the same way as many other programs in the drug and alcohol field; i.e. from clinical wisdom and clinical experience. Although the Holyoake intervention *seemed* to reflect the conceptual underpinnings as presented in Chapter 6.4, this thesis has attempted to test a model of intervention derived from the empirical literature and to ascertain whether the Holyoake intervention was consistent with that. Thus, this thesis was not only concerned with the testing of the Holyoake intervention, it was also concerned with the testing of its conceptual underpinnings.

Therefore, this thesis has examined and evaluated the Holyoake intervention in terms of both effect and durability on the mental health, coping, and relationship status of relatives of treatment resistant drinkers. In addition, it has examined whether improvements in relatives' psychological functioning facilitated reductions in their drinkers' consumption and/or increased help seeking behaviour. Finally, this thesis has evaluated the Holyoake intervention in terms of its consistency with the conceptual underpinnings of the "ideal" intervention derived from an understanding of the empirical literature.

7.2 Research questions

The research questions were concerned with (i) the pre intervention profiles of research participants and their treatment resistant drinkers in terms of their mental health, coping and relationship status prior to treatment; and (ii) the integrity of the research design. Both quantitative and qualitative data were collected and each has been examined separately in the results.

Research question 1

What was the pre intervention profile of research participants (i.e. relatives of treatment resistant drinkers)

Research participants (who were not dependent on any substance)[1] provided the following information at intake via self report questionnaires. This range of information was sought because (i) there was currently no comprehensive profile of Australian relatives of excessive drinkers in the literature; and (ii) the variables had already been identified by the research literature (and anecdotally) as relevant to relatives of excessive drinkers (see Chapters 1 and 2); viz.

a) Demographics;

[1] One of the selection criteria

b) Personal details; e.g. type of relationship with drinker (e.g. partner, mother, etc); history of parental drinking problems; childhood abuse; and whether participants had told their drinkers they were seeking help;

c) Mental health status; e.g. anxiety and depression;

d) Predominant ways of coping with their drinkers' unacceptable behaviour; and

e) Relationship status; e.g. quality of everyday interactions; degree of marital discord; marital satisfaction and degree of abuse from drinkers.

Research question 2

What was the pre intervention profile of research participants' treatment resistant drinkers (from research participants' perspectives)?

Given collaterals'[2] information about their drinkers' consumption patterns has been found to correlate reasonably well with drinkers' self reports (Meyers et al. 1999; Tonigan, Miller & Brown, 1997), the following information was sought regarding treatment resistant drinkers from research participants via self report questionnaires; viz

a) Demographics; e.g. occupation;

b) Degree of dependency (drinkers were required to meet the dependency criterion) and duration of problematic use of alcohol;

c) Duration of problematic substance use;

d) Consumption patterns; e.g. quantity, frequency, effect; and

e) Readiness to change (e.g. precontemplation, contemplation).

To examine the impact of the intervention program, a quasi experimental design involving a waitlist condition was applied to this research. Whilst every attempt was made to randomly allocate research participants to the two experimental groups; viz. Immediate Entry to treatment, or the Waitlist group, clinical, ethical, and organisational constraints[3] made this impossible to *fully* achieve. Therefore, it was crucial to the integrity of the research design to establish that there were no significant differences between the 2 groups prior to treatment. Therefore, the third research question was developed in relation to this research design; viz.

Research question 3

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[2] Close relatives in ongoing contact with drinkers

[3] The treatment program was evaluated under normal field conditions

Were there any significant differences between the 2 experimental groups; viz. the Immediate Entry to treatment group and the no treatment Waitlist group at Time 1 (pre treatment)?

It was crucial to establish whether any significant changes in research participants' (i.e. relatives of treatment resistant drinkers) situations had occurred during the no treatment waitlist period. Therefore, participants' mental health, coping, and relationship status, and drinkers' consumption patterns were measured twice; i.e. at the beginning and end of their waitlist period. This process ensured that any significant improvements in participants' situations which may have occurred during the no treatment waiting period were identified and controlled for in future analyses. Thus, significant gains made during *treatment* would be more likely be attributed to treatment, rather than merely as the result of the intake process. Thus, an additional research question was developed in relation to the research design; viz.

Research question 4

Were there any significant differences between the Waitlist group at pre treatment (Time 1) compared to the end of the minimum 2 week waitlist period?

Eighty three participants were allocated to either the Immediate Entry (n=54) to treatment group or the Waitlist group (n=29) . However, 15 of these did not commence treatment (the Non Starter group). Therefore, 68 participants (the Composite Treatment group) commenced treatment. However, 5 of these participants dropped out before completing 4 treatment sessions (the Early Dropout group) and 20 dropped out after completing 5 sessions (the Late Dropout group). Thus, 43 participants (the Full Treatment group) completed treatment and follow up procedures.

Given this research was mindful of the intention to treatment principle (Oakley, 1989), two additional research questions were developed to investigate possible differences between (i) the Non Starter group and the Composite Treatment group, and (ii) the Dropout Group (n=25) and the Full Treatment group; viz.

Research question 5

Were there any significant differences between the Non Starter group and the Composite Treatment group at pre treatment (Time 1)?

Given this research was mindful of the intention to treat principle

Research question 6

Were there any significant differences between the Dropout group and the Full Treatment group at pre treatment (Time 1)?

7.3 Intervention hypotheses

According to the empirical evidence, relatives of treatment resistant drinkers are likely to be experiencing elevated stress/anxiety; depression; marital discord and disturbance; and ineffective coping patterns. Given the Holyoake intervention being tested *seemed* to have been based on the conceptual framework and principles underpinning the successful treatment of the stresses and strains of relatives of excessive drinkers, (see Tables 6.2 & 6.3), and specifically targeted relatives' mental health status, the first intervention hypothesis was framed as follows:

Intervention hypothesis 1: The impact of the intervention on participants' mental health status

It was expected that there would be significant improvement in pre and post tests of research participants' mental health status as a result of the intervention and evidenced by:

a) Significantly reduced anxiety (i.e. free floating, somatic, phobic and obsessionality) as measured by Crown Crisp Experiential Index (CCEI);
b) Significantly reduced depression as measured by (i) the CCEI; and (ii) the Drinkers' Partners' Distress Scale (DPDS); and therefore,
c) Significantly reduced emotionality (sum of CCEI subscale mean scores).

Research participants' coping strategies

Although the literature is replete with anecdotal evidence regarding the coping patterns of relatives of excessive drinkers, there is very little corroborative data (e.g. Holmila, 1997; Orford et al.1998b). Moreover, with the exception of Dittrich (1993),

who reported significant post treatment reductions in partners' enabling behaviours, there is a paucity of empirical evidence (although there could be work in progress) regarding either quantitative and/or qualitative *changes* in relatives' coping patterns *as a result of treatment.* Miller et al. (1999) highlighted the need for qualitative data to describe *changes* in relatives' coping strategies and how they *applied* what they have learned from treatment.

Given the Holyoake intervention *seemed* to have been based upon the conceptual framework and principles underpinning the successful treatment of relatives' stresses and strains (see Tables 6.2 & 6.3), and had specifically targeted the coping status of relatives of excessive drinkers, the second intervention hypothesis was framed as follows:

Intervention hypothesis 2: The impact of the intervention on participants' coping status

It was expected that there would be significant changes in pre and post tests of research participants' coping status as a result of the intervention and evidenced by:

a) Significantly reduced control coping strategies;

b) Significantly reduced tolerant coping strategies; and

c) Significantly increased assertive coping strategies.

Marital discord and disturbance

The contributions of partners of excessive drinkers to the degree of marital discord and disturbance is characterised by varying degrees of (i) irritability, anger, and resentment; and (ii) overly caregiving and counselling behaviours; (iii) dysfunctional communication patterns; (iv) abusive and blaming behaviours; and (v) reduced problem solving.

Although the Holyoake intervention seemed to have been based upon the conceptual framework and principles underpinning the successful treatment of relatives' stress and strains, (see Tables 6.2 and 6.3), it did not specifically target relatives' marital discord and disturbance. However, given the operation of the stress, coping and transactional model (Orford, 1994), it was reasonable to expect reductions in levels of research participants' marital discord and disturbance would occur. Moreover,

reductions in research participants' *contribution*s to marital discord may indeed facilitate some degree of reduction in drinkers' abusive behaviours. Therefore, the third intervention hypothesis was framed as follows:

Intervention hypothesis 3: The impact of the intervention on participants' relationship status

It was expected that there would be significant changes in pre and post tests of research participants' relationship status as a result of the intervention and evidenced by:

a) Significantly reduced marital discord;

b) Significantly improved quality of interactions between research participants and their drinkers;

c) Significantly reduced abusive behaviour from drinkers towards research participants; and

d) Significantly improved marital state/satisfaction from research participants' perspective.

Drinkers' consumption patterns

The evidence appears to be quite strong that relatives of excessive drinkers are capable of exerting great *influence* over their drinkers' behaviour - for better or worse (Barber & Crisp, 1994; Barber & Crisp, 1995; Barber, Gilbertson & Crisp, 1997; Bowers *&* Al-Redha*,* 1990; Dittrich, 1993; Fairbairn & Grainger, 1998a, 1998b; Howells, 1981; McCrady, Stout, Noel, Abrams & Nelson, 1991; McKay et al. 1994; Meyers et al. 1999; Miller et al. 1999; Moos, Finney & Chronkite, 1990; Moos & Moos, 1984; Noel & McCrady, 1992; O'Farrell, 1993; O'Farrell & Bayog, 1986; O'Farrell & Cowles 1989; Orford et al. 1975; Orford, 1994; Smith, 1969; Wright & Scott, 1978).

However, this in no way implies that relatives are *ever* responsible for their drinkers' behaviour.

Assuming the Holyoake intervention did indeed empower relatives to take charge of their *own* lives by improving their (i) mental health and coping status; and (ii) reducing *their contribution* to marital discord and disturbance, it was likely (through the

operation of the stress/coping/transactional model: Orford, 1994) that this would have a positive "spin off" on their drinkers' consumption patterns - and perhaps even encourage and motivate them to seek help (see Figure 7.1). Therefore, the fourth intervention hypothesis was framed as follows:

> **Intervention hypothesis 4: The impact of participants' intervention process on their drinkers' consumption behaviour**
>
> It was expected that there would be significant changes in pre and post tests of drinkers' consumption behaviour as a result of the intervention with their relatives and evidenced by:
>
> a) Significant reductions in drinkers' consumption patterns; and
>
> b) Significantly increased help seeking behaviour.

7.4 Outcome follow up: the durability of intervention effects

There is very little empirical evidence regarding the *sustainability* of intervention effects on the psychological functioning of relatives of excessive drinkers (e.g. Binns et al., 1989; Meyers et al., 1999; Miller et al., 1999. Similarly, there seems to be a paucity of evidence regarding the *sustained* on their drinkers' consumption and help seeking behaviour which was facilitated by their relatives' improved functioning.

For instance, whilst Dittrich (1993) and Miller et al. (1999) reported the *frequency* of drinkers who were "engaged" into assessment/treatment as a result of interventions with their relatives, they did not investigate the subsequent *impact* of this engagement on drinkers' consumption patterns. Meyers et al. (1999) redressed this by tracking other drug users' consumption patterns (via their concerned significant others) for 6 months following users' attendance at an average of 8 treatment sessions. Meyers et al. found significant reductions in users' consumption only occurred if they had actually received treatment. However, because this was an uncontrolled study, these results must be viewed with caution. Moreover, data from all these researchers must be viewed with caution, because they gave no information regarding the participants who did not complete the interventions. Thus, their results may have been skewed in favour of the intervention.

Given the precedence from previous studies, it was reasonable to assume that the intervention being tested would also produce *sustained* intervention effects on relatives' functioning. Evidence of the durability of treatment gains would be demonstrated by no significant decrement in effect when comparing Time 3 (end intervention)[4] to Time 4 (3 months post intervention), and Time 5 (6 months post intervention). Similarly, assuming a positive "spin off" impact upon drinkers' consumption patterns and/or help seeking behaviour would have occurred by the end of their relatives' intervention program, that the reductions in drinkers' consumption patterns would also be sustained. Therefore, the durability of the effect of the intervention program would have been demonstrated.

The hypotheses in relation to the durability of treatment effects on research participants' mental health, coping and relationship status, and the durability of the "spin off" impact of these intervention effects on their drinkers' consumption and help seeking behaviour were framed as follows:

Intervention hypothesis 5: The durability of intervention effect on research participants' mental health status

It was expected that there would be no significant decrement of treatment effect on participants' post intervention mental health status when post treatment tests were compared to tests at 6 months post treatment as evidenced by:

a) No significant decrement of effect on anxiety;
b) No significant decrement of effect on depression (as measured by the CCEI and the DPDS); and therefore,
c) No significant decrement of effect on emotionality (sum of the CCEI subscales).

Intervention hypothesis 6: The durability of intervention effect on participants' coping status

[4] Time 1 refers to pre intervention; Time 2 refers to mid intervention

It was expected that there would be no significant decrement of treatment effect on participants' post intervention coping status when post treatment tests were compared to tests at 6 months post intervention as evidenced by:

a) No significant decrement of effect on control coping strategies; and
b) No significant decrement of effect on tolerant coping strategies.

Intervention hypothesis 7: The durability of intervention effect on participants' relationship status

It was expected that there would be no significant decrement of treatment effect in post intervention relationship status when post treatment tests were compared to tests at 6 months post treatment as evidenced by:

a) No significant decrement of effect on marital discord;
b) No significant decrement of effect on the quality of everyday interactions between participants and drinkers;
c) No significant decrement of effect on drinkers' abusive behaviour towards participants; and
d) No significant decrement of effect on participants' marital state/satisfaction.

Intervention hypothesis 8: The durability of intervention effect on drinkers' consumption behaviour

It was expected that there would be no significant decrement of treatment effect on drinkers' post intervention consumption behaviour when post treatment tests were compared to tests at 6 months post intervention as evidenced by:

a) No significant decrement of effect on drinkers' consumption; and
b) No significant decrement of effect on drinkers' help seeking behaviour.

7.5 An examination of the processes of change based on research participants' accounts: a qualitative perspective

The examination of the processes of change which had occurred during the intervention program for participants, their relationships, and their drinkers were drawn from participants' statements and perceptions, and how they had applied the various ideas

and strategies they had learned from the program. Therefore, qualitative research questions have not been framed as hypotheses. Rather they have sought to provide insight into the *nature* of the changes in participants' situations which may have occurred during the intervention program. Thus, prior to intervention, participants were asked to respond to the following questions:

"Just thinking about your partner's (or other family member's) drinking and/or behaviour over the past 3 months,

- What have you found most difficult to deal with in regard to his/her drinking and/or behaviour?;
- How do you usually handle that difficulty? and
- What happens between you and your partner (or other family member) when you handle it in that way?"

The same questions were asked again at mid treatment (after 5 treatment sessions) and end treatment (after 10 treatment sessions). Participants were asked to describe their experiences since their last interview (i.e. a 5 week period).

In addition, research participants were asked (if they had reported a change)

- "What's different about how you're handling your overall situation with your partner (or other family member)"?
- "What do you think has prompted that change?"
- "What's different about the quality of your relationship and how you interact together?"
- "What do you think has prompted that change?"
- "What's different about your partner's (or other family member's) drinking and/or behaviour?"
- What do you think has prompted that change?" ; and
- What is the most important thing which has helped you deal more effectively with your situation"?

CHAPTER 8

Method

8.1 Research participants

Eighty three (71 female, 12 male) research participants were selected from those presenting for entry into the FOCUS (Family, Options, Communication, Understanding, Self) program at the Australian Institute of Alcohol and Addictions (Holyoake) in Perth, Western Australia. FOCUS was a 12 session[1] psycho-educational plus group therapy program designed for people who were adversely affected by another's excessive alcohol use. Research participants were selected if they met three criteria; viz. (i) they were not dependent on alcohol (ii) they were in regular contact with excessive drinkers who *were* dependent on alcohol, and (iii) their drinkers were resistant to change. Initially, only partners were selected. However, due to the scarcity of partners of *treatment resistant drinkers* (many partners who had enrolled in the Holyoake FOCUS program were either separated from their drinkers, or their drinkers were in treatment), it became obvious that other relatives who met the selection criteria would need to be recruited if the necessary numbers were to be obtained. As a result, as well as 70 partners, 13 other relatives were recruited. Barber and Crisp (1995) reported similar problems obtaining partners of excessive drinkers to join their South Australian study. Barber and Crisp ultimately decided to recruit additional partners from Victoria.

8.2 Measures

To obtain a comprehensive assessment and analysis of the therapeutic impact of the FOCUS program on research participants and their treatment resistant drinkers, three levels of measurement were used; viz. (i) measures to address the selection criteria; (ii)

[1] Research participants attended only 10 of the 12 sessions

non psychometric and qualitative instruments to obtain personal information from research participants about themselves and their drinkers; and (iii) psychometric instruments to assess the impact of the intervention on research participants. Table 8.1 presents the dependent variables and how they were measured, and is followed by a description of the psychometric and non psychometric measures used in this research

8.2.1 Psychometric instruments (see Appendix 1)

The psychometric instruments were chosen to provide a base line measure of (i) research participants' mental health status as evidenced by their levels of anxiety and depression; (ii) the degree of problems and associated distress research participants were experiencing in reaction to their drinkers' excessive consumption; and (iii) the quality of their relationships with their drinkers. Moreover, as these measures were also applied at mid treatment, end treatment, and 3/6 months post treatment, they provided evidence of the impact of the intervention and the durability of treatment gains.

(i) Crown-Crisp Experiential Index (CCEI)

Given the FOCUS program aimed to improve the well-being of partners of excessive drinkers, it was essential to measure research participants' mental health status and ascertain whether any possible improvements could be attributed to treatment. The CCEI (Crown & Crisp, 1979) was chosen for this research because it was a brief, conveniently administered, reasonably valid and reliable measure of personality for use in research and screening. The 48 item CCEI was published in its original form as the Middlesex Hospital Questionnaire (MHQ). Moreover, the CCEI was designed to screen for psycho-neurotic traits, and measure therapeutic gains after defined interventions; e.g. group psychotherapy.

Table 8.1
Dependent variables and measuring instruments

Dependent variables	Measurement instruments
1. Research participants (relatives of treatment resistant drinkers)	
• Mental health (anxiety & depression)	• Crown-Crisp Experiential Index (CCEI) (free floating anxiety, somatic anxiety, phobic anxiety, obsessionality & depression)
	• Drinkers' Partners' Distress Scale (DPDS) (depression subscale)
• Coping strategies	• Drinkers' Partners' Coping Questionnaire (DPCQ)
2. Relationship between research participants and drinkers	
• Quality of interactions when drinker drinking as opposed to not drinking	• Non psychometric general questionnaire (research participants' perceptions)
• Degree of marital discord	• Drinkers' Partners' Distress Scale (DPDS) (marital discord subscale)
• Degree of abuse from drinkers towards participants	• Non psychometric general questionnaire (research participants' perceptions)
• Marital state/satisfaction	• Golombok Rust Inventory of Marital State Questionnaire (GRIMS)
3. Treatment resistant drinkers	
• Consumption patterns (frequency, effect & volume)	• Non psychometric general questionnaire (partners of treatment resistant drinkers' observations; i.e. research participants)

Given relatives (particularly partners) of excessive drinkers have often been "neuroticised" in the literature (e.g. Bailey, 1967; Watts, Bush & Wilson, 1994; Whalen, 1953), this questionnaire is eminently suitable. As well as the profile of six subscales; viz. free floating anxiety, phobic anxiety, obsessionality, somatic anxiety, depression, and hysteria. The total score gives a measure of general emotionality or "neuroticism" as opposed to emotional resilience or toughness.

Free floating anxiety was described as dread, indefinable terror, tension without a cause, or panic; e.g. "Do you often feel "strung up" inside?"; (ii) phobic anxiety as that experienced in specific situations; e.g. "Do you feel panicky in crowds?"; (iii) obsessionality as excessive meticulousness, the tendency to over check; etc.; e.g. "Does it irritate you if your normal routine is disturbed?"; (iv) somatic anxiety as the somatic concomitants of anxiety; e.g. "Are you troubled by dizziness or shortness of breath?"; (v) depression as sadness of mood, difficulty in thinking clearly and slowing of actions and activity; etc.; e.g. "Do you experience long periods of sadness?"; and (vi) hysteria was described as shallow labile affectivity, and over dependence on others; e.g. "Do you enjoy being the centre of attention?"

Psychometric properties of the CCEI

Crown and Crisp (1979) report split-half and test-retest reliabilities for each subscale. However, no reliability figures are available for the total score. Crown and Crisp defend their poor split-half reliability coefficients which range between .37 and .84 for psycho-neurotic out-patients (n=62) and .35 and .64 for "normals" (i.e. nurses and medical students, n=43) by claiming that split-half reliability is not an appropriate measure of reliability for the CCEI.

According to Crown and Crisp, this is because the CCEI measures *both* personality traits and symptoms. Two questions from the obsessionality subscale illustrate this; viz. "Do people ever say that you are too conscientious?" as opposed to, "Do you have to check things you do to an unnecessary extent?" Moreover, phobias are, by definition, specific and sometimes unifocal. Whilst 2 to 3 questions in the scale might be sufficient to correctly identify the phobia, if respondents are not found to be phobic on the remaining questions, split half reliability is subsequently reduced.

Crown and Crisp claim acceptable test-retest reliability figures are much more relevant to a test like the CCEI. They report correlations for a sample of 129 males (working in industry) which ranged from 0.68 to 0.72; and between .55 and .84 for neurotic patients seen by general practitioners (n=74). Given these correlations were obtained over a 12 months and 4 weeks respectively, they are indeed acceptable and attest to the good temporal stability of the CCEI.

Regarding validation, Crown and Crisp report two separate validation studies which were carried out on patients in large urban and rural general practices. "Striking ...similarity" was found between the distribution of scores between these two groups which is empirically relevant to the use for the CCEI in screening surveys. Moreover, the mean scores of 5-10% of the total population on all subscales (excluding Hysteria) closely approximated the mean scores of the clinically identified psychoneurotic population.

Various studies (Alderman, 1983; Kahn and Cooper, 1991; Joukamaa, 1992, Ross & Hafner, 1991) confirm the acceptable reliability, validity, factorial structure, and cross cultural utility of the CCEI and its predecessor the MHQ (Bagley, 1980; Crisp, Jones, Gaynor & Slater, 1978; Dasberg, 1978; Hurwitz, Nichol, Beiser & Kozak, 1987; Mavissakalian & Michelson, 1981; and Nielsen, Cilli, Fontanesi & Javazzo, 1986). Moreover, Birtchnell, Evans and Kennard, (1988) found the CCEI *total score* a "useful and valid measure of psychoneurotic pathology". However, others (Burgess, Mazzocco & Campbell, 1987; Knight, Waal-Manning & Spears, 1983) had reservations about the discriminant validity of the obsessionality and/or the hysteria subscales.

The present research supported the temporal stability of the CCEI subscales and the total score. Good correlations (according to Jaccard & Becker, 1990) were found between administrations at the beginning and the end of the 2 week waiting period (see Appendix 5). Although reliability analysis of the total 48 item scale revealed excellent internal consistency (Chronbach's alpha = .90), 7 items had corrected item total correlations of less than 0.13. The majority (n=5) of these items belonged to the hysteria subscale. Professor Crisp has confirmed[1] that the hysteria subscale has validity and reliability problems, and suggested ignoring it when reporting individual profiles or

[1] Personal communication to Mr Edwin Milliken, psychologist, Northern Territory of Australia, 1996

calculating total scores.[2] Comparisons between the reliability figures quoted by Crown and Crisp (1979) and those which were found in the present research (see Appendix 5) confirm the concerns regarding both the hysteria and obsessionality subscales. Therefore, whilst the obsessionality subscale was retained for clinical interest and the calculation of the CCEI total score, the hysteria subscale was not used in this research.

(ii) Drinkers' Partners' Distress Scale (DPDS)

The DPDS was chosen because initially this research was focussed upon partners of excessive drinkers. Because there were not enough partners available, 13 other relatives were recruited. It was decided to ask other relatives to complete the DPDS because only 2 of the 24 items were partner specific[3] (items 12 and 24, see Appendix 1). Relatives marked these items as "not applicable" and they were scored as "never".

Given the Holyoake FOCUS program aimed to minimise the harm experienced by relatives of excessive drinkers, it was essential to evaluate that component of the program. The DPDS (Crisp & Barber, 1995) was chosen because it is the only scale which has been specifically designed to identify the problems experienced by partners of excessive drinkers *as well as* the associated degree of distress and marital discord. The DPDS is comprised of two identical 12 item companion scales. Whilst the first scale asks participants to indicate on a 5 point Likert scale the frequency with which certain problems occur which can be attributed to their associates' drinking, the companion scale asks about the level of distress associated with each of these problems.

The DPDS has 2 subscales; viz. depression and marital discord. The depression subscale is comprised of 7 pairs of items from the companion scales and asks about partners' feelings and experiences in relation to their drinkers' consumption; viz. embarrassment, loneliness, neglect, lack of stimulating adult company, worry about leaving heavy drinkers in charge of household responsibilities, unsatisfactory sex,[4] and insecurity about the relationship. The marital discord subscale is comprised of 5 pairs of items and asks about partners' irritability and anger in reaction to their drinkers'

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[2] All total scores in this research have been calculated without hysteria
[3] Asking partners about sexual satisfaction with their drinkers

consumption; money shortages; and verbal and physical abuse directed towards partners by their drinkers. Subscale scores are obtained by averaging the sum of the products of each group of item pairs.

Psychometric properties of the DPDS

According to Barber, Gilberston and Crisp, (1997) and Crisp & Barber (1995), baseline data (n=32) of the DPDS was found to contain 2 internally consistent subscales; viz. the 7 item depression scale and the 5 item marital discord scale with Chronbach's alphas of .86 and .83 respectively. Moreover, test-retest reliability with a 3 month interval was r=.71 for depression and r=.50 for marital discord. Construct validity of the depression subscale was supported by correlations of r =-.75 with the Wolcott and Glezer's (1989) General Well-being scale and r=-0.60 on the Self Esteem scale. The construct validity of the marital discord subscale[5] was supported by its significant correlation[6] (r=-.60) with Wolcott & Glezer's Marital Consensus Scale. Discriminant validity for the marital discord subscale was supported by its relatively low correlation with the Wolcott and Glezer measures of Well-being (r=-.25) and Self Esteem (r=-.26).

(iii) Drinkers' Partners' Coping Questionnaire (DPCQ)

The Drinkers' Partners' Coping Questionnaire (DPCQ) was developed especially for this research and also focussed on partners' experiences. However, given the difficulty finding enough partners, 13 other relatives also responded to this questionnaire. As for the DPDS, these relatives marked 3 items of 36 (i.e. items 9, 20 and 23, as "not applicable" and these items were scored as "never".

One of the aims of the FOCUS program was to improve coping. Given the coping questionnaire was to form part of an assessment package which was to be applied 5 times, it was essential that it be as short as possible to enhance user friendliness and compliance, especially as participants were asked to complete their

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[4] Other relatives scored this question as "no"

[5] The current study found a positive correlation of 0.54 (at the .01 level) between the marital discord subscale and the Golombok Rust Inventory of Marital Satisfaction (GRIMS)

[6] The current study found the depression subscale (n=66) correlated significantly (r=0.57) at the .01 level with the CCEI Depression subscale (n=83)

questionnaire packages 5 times.[7] Although there was an appropriate 68 item coping questionnaire available,[8] there was no relatively *short* questionnaire publicly available which focussed on the coping strategies utilised by relatives of excessive drinkers. Therefore, the present author developed the 36 item Drinkers' Partners' Coping Questionnaire (DPCQ).

The framework for the development of the DPCQ came from 2 sources. Firstly, Orford (1992) had defined 8 coping categories typically used by relatives of excessive drinkers; viz. control, emotional, tolerant, avoidance, inactive, confronting, independent, and supporting user, and presented 2 items for each category. The second source which contributed to the development of the DPCQ was the 90 item Enabling Behaviors Inventory (EBI) developed by Dittrich & Trapold (1984). The EBI asks respondents to endorse thoughts/beliefs/behaviours they have had during the past month regarding; e.g. "Thought if your spouse really cared about you, s/he would quit using alcohol or drugs"; "Believed that you are one of the reasons that your spouse drinks/uses drugs"; and "Helped nurse your spouse through a hangover". The total EBI was also unsuitable for 3 reasons; (i) it was too long to include in the total assessment package; (ii) the questions relating to thoughts and feelings were not appropriate for this research; and (iii) no EBI items focussed on assertive behaviour (a category identified by Orford, 1992).

The process of developing the DPCQ

A pool of items was created by selecting items from the EBI which specifically related to coping behaviours and sorting these into Orford's (1992) 8 categories. Some items were combined into broader concepts and/or reworded to make them more appropriate for this population; e.g. "Paid attorney or court fees or bailed your spouse out of jail", "Borrowed money to pay bills", and "Helped pay off some of your spouse's financial debts" were combined as, "Took responsibility to pay financial debts which were created by your partner's excessive expenditure on alcohol."

[7] One of the participants decided to leave the research program because the questionnaires were "too burdensome" given her problems at home

A review panel of 7 independent experts and 3 lay people was formed; viz. 3 academics[9] who had extensively published in the addiction field (with particular reference to partners of excessive drinkers); 4 professionals who had been involved for many years in treatment programs for partners of heavy drinkers; and 3 partners of excessive drinkers who had successfully coped with the problem of alcohol abuse in their families. Initially, these people were asked to (i) provide as many items as possible in addition to the EBI items grouped with Orford's (1992) two sample items for each category.

Each person on the review panel was then asked to choose 6-7 items which they thought best represented Orford's definitions from the now expanded list of items in each category. The items with the most endorsements were selected and the resulting 48 item DPCQ (with 6 items in each of Orford's categories) was given to participants as part of their questionnaire package. Participants were asked (at their initial interview) with what frequency, on a 5 point Likert scale ranging from "never" to "always", they had used each coping strategy over the past 2-3 months (or 5 weeks at their mid program interviews or 3 months at their post treatment interviews).

Psychometric properties of the DPCQ

When the 48 item DPCQ was subjected to reliability analysis (n=63) a Chronbach's alpha of 0.75 was produced. The removal of 11 items increased this to .91. Because the sample size was too small to factor analyse, or to retain all Orford's 8 coping categories, the author combined categories which loaded onto a central concept; viz. (i) items in the control and emotional categories were combined into one category called "control"; (ii) items from the tolerant, inactive and avoidance categories were combined into one "tolerant" category, and (iii) items from assertive confronting, independent and supporting user categories were combined into one "assertive" category. Internal consistencies of the resulting control, tolerant, and assertive

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[8] Professor Orford supplied the author with his full list of coping items (n=68) but they did not arrive in Australia until after the DPCQ had been constructed. Given a short questionnaire was essential to enhance user compliance all 68 items would not have been appropriate in any case

[9] Two of whom were Dr Crisp and Professor Barber (who developed the DPDS)

subscales were .84, .81, and .77 respectively. Table 8.2 presents the subscale descriptions and examples of items.

The DPCQ performed equally well when these subscales were subjected to test-retest reliability (investigated by Pearson's Product Moment). Mean scores at the beginning and end of the 2 week waiting period were correlated resulting in significant correlations (at the .01 level); viz. Control r=.76; Tolerant r=.67; and Assertive r=.83. The 36 item questionnaire has been presented in Appendix 1.

(iv) Golombok Rust Inventory of Marital State Questionnaire (GRIMS)

One of the aims of this research was to investigate whether the Holyoake FOCUS program produced an unintended result of improved marital relationships for participants. The 28 item GRIMS (Rust, Bennum, Crowe, & Golombok, 1988) was chosen because it assesses the overall quality of a couple's relationship. According to Rust et al. the GRIMS items focus on areas in which a marriage guidance counsellor or family therapist would hope to see change during therapy[10]; viz. beliefs, attitudes and feelings about; (i) shared interests; (ii) communication; (iii) warmth, love, and the incidence of hostility; (iv) trust and respect; (v) roles expectations and goals; (vi) decision making; and (vii) coping with problems and crises. Moreover, the GRIMS has a standardised format, is quickly and simply administered and scored via a carbonised self scoring sheet. Respondents are asked to respond to each statement along a 5 point Likert scale which ranges from Strongly Agree to Strongly Disagree. A high score represents a problematic relationship (see Appendix 1).

[10] The GRIMS does not ask about sexual problems. These are dealt with by a companion scale; viz. the Golombok Rust Inventory of Sexual Satisfaction (GRISS)

Table 8.2
Drinkers' Partners' Coping Questionnaire (DPCQ) subscales, descriptions, and example items.

Subscale	Subscale description	Example items
Control (14 items)	• Attempts to directly control use or events directly related to use.	• Covered up. lied, or made excuses for your partner's drinking behaviour to family, friends, or business associates.
	• Expression of strong emotion towards the partner because of his/her drinking behaviour.	• Accused your partner of not loving you or letting you down because of the drinking.
Tolerant (13 items)	• Actions that support use or which protect user from harmful consequences of use.	• Helped your partner through a crisis created by his/her drinking.
	• Responses indicating lack of action.	• Had sex with your partner when you really didn't want to because s/he had been drinking.
	• Partners deliberately putting distance between themselves and users.	• Waited for your partner to fall asleep before going to bed.
Assertive (9 items)	• Calm open communication to the user about partner's position and needs concerning the drinking.	• Made it quite clear to your partner (when s/he was sober) that the drinking was causing you upset and that you wanted him/her to do something about it.
	• Actions indicating personal independence or lack of dependence.	• Put the interests of other members of your family before those of your partner.
	• Actions that support user in modifying use or in pursuing alternative personal goals.	• Communicated your pleasure to your partner about his/her reduced/nil alcohol intake.

Psychometric properties of the GRIMS

Reliability was assessed by internal consistency and split half techniques (Rust et al. 1988). Internal consistency of the scale ranged between .89 for females and .92 for males. Split half reliability similarly ranged between .86 and .94. Content validity of the GRIMS was high with respect to its specification, and high face validity has been incorporated into the item selection. Diagnostic validity was obtained at marital clinics

where GRIMS mean scores compared to diagnoses made by therapists at marital clinics. In the present study, test retest reliability over the 2-3 week waitlist period was significant at the .01 level with r =.78.

8.2.2 Non psychometric instruments (see Appendix 2)

To obtain ongoing information about participants and their drinkers' consumption, the author designed general questionnaires and structured qualitative interviews which were applied at each assessment point.

(i) General questionnaires

The pre intervention general questionnaire was designed to obtain (i) demographic and personal information about participants; (ii) their family of origin, (iii) their drinkers' consumption patterns; and (iv) the relationship between participants and their drinkers. Questions seeking participants' personal information focussed on their current use of medication, counselling or self help groups; and the incidence of previous relationships where alcohol/other drugs had been a problem. Family of origin questions focussed on parental patterns of alcohol/other drug use, and the incidence of childhood abuse (emotional, verbal, physical, and sexual).

Questions relating to drinkers' consumption sought participants' perceptions regarding the duration of the drinking problem, pattern of use, frequency, volume of consumption, and degree of resulting intoxication. Participants' information was deemed to be valid because collaterals' estimates of consumption patterns correlate well with drinkers' estimates (Jarmas & Kazak, 1992; McAuley, Longbraugh, & Gross, 1978; Meyers, Miller, Hill & Tonigan, 1999). Relationship questions asked for participants' perceptions of the quality of their interactions when their drinkers were drinking as opposed to when they were not drinking, and the degree of abuse (emotional,[11] verbal, financial, physical, and sexual) research participants were receiving from their drinkers.

The general questionnaire was given at the end of the waitlist period, mid treatment, end treatment, and 3/6 months post treatment to identify any changes which

may have occurred in (i) participants' use of medication, counselling or self help groups; (ii) drinkers' consumption patterns; and (iii) relationship between research participants and their drinkers. Relationship questions covered by this questionnaire included participants' perceptions (over the past 3 months) regarding the *quality* of their interactions with their drinkers when drinkers were drinking as opposed to not drinking, and the degree of abuse directed towards participants by their drinkers.

(ii) Structured qualitative interviews

The qualitative interviews were used to augment and enrich the quantitative data by "tapping" participants' (i) perceptions and evaluative analysis of their situations; (ii) explanations for change which may have occurred; and (iii) perceptions of factors which underpin or impede change. The pre treatment interview asked participants (i) what they were finding most difficult to deal with regarding their drinkers' consumption and/or behaviour over the past 2-3 months; (ii) how they usually handled that particular difficulty; and (iii) what happened when they handled it in that fashion. Other questions related to their level of support, what they wanted from treatment, and whether they had notified their drinkers that they were seeking help. Where necessary and appropriate, additional clarifying and extending questions were asked; viz. "Would you explain what you mean by ..... ?" and "Would you expand on ..... ?"

Subsequent qualitative interviews[12] at mid treatment, end treatment and 3/6 months post treatment asked participants whether any changes had occurred during the intervening period; viz. (i) how they were handling their situation; (ii) how they were feeling; (iii) their observations of drinkers' consumption and/or behaviour; and (iv) the quality of their relationships with their drinkers. If participants identified a change in any of these areas (either positive or negative), they were asked what they thought had prompted that change. Participants were also asked to identify (if anything) the most important thing that was helping them deal more effectively with their situations.

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[11] Emotional abuse refers to drinkers' manipulative, guilt provoking, and often passive aggressive behaviour

[12] The Waitlist group was interviewed at the end of the waitlist period primarily to check whether there had been changes in drinkers' consumption (see Appendix 3)

Qualitative interviews were transcribed and each question was analysed according to content analysis principles where the essence and meaning[13] of participants' responses, and subsequent themes were identified. This was different from some of the best known ways of doing qualitative research; e.g. discourse analysis or grounded theory.

Answers to specific questions were coded, using only one category for each question per participant, and the data were sometimes used in a quasi-numerical fashion. For example, in answer to the question, "Over the past 2-3 months, what are you finding most difficult to deal with in relation to your partner's drinking/behaviour?", one participant replied, "He changes from a lovely person to a total ogre when he drinks. It's like living on a knife edge". This response was placed within the "aggressive mood swings" theme (within the abusive behaviour category). If participants gave more than one response, they were asked to choose which one they found most difficult. Emerging themes were subsequently grouped into categories.

A random selection of 30% of interviews (n=13) was used to examine inter-rater reliability between the researcher and the independent research assistant regarding (i) the essence and meaning of participants' responses to each question, and (ii) emerging themes. Initially, 88% inter-rater agreement was achieved, which improved to 99% after discussion between raters.

8.3 Procedure

8.3.1 Selection instruments (see Appendix 3)

Research participants were selected if they met three criteria; viz. (i) they were not dependent on alcohol/other drugs, (ii) they were in regular contact with excessive drinkers who *were* dependent on alcohol/other drugs; and (iii) their excessive drinkers

[13] If participants' initial response was unclear or insufficient in length, they were asked to clarify or expand. Some participants gave longer answers than was required. Therefore, raters had to make a decision regarding the *essence* and *meaning* of each participants' responses

were resistant to change. The following instruments were used to screen participants for eligibility.

a) Alcohol dependence of research participants and their drinkers

Short Michigan Alcohol Screening Test (SMAST)

The SMAST is a 13 item, shortened version of the Michigan Alcoholism Screening Test (Silber, Capon & Kuperschmit, 1985). The items consist of questions directly related to drinking behaviour; e.g. "Are you always able to stop drinking when you want to?" Scores range between 0 and 13, and Selzer, Vinokur & van Rooijen (1975) suggest a minimum score of 3 is required for the "diagnosis of alcoholism" and scores lower than 3 "identifies non alcoholics."

The SMAST (Moore, 1972; Selzer et al. 1975) was chosen because it was a reliable screening instrument for alcohol related problems and could be used to assess the dependency levels of drinkers in absentia. This is because the SMAST has been successfully converted to family forms (Jarmas & Kazak, 1992; McAuley, Longbraugh & Gross 1978) which allow collaterals to complete the questionnaire *on behalf* of their drinkers. Therefore, participants completed the SMAST for themselves and the SMAST Family Form on behalf of their drinkers. This questionnaire has also been used by Barber and Crisp (1995) to assess the dependency of excessive drinkers through their partners' reports.

The SMAST Family Form is identical to the SMAST except that the pronouns in each question are changed from "you' to "s/he"; e.g. the question cited above is changed to, "Is s/he always able to stop drinking when s/he wants to?" Participants were selected if (i) their personal score on the SMAST was less than 3 and (ii) their drinkers scored 3 or more on the SMAST family form.

b) Drinkers' readiness to change

The Change Questions

To assess drinkers' resistance to change, research participants were asked to respond to 3 questions which were developed by the present author and based on the

stages of change model developed by Prochaska and DiClemente (1986) and Prochaska, Norcross and DiClemente (1994); viz.

- Do you think your partner is thinking about changing his/her drinking?;
- Is s/he actually doing something about changing his/her drinking?; or
- Is s/he not even thinking about changing his/her drinking?

8.3.2 Research setting and preparation for subject recruitment and assessment

The author established the research program at The Australian Institute of Alcohol & Addictions (Holyoake) in Perth, Western Australia. She trained two staff in interview procedures, data collection, scoring of questionnaires, and general administration of the research program. Neither of these staff was involved with the group therapy facilitation or individual counselling of participants in the FOCUS program.

The training was accomplished by (i) ensuring each Research Assistant (RA) had a thorough understanding of the research project; (ii) role plays of standardised procedures (see Appendix 4); (iii) author modelling procedures; and (iv) author observing RAs conducting interviews and scoring questionnaires to ensure satisfactory concordance. Additional training was provided to the RA (a 3rd year psychology student) responsible for providing participants with written feedback regarding their questionnaire results. The complete training process was continued until an acceptable level of procedural interview fidelity was achieved and maintained.

Over the 2 year data collection period, the author maintained quality control by providing ongoing supervision, support, and written feedback particularly in relation to the audio-taped qualitative interviews. This process was designed to encourage RAs by ensuring they were informed of the positive aspects of their qualitative interviews, what needed to be improved, and how this could be done.

The major benefit from conducting the research at one organization was the opportunity it gave to thoroughly evaluate a fairly intensive intervention. Moreover, it was cost effective in terms of time as the author was able to train the two research assistants together and they were able to assist and support each other as the research

progressed. Moreover, the Holyoake organization wanted to have their FOCUS program evaluated and were prepared to give the necessary support to enable this to happen.

8.3.3 Identification and recruitment of research participants

Holyoake counsellors were fully briefed regarding the purpose and benefits of the research and were asked to refer all clients who had registered for the FOCUS program to one of the research team who would assess their suitability and willingness to take part in the research, and arrange start dates.

Once verbal screening established clients were in ongoing contact with a treatment resistant drinker, they were asked to confirm their eligibility for the research by completing the SMAST and the SMAST family form (on their drinkers' behalf). If the dependency criteria were met (for both client and drinker), clients were asked to respond to the Change Questions; viz. "Do you think your partner is thinking about changing his/her drinking?; Is s/he actually doing something about changing his/her drinking?; and is s/he not even thinking about changing his/her drinking?" Clients were selected to take part in the research if their response indicated their excessive drinking associates were not taking any action toward reducing their drinking. Once eligibility was confirmed, participants read and signed the Consent Form and provided their confidential code (see Appendix 3).

8.3.4 Pre intervention assessments[14]

Once the process of obtaining informed consent was complete, the pre treatment qualitative interviews were audio-taped, and eligible research participants completed their pre treatment questionnaire packages described above (i.e. general questionnaire, DPDS, DPCQ, CCEI, and GRIMS[15]). Participants were then allocated to either the Immediate Entry to treatment group or the Waitlist group. When questionnaires were scored, results were entered onto the Questionnaire Results Forms (see Appendix 1) which were given to participants during their Feedback interview (usually just before

[14] Those in the Waitlist group received an additional interview and questionnaire package at the end of the waitlist period

they commenced their first treatment session). All scored questionnaires and audio-taped interviews were sent to the author in New South Wales for analysis.

8.3.5 Research design

Prior to commencing treatment, the 83 research participants were allocated to one of 2 research groups; viz. Immediate Entry to treatment (n=54) or Waitlist group (n=29). Given Holyoake had established a practice of allowing their clients to commence treatment immediately after assessment, a *minimum* waitlist period of 2 weeks was decided upon.[16] Although the waitlist period was not the ideal equivalent length to the intervention (or at least the length of the first measuring point; i.e. 5 weeks), it was as much as organisational constraints would allow. Whilst the short waitlist period was a major drawback associated with the evaluation of an existing intervention, at least it enabled any pre intervention changes which may have occurred in participants' mental health, coping or relationship status, or their drinkers' consumption, to be identified.

Once the waitlist period was over, and homogeneity established, both research groups were combined into the Composite Treatment Group (see Figure 8.1). Data was generally analysed by 1 x 5 repeated measure MANOVA with Treatment and Time (pre treatment, mid treatment, end treatment, and 3/6 months post treatment) as the independent variables. Preliminary analyses (detailed in Chapter 9) confirmed that there were no significant differences between the Waitlist and Immediate Entry groups on the dependent variables listed in Table 8.1. Wherever, possible, data was analysed according to the intention to treat principle (Oakley, 1989). This was because data tends to be skewed in favour of the intervention if participants who were allocated to treatment, but did not commence, are ignored. Thus, participants allocated to the research have been included (wherever possible) in the results even though they did not commence treatment or complete treatment.

Waitlist group participants commenced their 10 treatment sessions at the end of their waitlist period. Fifteen participants were lost to the research (4 from the Waitlist

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[15] The GRIMS was only given to partners in the study
[16] Most participants waited between 2 and 3 weeks to commence their program

group) before treatment commencement. Fourteen did not present for treatment and one decided not to continue with the research because she found the questionnaires "too burdensome" given her "problems at home". Therefore, only 68 participants (43 from the Immediate Entry group and 25 from the Waitlist group) actually commenced treatment.[17] Figure 8.1 presents the flow of participants from selection to treatment commencement.

It was therefore virtually impossible to randomly allocate participants to the Waitlist group. Moreover, because some members of the Waitlist Group were lost during treatment, participants were often allocated to the Waitlist Group merely to restore the numbers required for successful statistical analysis. This situation was further exacerbated by various organisational, clinical, and ethical constraints upon not giving participants a choice of when they could commence the intervention program. Thus, the design for this research was forced to be quasi-experimental (Cook & Campbell, 1979) with all the associated threats to internal validity resulting from incomplete randomisation and the short waitlist period. Thus, the inability to control these important aspects of the research was the main drawback of evaluating an existing program in the field.

[17] Additional details regarding this Non Starter group have been presented in Chapter 9

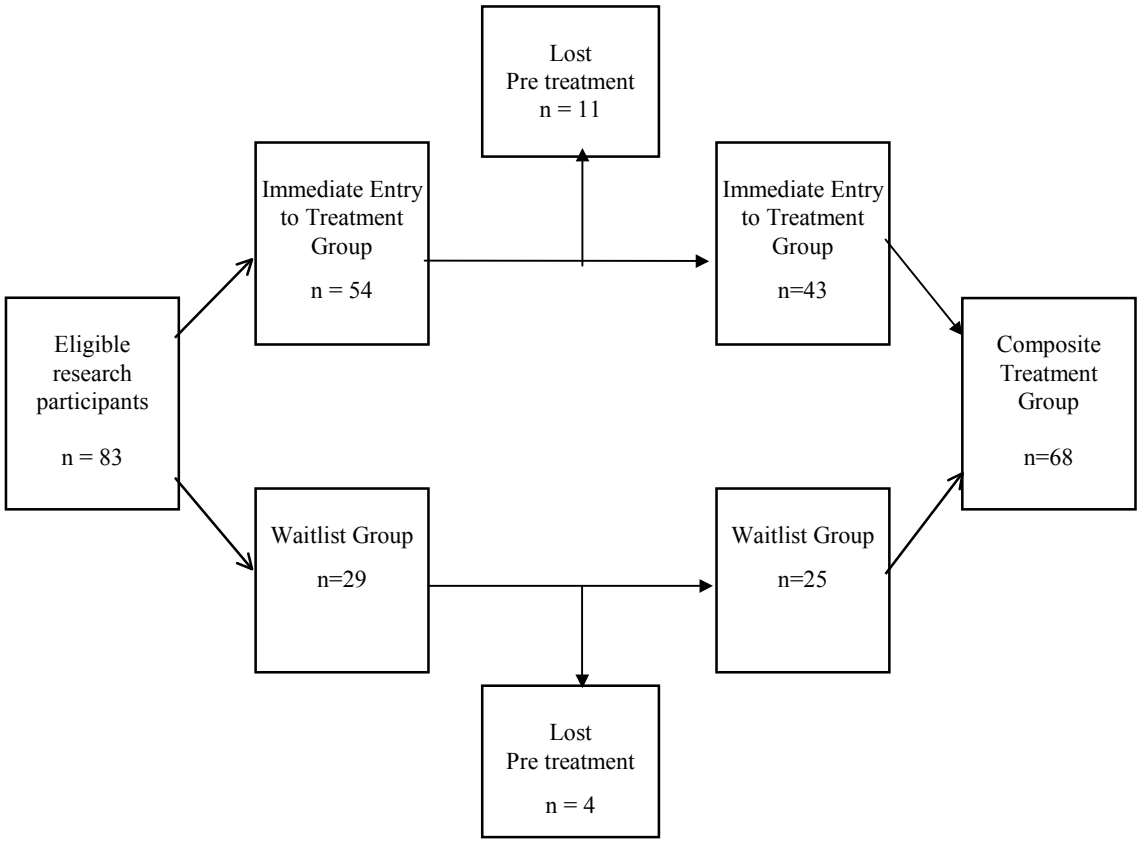

Figure 8.1 Flow of research participants from initial selection to treatment via Immediate Entry or Waitlist groups

8.3.6 The Holyoake FOCUS intervention

Initially, it was intended to test the conceptually derived intervention described in Chapter 6.5 and Table 6.3 at one of the alcohol treatment agencies in Wollongong (a regional city in New South Wales) who worked individually with the relatives of drinkers who were already in treatment However, the staff at that agency were not prepared to advertise for relatives of *treatment resistant drinkers*, nor ask relatives to take part in a research program which aimed to investigate the "spin off" effect of

relatives' treatment on their resistant drinkers because they believed that was tantamount to blaming relatives.

Thus, it was impossible to recruit enough relatives for the study in Wollongong within the time frame of a PhD thesis. Given Barber and Crisp (1995) had experienced similar problems in obtaining enough partners of excessive drinkers to take part in their study at Flinders University in Adelaide, South Australia, it was reluctantly decided to evaluate an already existing program.

The Holyoake FOCUS intervention was selected because it was the *only* program in Australia (apart from Alanon) which *specifically* catered for relatives of excessive drinkers. Moreover, the FOCUS program had an excellent reputation in Western Australia and received many referrals from psychiatrists, general practitioners and other mental health professionals. Thus, it provided a good opportunity to study the way relatives changed during treatment as well as the possible "spin off" of this on their treatment resistant drinkers. Although the FOCUS program had been *clinically* derived, it appeared to be based on ideas from systems theory and social learning, within a stress and coping framework. Therefore, it was likely to embody many features which would be supported by the literature, as well as other features which may not be supported - or may be incidental to an "ideal" *conceptually* derived intervention.

The 12 session FOCUS program aimed to (i) minimise the harm experienced by concerned significant others (CSOs), (ii) improve their emotional well-being and coping; and (iii) assist CSOs to recognise behaviours that might unwittingly enable the alcohol/other drug problem to continue (see Table 8.3 for program topics and learning objectives). However, for ease of data collection (as explained in 8.3.7), research participants only completed 10 treatment sessions. The ongoing, revolving structure of the program enabled participants to commence treatment at any one of the twelve weekly sessions, and continue until they had completed the required 10 sessions.

Table 8.3
Program topics and learning objectives of the FOCUS intervention program[1]

Program topics	Learning objectives
The process of dependency	Increase awareness & understanding of (i) the process of dependency; (ii) the dynamics underpinning users' ways of coping, and (iii) that partners are not responsible for their drinkers' consumption and/or behaviour.
Codependency	Develop an awareness of (i) the set of behaviours that partners of excessive drinkers tend to develop to maintain control over their situation; (ii) how these behaviours affect them and others around them; and (iii) how to recognise and change them.
Letting go	Help participants (i) break their often entrenched patterns of relating to their drinkers; (ii) learn positive ways of dealing with this; and (iii) minimise the harmful impact on the family.
Boundaries	Raise awareness of (i) personal, emotional, and spiritual boundaries; (ii) how they develop; (iii) how unclear or inappropriate boundaries affect behaviour and relationships; and (iv) the need for personal responsibility for setting and maintaining boundaries.
Denial	Raise awareness that (i) denial is one of many natural defence mechanisms; (ii) there are many ways people deny problems; and (iii) it is important to replace denial with acceptance.
Grief	Raise awareness (i) that grief is a natural response to loss; (ii) that grief has recognisable stages; (iii) of the grief in their own lives; and (iii) what they can do about it.
Self responsibility	Increase clients' awareness of (i) the need to be responsible for their own feelings, thoughts, needs, and behaviour and not those of others; and (ii) the need to identify where they have been neglecting their own needs.
Family dynamics	Increase clients' ability to recognise specific behaviours, roles and rules in their family and how this impacts upon them.
Effective communication	Increase client's awareness of passive, aggressive and assertive communication styles; increase ability to actively listen and communicate feelings without blaming.
Challenging beliefs	Raise awareness of the connections between thoughts, beliefs, and behaviour and to develop an understanding of how beliefs originate and how to change unhelpful beliefs.
Self esteem	Raise awareness that (i) poor self esteem is often the result of distorted personal perceptions rather than a reflection of the true self; and (ii) how sense of self impacts on behaviour, emotions, and relationships.
Intimacy & sexuality	Raise awareness (i) of how substance abuse and associated behaviour patterns may impact upon the quality of intimacy; and (ii) that intimacy starts to develop when feelings are accepted, acknowledged, and expressed.

[1] Research participants only completed 10 of these sessions

Information was delivered through lectures[2] (which were usually interactive) complemented by a participant manual. After the educational input, group participants proceeded to small therapy groups where they were asked to identify one important aspect from the presentation to which they personally related, and how they felt about that. The facilitator summarised this information, explored emerging themes, and facilitated challenging and problem solving procedures. At the completion of group, participants were asked to nominate personal goals for the forthcoming week, and report on these at the next session.

Five discrete groups of 8-10 participants were operating at any one time during the 2 year data collection period, and each group had its own facilitator. Whilst Holyoake made every attempt to maintain stability, the same facilitators were not always with the same group: given the Holyoake voluntary group facilitators were perceived to be so well trained, many were offered paid work with other organizations.

Training of group facilitators

Holyoake selected their trainee group facilitators through formal application and interview. During the period of this research, the training group was comprised of 17 professional graduates (e.g. social work, social welfare, psychology), 4 community volunteer workers (e.g. Lifeline), 2 Holyoake graduates, and 1 psychology student. Thirty two hours of basic competency based group facilitation training was provided concurrently with attendance in one of the Holyoake groups conducted by experienced facilitators. Initially, trainees were only permitted to observe, and share their experiences/learning during formal training sessions. After a gradual process of increased participation in group, cross feedback, action learning, and ongoing feedback and assessment, the trainee progressed to the role of co-facilitator.

Ultimately, lead facilitators absented themselves from one group session to give trainees full responsibility whilst being assessed by the Training Coordinator. Trainees who achieved more than the mandatory 60% competency level were then permitted to officially *co-facilitate* a group with an experienced facilitator, and after ongoing

[2] Given the variety of programs running at any one time (FOCUS, Men and Women dependents, and Adult Children), up to 200 people attended Holyoake at any one time. Educational input was similar across programs and complemented by manuals specific to each program

supervision and assessment, ultimately became fully fledged group facilitators/team leaders.

8.3.7 Mid treatment, end treatment, and follow up assessments

Once the Composite Treatment Group had commenced the intervention program, they were assessed at mid treatment (5 sessions) and end treatment (10 sessions). Participants received identical questionnaire packages; viz. general questionnaire (see Appendix 2) and psychometric measures (see Appendix 1) at their 5th and 10th treatment session, and after completing them at home, returned them prior to their 6th and 11th treatment sessions when they had their audio-taped qualitative interview (see Appendix 2). Questionnaire Results Forms (Appendix 1) were completed and given to participants (after results were explained) 1 week later at their Feedback interview (i.e. prior to the 7th and 12th treatment session).

End treatment questionnaire packages were given to participants at the 10th rather than the final 12th session to (i) minimise inconvenience to participants so that they did not have to make special visits to return their questionnaires, have their qualitative interview, and receive feedback regarding their results; and (ii) maximise participant compliance.

Research participants were telephoned one week before their 3/6 month post treatment assessments were due and appointments for interviews were made. Questionnaire packages (see Appendix 1) were posted and participants returned these at their forthcoming appointments. Once questionnaires were scored, the Questionnaire Results Forms were forwarded to participants (if there had been a deterioration the person was contacted in person. All assessment materials were then sent to the author in New South Wales for analysis.

8.3.8 Participants who partially completed treatment

Thirty seven percent (n=25) of the Composite Treatment group did not complete the entire treatment program. Five terminated after less than 4 sessions (the Early Dropout group) and 20 terminated after 5 sessions (the Late Dropout group). Whilst

every attempt was made to follow up these participants, only 17 were available to complete their questionnaires and interviews as if they had completed the Holyoake intervention. This degree of attrition compounded the problems presented by the scarcity of prospective research participants presenting for the intervention who were still in ongoing contact with their treatment resistant drinkers. Therefore, it took 2 years to achieve a total of 43 participants who had completed the *entire* treatment program and follow up procedures. Data collection was terminated at this point because it was no longer possible for Holyoake to continue the allocation of their scarce resources.[3] Figure 8.2 presents the flow of participants in the Composite Treatment Group after commencing treatment.

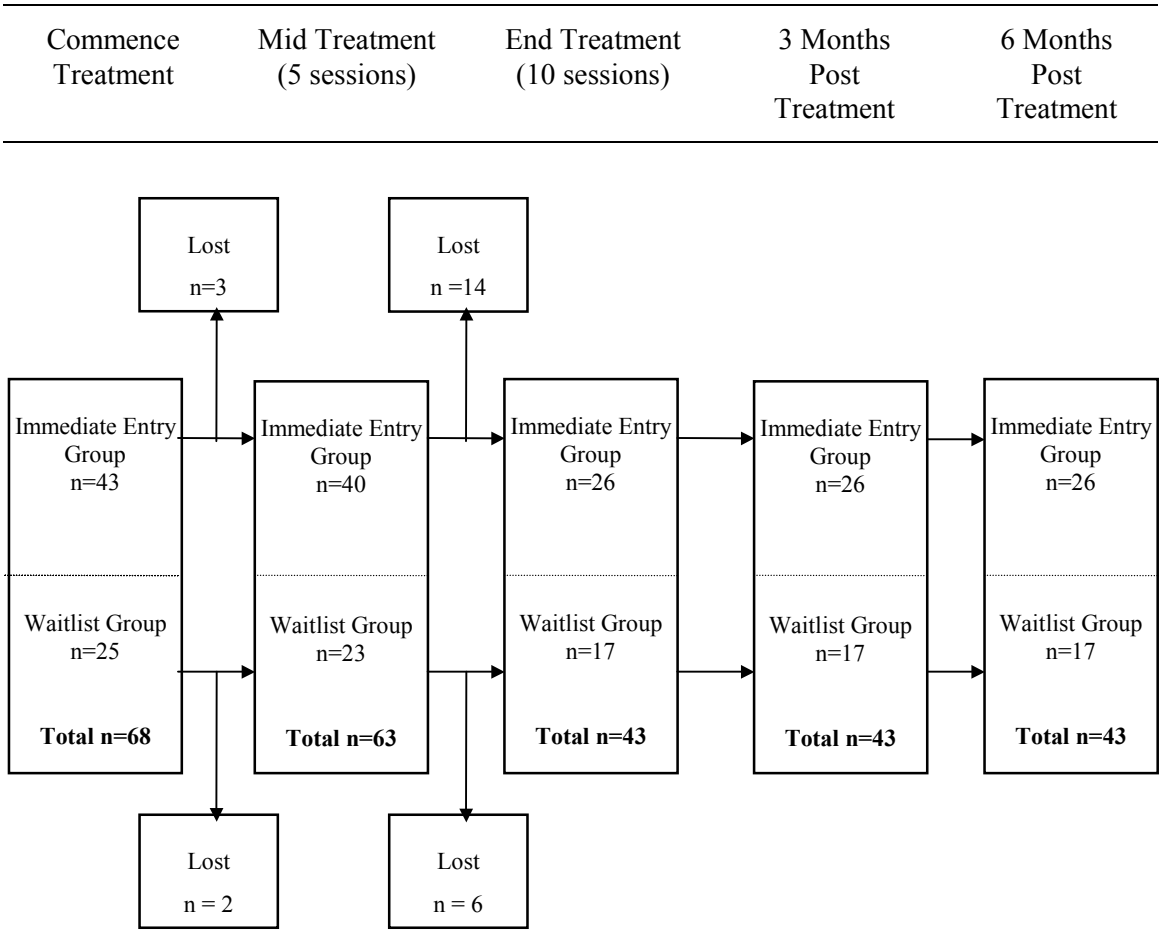

Figure 8.2 Flow through treatment of Composite Treatment Group

[3] Also the research team was exhausted!

CHAPTER 9

Results

The effect of the Holyoake intervention and the durability of its effects

The data in this thesis has been treated in 3 sections; viz. (i) data which describes the participants, their relationships with their treatment resistant drinkers, and their drinkers' consumption patterns; (ii) grouped data which has been analysed in terms of inferential statistics to investigate the impact and durability of the Holyoake intervention; and (iii) qualitative data to augment and enrich the total picture.

This chapter will present the data in relation to the effect of the intervention program and the durability of its effects on participants, their relationships with their treatment resistant drinkers, and their drinkers' consumption patterns. The next chapter will discuss these results and Chapter 11 will present and discuss the qualitative data regarding participants' experiences during treatment.

9.1 Pre intervention profile of research participants and their treatment resistant drinkers (n=83)

As illustrated in Figure 8.1, whilst 83 relatives of treatment resistant drinkers were allocated to the Waitlist Control or Immediate Entry to treatment group, only 68 of these relatives actually commenced treatment; i.e. the Composite Treatment group. Under the intention to treat principle, the pre intervention profile was constructed from data collected from *all* participants who were allocated to treatment. A profile has also been provided of the 15 participants who did not commence treatment, and comparisons have been made between this "non starter" group and the Composite Treatment group.

9.1.1 Selection criteria

a) Alcohol dependence of research participants and their drinkers

Prospective research participants completed the Short Michigan Alcoholism Screening Test (SMAST) for themselves, and the SMAST Family Form on behalf their drinkers. As already described in Chapter 8, the SMAST scores ranged from 0 – 13 and research participants were selected if their personal score was less than 3 (non dependent) and their drinkers score was 3 or more (thus meeting the criterion for dependence). As Table 9.1 illustrates, whilst participants' mean scores ranged between 0 and 2, drinkers' mean scores ranged between 3 and 12 with a mean score of 7.05. Drinkers' mean score on the SMAST was similar to that found by Barber and Crisp (1995) who described their mean of 7.26 as "heavily dependent" (p.275).

Table 9.1
Descriptive statistics for research participants on the SMAST and treatment resistant drinkers on the SMAST Family Form (n=83)

Scores	Participants	Drinkers
Minimum	0.00	3.00
Maximum	2.00	12.00
Mean	0.24	7.05
Median	0.00	7.00
Mode	0.00	6.00
sd	0.36	2.36

b) Drinkers' readiness to change

Prospective participants were asked to respond to the Change Questions developed by the present author from Prochaska and DiClemente (1986) and Prochaska, Norcross, and DiClemente, 1994); viz.

- Do you think your partner (or other family member) is thinking about changing his/her drinking?;
- Is s/he actually doing something about changing his/her drinking?; or

- Is s/he not even thinking about changing his/her drinking?

Research participants were selected only if their responses indicated that drinkers were *not* in the action stage of change. Fifty four percent (n=45) of participants' drinkers were categorised as precontemplators (not thinking about changing) and 46% (n=38) were categorised as contemplators (thinking about it but not taking any action). Examples of participants' responses to the Change Questions are presented in Table 9.2.

Table 9.2
Examples of participants' responses to the Change Questions categorised as precontemplation or contemplation (n=83)

Precontemplation responses (n=45)	Contemplation responses (n=38)
• He's not at all ready to change.	• At times (usually after a binge) some thoughts about reducing or stopping drinking behaviour.
• I don't think she's ready to change. I don't think she wants to change.	• Does a lot of thinking but not a lot of action.
• It's not a problem to *him*.	• Says he will, but he doesn't. He just says it to shut me up.
• He'd like to give it up but he also says, "Stuff it, why should I? I enjoy it!"	• All words, but no action. He's been to all the courses but nothing seems to work.

9.1.2 Research question 1

What was the pre intervention profile of research participants? (n=83)

Although only 68 participants actually commenced treatment, this profile of research participants has been compiled from pre treatment data from all 83 participants who were allocated to treatment. The pre intervention profile has been divided into 5 sections; viz.

a) Demographic information;

b) Personal information;

c) Family of origin;

d) The relationship between participants and their drinkers; and

e) Participants' pre intervention mental health and coping status.

a) Demographic information (n=83)

Demographic information was obtained from participants' responses to the pre treatment non psychometric General Questionnaire (see Appendix 2) and included country of birth; age, sex, education completed; and occupation and family income.

Research participants' country of birth, age, sex, and years of education

Seventy six percent of participants (n=63) were born in Australasia and 19% (n=16) were born in the UK or Ireland. The remaining 4 participants were born in Asia (n=3) and Europe (n=1). Those born outside Australasia had lived in Australia between 4 and 48 years (mean=19, sd=11.42). Participants' ages ranged between 20 and 69 with a mean of 41 years, and 86% were female (n=71). The formal education participants had completed ranged from 8 years to post graduate, with the mean being at 12 years. Participants' mean ages and years of education are presented in Table 9.3.

Table 9.3
Mean scores and standard deviations of participants' age, and education completed (n=83)

Age				Education completed			
Min	Max	Mean	sd	Min	Max	Mean	sd
20	69	41	11.1	8 yrs	Post grad. degree	12 yrs	1.43

Research participants' occupation and family income

Participants' occupations were classified according to the 1996 Australian Standard of Classifications of Occupations (ASCO).[1] Thirty seven percent (n=31) of participants were employed in trades or advanced clerical positions, 28% (n=24) in managerial or professional capacities, and 35% (n=28) were unemployed or retired. Mean family income was between $30,000 & $40,000. Table 9.4 presents frequencies and percentages of occupational and family income categories.

[1] Published by the Australian Bureau of Statistics

b) Research participants' personal information (n=83)

The personal information was obtained from participants' responses to the pre treatment General Questionnaire and pre treatment qualitative interview (see Appendix 2) and included:

- Current prescribed medication;
- Previous heavy drinking partners;
- Reasons why participants sought help;
- What participants hoped to gain from the Holyoake program; and
- What degree of support they received from family or friends to help them deal with the drinking problem in their family.

Table 9.4
Participants' occupational categories and family income levels (n=83)

Participants' Occupation	%	Family Income ($)	%
Unemployed/retired	34.9	Less than 10,000	10.8
Manager/Administrator	3.6	10,000 - 20,000	12.1
Professional	19.3	20,000 - 30,000	16.9
Associate professional	4.8	30,000 - 40,000	18.1
Tradesperson	13.3	Over 40,000	33.7
Advanced clerical	24.1	Don't know	8.4
Total	100	*Total*	100

Participants' current prescribed medication

The majority of participants (69%, n=57) were not taking any prescribed medication. Thirty one percent (n=26) had been prescribed medication to treat a variety of conditions; e.g. asthma, hypertension, and migraine. Only 5 of these participants had been prescribed mood altering medication.

Participants' previous heavy drinking partners

The majority (82%, n=68) had not had a prior marital/defacto relationship with a heavy drinker. Eleven percent (n=9) reported 1 previous relationship, 5% (n=4) reported 2; and 2% (n=2) had had 3 prior heavy drinking partners.

Reasons why participants sought help and what they hoped to gain

When asked why they sought help the majority of participants (56%, n=47) identified therapy for themselves as their primary motivator. Others identified a general crisis point (16%, n=13); drinkers' unacceptable behaviour (16%, n=13); and relationship breakdown (12%, n=10). When asked what they hoped to gain from the Holyoake FOCUS program, participants identified 3 main categories; viz. therapy for self (44%, n=37); strategies to handle their situation (25%, n=21); and information (21%, n=17). A lesser percentage (10%, n=8) wanted to encourage their drinkers into treatment.

Level of support participants received from family or friends

Almost half the participants (49%, n=41) did not receive any support at all from family or friends. Many participants kept their problems to themselves because they wanted to avoid friends' intolerance and being blamed by various family members (usually mothers in law). Fifty one percent (n=42) reported being well supported by family and/or friends.

c) Research participants' family of origin (n=83)

Family of origin data included parental alcohol use and participants' history of childhood abuse.

Participants' parents' alcohol use

Parental alcohol use was included in the data collection because the literature reports (e.g. Black et al. 1986) many women in relationships with excessive drinkers have a history of parental problem drinking. Parental drinking categories (non drinker, social, heavy, problem, ex problem drinker) were based on distinctions generally made by the community. "Heavy" and "problem" drinking categories were separated because many people do not equate heavy use with problem drinking.

The majority of participants described their parents as social or non drinkers. However, 18% (n=15) described their mothers as heavy, problem or ex-problem drinkers, whilst 39% (n=32) similarly described their fathers (see Table 9.5). Twelve percent (n=10) reported both parents as heavy, problem, or ex problem drinkers.

Table 9.5
Participants' parents' use of alcohol (n=83)

	Mother's use	Father's use
	%	**%**
Non drinker	30.1	9.6
Social drinker	51.9	51.9
Heavy drinker	9.6	15.7
Problem drinker	4.8	10.8
Ex problem drinker	3.6	12.0
Total	100	100

Participants' history of childhood abuse

Forty six percent of participants had been subjected to some type of childhood abuse; viz; 23% emotional (i.e. manipulative, passive aggression) and/or verbal abuse, 13% sexual abuse and 10% physical abuse.

d) Research participants' relationships with their drinkers (n=83)

Relationship data included:

- Type of relationships between participants and their drinkers;
- Whether participants had notified their drinkers that they were seeking help;
- Quality of everyday interactions between participants and drinkers;
- Degree of marital discord;
- Participants' marital state; and
- Level of abuse from drinkers towards participants.

Type of relationships between participants and their drinkers

The majority of participants (84%, n=70) were either living with or in regular contact with their partners; viz. 62 females and 8 males. Three of these females were

living in lesbian relationships, and 1 male was in regular contact with his male partner. Thirteen participants were living in non conjugal relationships (see Table 9.6).

Table 9.6
Type of relationships between participants and their drinkers (n=83)

Participants living with their partners (n=55)		Participants in regular contact with their partners(n=15)		Participants living with other* (n=9)		Participants in regular contact with other** (n=4)	
Female	Male	Female	Male	Female	Male	Female	Male
50	5	12	3	5	4	4	0

* *7 living with adult children; 1 living with mother; and 1 living with brother in law*
** *3 in regular contact with mother; 1 in regular contact with son*

Did participants notify their drinkers that they were seeking help?

Sixty eight percent (n=56) of participants notified their drinkers prior to starting treatment that they were seeking help; 22% (n=18) notified mid way through treatment, and 3% (n=3) notified at the completion of their treatment. Seven percent (n=6) did not notify at all. Drinkers responded variously to the news that their partners were seeking help because of their (the drinkers') excessive drinking. Examples of drinkers' reactions are presented in Table 9.7.

Quality of everyday interactions between participants and their drinkers

Participants were asked about the quality of their everyday interactions with their drinkers over the past 3 months when drinkers were drinking or not drinking. Scores ranged between "very good" (score of 1) and "very poor" (score of 5). Mean scores (see Table 9.15) indicated everyday interactions were "poor" when drinkers were drinking, and "so-so" when they were not drinking.

Table 9.7
Examples of drinkers' responses to participants' notification that they were seeking help (n=83)

- Don't know why *you're* going *there* for!
- Oh God! Why are *you* going?
- Why would *you* want to go *there?* No one's got a drinking problem in *our* family!

- Don't be so stupid. *You* don't need to go there!
- Good for you but don't involve *me*!
- You're a mental case, woman!
- Good on you. *You* really need help all the help you can get!

Degree of marital discord

Although the DPDS was designed for female partners of excessive drinkers, it was given to all 83 relatives in the current study (partner specific questions were scored as "never". The resulting pre treatment mean score of 8.48 (sd=3.37) for the marital discord subscale was approximately half a standard deviation less than Crisp & Barber's (1995) mean of 10.94 (sd=4.94). It was interesting to note that the mean score of 6.73 (sd=2.11) for male relatives in the current study (n=12) was not significantly different from the female relatives' (n=71) mean score of 8.81 (sd=3.73). However, the difference between the male partners' (n=8) mean score of 6.73 (sd=2.42) and the female partners' (n=62) mean score of 8.81 (sd=3.73) approached significance (t=1.54, p=.055).

Marital state

The pre treatment mean score of 46.77 (sd=10.04) on the Golombok Rust Inventory of Marital State (GRIMS) revealed participants were experiencing "very severe problems" associated with their beliefs, attitudes and feelings about (i) shared interests; (ii) communication; (iii) warmth, love, or hostility; (iv) trust and respect; (v) roles expectations and goals; (vi) decision making; and (vii) coping with problems and crises. There was no significant difference (Mann-Whitney U=162, p>.05) between the mean score for female participants (n=63)[2] of 47.42, sd= 11.2 and the male (n=7) mean score of 42.85, sd=6.67.

Degree of abuse from drinkers towards participants

Participants were asked to rate the degree of abuse they had experienced from their drinkers over the past 3 months (see Table 9.8). Scores ranged between "no abuse"

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[2] 70 partners were in the pre treatment sample; i.e. 63 females and 7 males

(score of 0) and "very severe abuse" (score of 4). Sixty three percent of participants (n=47) reported verbal abuse, and 56% reported emotional abuse (n=42).

However, participants reported a much lesser incidence of financial (n=20, 24%, mean=.51), physical (n=14, 17%, mean=.16), or sexual abuse (n=6, 7%, mean=.15). Given these scores presented a floor effect problem and seemed non problematic for this sample, they were removed from the data set for subsequent analyses investigating the efficacy of the intervention.

Table 9.8
Pre treatment degree of abuse from drinkers towards participants (n=83)

Degree of abuse	Verbal Abuse	Emotional Abuse	Financial Abuse	Physical Abuse	Sexual Abuse
	%	**%**	**%**	**%**	**%**
No abuse	37.5	44.5	75.9	83.1	92.8
Minimal	9.6	4.8	8.4	7.2	3.6
Moderate	30.1	22.9	6.0	8.4	1.2
Severe	10.8	13.3	8.4	1.2	1.2
V. Severe	12.0	14.5	1.3	0	1.2
Total	100	100	100	100	100

e) Participants' pre treatment mental health and coping status (n=83)

Participants' pre treatment mental health status

Analysis of pre treatment mean scores on the Crown-Crisp Experiential Index (CCEI) revealed both female and male and female participants had elevated mean scores on free floating anxiety, somatic anxiety, and depression when compared to the CCEI's normative data (see Table 9.9). Whilst females' mean score for free floating anxiety was greater than 1 standard deviation above the mean when compared to the CCEI normative data, males' mean score was not. Although female and male mean scores were not significantly different from each other for depression, obsessionality and phobic anxiety, female mean scores were significantly higher than male mean scores on free floating anxiety.

Depression as measured by the DPDS

Although the DPDS was designed for female partners of excessive drinkers, it was given to all 83 relatives in the current study (partner specific questions were scored as "never"). The resulting pre treatment mean score of 9.24 (sd=4.52) for the depression subscale was approximately half a standard deviation lower than Crisp & Barber's (1995) mean of 12.01 (sd=5.29). It was interesting to note that the mean score

Table 9.9
Comparisons between mental health variable mean scores for female and male participants and the CCEI's normative data (n=83)

	Females (n=71)				Males (n=12)			
Variable	This research		CCEI normative data		This research		CCEI normative data	
	M	sd	M	sd	M	sd	M	sd
Free floating anxty	8.7	3.7	5.4	3.5	4.8	3.9	2.8	2.8
Depression	6.3	3.0	4.4	2.5	4.5	3.9	3.2	2.3
Somatic anxiety	6.6	3.6	5.7	3.3	3.8	2.8	4.3	3.0
Obsessionality	6.6	3.2	7.4	2.9	5.3	2.6	6.8	2.8
Phobic anxiety	4.8	3.4	4.7	2.9	2.9	2.2	2.8	2.2

of 9.47 (sd=4.60) for female relatives (n=71) in the current study was not significantly higher than the mean scored for the 12 male relatives (7.88, sd=3.93). Moreover, there was no significant difference between the 62 female partners' mean score of 9.95 (sd=4.57) and the 8 male partners' mean score of 8.52 (sd=4.43).

Participants' pre treatment coping status

Participants were asked to rate their coping strategies on the Drinkers' Partners' Coping Questionnaire (DPCQ) for the 3 month period prior to seeking treatment. Mean scores (see Table 9.11) revealed that participants were utilising control coping (i.e. attempts to control use or events directly related to use, or emotional strategies) and tolerant strategies (i.e. protecting user from harmful consequences of use, inaction, avoidance, or self sacrificial behaviour) within the "often" range. On the other hand, participants were using assertive coping strategies (i.e. assertive confrontation, independent, and supportive strategies) within the "sometimes" range.

9.1.3 Research question 2

What was the pre intervention profile of research participants' treatment resistant drinkers (from research participants' perspective)?

Partners' reports of drinkers' consumption patterns have been found to correlate well with drinkers' estimates (e.g. Jarmas & Kazak, 1992; McAuley, Longbraugh, &

Gross, 1978; Meyers, Miller, Hill & Tonigan, 1999). Therefore, drinkers' data was provided by research participants in their non psychometric General Questionnaires and qualitative interviews (see Appendix 2). Drinkers' data included a) level of education and occupation; and b) consumption patterns.

Drinkers' education and occupational groupings

Drinkers' level of education ranged through 8 years to post graduate degree with the mean at 12 years. Occupational groupings[3] are presented in Table 9.10.

Table 9.10
Drinkers' occupational categories (n=83)

Drinkers' occupational categories	%
Unemployed/retired	28.9
Managers/administrators	14.5
Professionals	8.5
Associate professionals	6.0
Tradesperson	33.7
Advanced clerical/service	8.4
Total	100

Duration of participants' concerns regarding their drinkers' consumption

As Table 9.11 illustrates, 49% (n=41) of participants had been concerned about their drinkers' problematic consumption for longer than 5 years. Participants' reports revealed that the majority of their drinkers were daily drinkers, consumed an average of 9-12 drinks on any given drinking day, which left them a "fair bit drunk." Moreover, partners' scores on the Short Michigan Alcoholism Screening Test (SMAST) revealed their drinkers' mean score was 7.05 which was consistent with Barber & Crisp (1995) who rated these drinkers as "heavily dependent".

[3] Classified according to the 1996 Australian Standard of Classifications of Occupations (ASCO)

Table 9.11
Length of time participants had been experiencing problems due to their drinkers' excessive consumption (n=83)

Length of time	**n**	**%**
During the last month	2	2.4
During the last 6 months	7	8.4
During the past year	5	6.0
1-2 years ago	14	16.9
3-4 years ago	14	16.9
Longer than 5 years	41	49.4
Total	83	100

9.1.4 Summary pre treatment profile of research participants and their treatment resistant drinkers (n=83)

The majority of participants were female partners with a mean age of 43 years, born in Australasia, with 12 years education, and an average family income of $35,000. Thirty five percent of participants were unemployed. Almost 50% of participants reported that they had been adversely affected by their drinkers' excessive consumption of alcohol for more than 5 years. The majority had sought therapy because they could not cope with their own level of distress *in reaction* to their drinkers' behaviour. Participants wanted therapy for *themselves* and wanted to learn more effective coping strategies. The majority had elevated anxiety and depression, often utilised control and tolerant coping strategies, and sometimes used assertive coping strategies. Thirty one percent of participants had been prescribed medication for stress related conditions.

The average treatment resistant drinker (as described by research participants) was a male manager/tradesperson whose drug of choice was alcohol. He was heavily dependent, and consumed an average of 9-12 drinks on any given drinking day which left him a "fair bit drunk". The majority (56%) of drinkers were not thinking about changing their consumption patterns: 44% were thinking about it (some for many years) but had not taken any action. The majority of participants had told their drinkers that they were seeking help.

The quality of participants' everyday interactions with their drinkers was poor and they experienced average levels of marital discord and distress when compared to

other relatives of excessive drinkers. Moreover, participants were experiencing severe problems in their marital state: 52% rated their drinkers' emotional or verbal abuse as between "moderate" and "very severe." Fifty seven percent of participants described one parent as heavy, problem, or ex-problem drinkers (18% mothers, 39% fathers), and 12% similarly described both parents. Forty six percent of participants had been subjected to some form of childhood abuse.

9.1.5 Consistency of this profile of relatives of excessive drinkers with others' findings

This profile of relatives of treatment resistant drinkers was consistent with that found by other researchers in terms of age and education (e.g. Barber & Crisp, 1995; Thomas et al. 1987), stresses and strains associated with drinkers' behaviour (Orford et al. 1998a), and mental health, coping and relationship status (e.g. Barber & Crisp, 1995; Dittrich, 1993; Holmila 1997; Meyers et al. 1999; Orford, et al. 1992 & 1998b). Moreover, there was also consistency between the current research and others regarding the degree of drinkers' dependency (Barber & Crisp; Meyers et al.), and the duration of drinkers' problematic consumption (Barber & Crisp; Thomas et al.).

The incidence of parental problem drinking and childhood abuse among the participants in this study was also consistent with the national Australian figures (Crosbie et al. 1997) where at least 1% of the population have a family member with alcohol problems serious enough to come to the attention of health or welfare agencies (Mattick, 1993), more than half the instances of domestic violence are alcohol related, and alcohol is a major contributor to child abuse.

9.2 The effect and durability of the Holyoake intervention for the Full Treatment group (n=43)

This section presents the effect and durability of the Holyoake intervention on research participants, their relationships with their treatment resistant drinkers, and their drinkers' consumption patterns and help seeking behaviour. However, although 83 research participants were allocated to treatment, 15 did not commence (the Non Starter group). Moreover, 5 participants terminated treatment after completing less than 5

sessions (the Early Dropout group) and 20 participants terminated after they had completed 5 sessions (the Late Dropout group). Thus (as Figure 8.2 has illustrated), 68 participants commenced the Holyoake intervention and 43 completed treatment. Whilst it was not possible to follow up the Non Starter Group, 17 participants from the Dropout groups (4 from the Early Dropout and 13 from the Late Dropout group) were available for follow up *as if* they had completed treatment; i.e. at the mid treatment and/or end treatment measuring points.

The data investigating the effect and durability of the Holyoake intervention has been dealt with in 3 ways; viz..

1. Progress of participants in the Full Treatment group (n=43) who completed 10 sessions and were followed up at 3 months and 6 months post treatment;
2. Progress of participants in the Late Dropout group (n=13) who received only 5 treatment sessions and were followed up as if they had completed treatment (i.e. at the end treatment point); and
3. Investigation of the raw data describing the consumption patterns and help seeking behaviour the 25 participants in both the Late Dropout group (n=20) and the Early Dropout group (n=5) through 5 treatment sessions and 5 weeks post treatment.

However, before these analyses were conducted, preliminary investigations were undertaken to answer an additional 4 research questions; viz. (i) Were there any significant differences between the Immediate Entry group (n=54) and the Waitlist group (n=29) at Time 1 (pre treatment)?; (ii) Were there any significant differences between the Waitlist group at Time 1 and at the end of the 2 week waitlist period? (Time 2); (iii) Were there any significant differences between the Non Starter group (n=15) and the Composite Treatment group who commenced treatment (n=68), and (iv) Were there any significant differences between the Drop Out group (n=25) and the Full Treatment group (n=43)? (see Figures 8.1 and 8.2).

9.2.1 Research question 3: A comparison between the Immediate Entry to Treatment group and the Waitlist group

Were there any significant differences between the 2 experimental groups; viz. the Immediate Entry to treatment group (n=54) and the Waitlist group (n=29) at Time 1 (pre treatment)?

As previously outlined in the research design section in Chapter 8.3, participants were allocated to either the Immediate Entry to treatment group (n=54) or the Waitlist group (n=29). To answer this research question, pre treatment data for each group were compared across the 3 major variable groups; viz. participants, their relationships with their treatment resistant drinkers, and their drinkers' consumption patterns. This process determined whether the Immediate Entry and Waitlist groups were homogenous and could therefore be combined into a Composite Treatment group for future analyses to investigate the efficacy of treatment.

Participants' data included mental health status, whether participants had notified their drinkers that they were seeking help, and coping status. Relationship data included participants' perceptions of the quality of interactions when their drinkers were drinking as opposed to not drinking; degree of marital discord; level of abuse from drinkers; and participants' marital state. Drinkers' data (which was provided by participants) included scores on the SMAST Family Form; duration of problematic use (from participants' perspective); and consumption patterns.

Multivariate data were subjected to a one way, between subjects MANOVA which compared the Immediate Entry group to the Waitlist group across the three major variable groups. Univariate analyses were conducted by Mann-Whitney *U* tests (because of unequal cell sizes). Because somatic anxiety (within the participants' mental health group of variables) and sexual abuse (within the "abuse from drinkers" variable) both violated the MANOVA assumption of homogeneity of variance-covariance, they were also analysed non parametrically by the Mann-Whitney *U* test. Pearson's Chi Square was used to investigate whether there was a significant difference between groups in the numbers of participants who had notified their drinkers that they were seeking help.

As Table 9.12 has illustrated, there were no significant multivariate differences between the Immediate Entry to treatment and the Waitlist groups across the 3 major variable groups; viz. participants, their relationship with their drinkers, and drinkers' consumption patterns for either the group of participants who were allocated to treatment (n=83) or the group who actually commenced treatment (n=68).

Table 9.12
Pre treatment comparisons between participants allocated to either Immediate Entry or Waitlist groups for all participants allocated (n=83) and participants who commenced treatment (n=68) across the three major variable groups; i.e. participants, their relationships, and drinkers' consumption patterns

Variable	Allocated to Immediate Entry (n=54) or Waitlist group (n=29) Total n=83	Allocated to Immediate Entry (n=43) or Waitlist group (n=25) **and commenced treatment** Total n=68
1. Participants		
a) Mental health (CCEI)[4]	Wilks' Lambda F(4,78)=2.33, *p*>.05	Wilks' Lambda F(4,63)=1.88, *p*>.05
Somatic anxiety	Mann-Whitney *U*=300, *p*>.05	Mann-Whitney *U*=508, *p*>.05
Depression (DPDS)	Mann-Whitney *U*=469, *p*>.05	Mann-Whitney *U*=321, *p*>.05
b) Notification of drinkers	Pearson's Chi Square = 5.19, *p*>.05	Pearson's Chi Square = 1.26, *p*>.05
c) Coping status	Wilks' Lambda F(3,79)=.55, *p*>.05	Wilks' Lambda F(3,64)=.55, *p*>.05
2. Relationship between participants and drinkers		
a) Interactions		
-when drinking	Mann-Whitney *U*=696, *p*>.05	Mann-Whitney *U*=208, *p*>.05
-when not drinking	Mann-Whitney *U*=663, *p*>.05	Mann-Whitney *U*=200, *p*>.05
b) Marital discord	Mann-Whitney *U*=528, *p*>.05	Mann-Whitney *U*=333, *p*>.05
c) Abuse from drinkers[5]	Wilks' Lambda F(4,78)=.29, *p*>.05	Wilks' Lambda F(4,63)=.05, *p*>.05
- sex abuse	Mann-Whitney *U*=736, *p*>.05	Mann-Whitney *U*=488, *p*>.05
d) Marital state	Mann-Whitney *U*=457, *p*>.05	Mann-Whitney *U*=317, *p*>.05
3. Drinkers' consumption patterns		
a) Scores on SMAST	Mann-Whitney *U*=673, *p*>.05	Mann-Whitney *U*=269, *p*>.05
b) Duration of problem[6]	Mann-Whitney *U*=665, *p*>.05	Mann-Whitney *U*=239, *p*>.05
c) Consumption patterns	Wilks' Lambda F(5,77)=.27, *p*>.05	Wilks' Lambda F(5,62)=.09, *p*>.05

[4] Excluding somatic anxiety
[5] Excluding sex abuse
[6] From research participants' perspective

9.2.2 Research question 4: An exploration of the effect of the waitlist period

Were there any significant differences between the Waitlist group (n=29) at pre treatment (Time 1) compared to the end of the minimum 2 week waitlist period?

Whilst every attempt was made to randomly allocate research participants to either the Immediate Entry group or the Waitlist group, clinical, ethical, and organisational constraints made this impossible to fully achieve. Participants allocated to the Waitlist group were measured twice; viz. at the beginning of their waitlist period and again before they began their treatment program. This process ensured that significant changes in participants' situations which occurred *before treatment commenced* were identified and subsequently controlled for in future analyses. Thus, significant gains made during treatment *may* have been more likely to be attributed to the intervention, rather than merely as the result of one assessment interview and the completion of various questionnaires. However, given the 10 week intervention and a minimum waitlist period of 2 weeks,[7] "treatment" gains needed to be interpreted with caution.

Pre treatment Waitlist group data were subjected to one way, within subjects MANOVA (or Paired Sample t-tests where appropriate) across the 3 major variable groups. Table 9.13 has presented comparative analyses for the Waitlist group at Time 1 (pre waitlist) and Time 2 (end waitlist) and confirmed there were no significant changes in mean scores for participants' mental health, drinkers' consumption patterns, and the majority of the relationship variables.

However, there were significant reductions during the waitlist period in control and tolerant coping mean scores, and marital discord mean scores. The MANOVA found a significant strong multivariate effect of the waitlist period on participants' coping status (Wilks' Lambda $F(3,26)=3.86$, $p<.05$, $eta^2=.31$). Further univariate analyses revealed that significant reductions in mean scores had occurred during the waitlist period in 2 of the 3 coping variables; viz. control coping[8] and tolerant coping.[9]

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[7] Due to the revolving nature of the intervention, the organization's policy was to allow participants to commence their program immediately after their initial assessment

[8] Defined as participants' attempts to directly control their drinkers' consumption or the expression of strong emotion towards drinkers

[9] Defined as participants' attempts to protect their drinkers from the consequences of their excessive consumption

There was no significant effect of the waitlist period on participants' assertive coping mean scores [10] (see Table 9.13).

Table 9.13
Comparative analyses for the Waitlist group at the beginning and end of the waitlist period for participants, their relationships and their drinkers' consumption patterns (n=25)

Variable	Comparative analyses between the beginning and end of the waitlist period
1. Participants	
a) *Mental health status (CCEI)*	Wilks' Lambda F(5,24)=1.31, $p>.05$
Depression (DPDS)	$t=1.34$, $p>.05$
b) *Coping status*	
Control	**Wilks' Lambda F(1,28)=12.08, $p<.01$**
Tolerant	**Wilks' Lambda F(1,28)=8.26, $p<.01$**
Assertive	Wilks' Lambda F(1,28)=4.61, $p>.05$
2. Relationship between participants and drinkers	
a) *Interactions*	
-when drinking	$t=1.06$, $p>.05$
-when not drinking	$t=1.13$, $p>.05$
b) Marital discord (DPDS)	**$t=3.39$, $p<.01$**
c) Abuse from drinkers	Wilks' Lambda F(5,24)=1.88, $p>.05$
d) Marital state	$t=1.06$, $p>.05$
3. Drinkers' consumption patterns	Wilks' Lambda F(5,23)=1.01, $p>.05$

It was interesting to note the significant positive correlation between both participants' control and tolerant coping strategies and marital discord (r=.60 and 5=.59 respectively; $p<.05$). This suggested that although drinkers' behaviour was undoubtedly the major contributor to the level of marital discord, participants' *reactions* to their drinkers' behaviour was also likely to be an important factor.

Given the significant reduction in control and tolerant coping mean scores and marital discord mean scores during the waitlist period, these variables were subjected to a MANOVA which included end waitlist data as well as data from other measuring

[10] Defined as participants' confrontation of their drinkers regarding excessive use, personal independence from drinkers, and support of moderated use

points in all further analyses; i.e. pre treatment, mid treatment, end treatment, and follow up at 3 months and 6 months post treatment. This was done to enable the impact of the waitlist period (and the intervention) to be mapped more accurately.

9.2.3 Research question 5: A comparison between the Non Starter group (n=15) and the Composite Treatment group who commenced treatment (n=68)

Were there any significant differences between the Non Starter group and the Composite Treatment group at pre treatment (Time 1)?

Fourteen participants (12 females and 2 males) who were allocated to the intervention[11] did not present for treatment (see Figure 8.1). One of the female participants who had been allocated commenced treatment but decided not to continue with the research program because she found the questionnaires "too burdensome" given her "problems at home". The 12 females were either living with (n=10) or in regular contact with their drinkers. One of the males was living with his son and the other was in regular contact with his mother. Although the data investigating the efficacy and durability of the intervention was analysed wherever possible by the intention to treat principle, these 15 participants were not available for follow up.

However, comparative analyses (see Table 9.14) were carried out to investigate possible differences across all variables between this Non Starter group and the 68 participants who had commenced treatment (the Composite Treatment group). Univariate analyses by the Mann-Whitney *U* Test found no significant difference on age, family income or occupations, duration of drinkers' problematic use substance used. Nor was any significant difference found regarding the incidence of participants' parental drinking patterns or childhood abuse. Similarly, Pearson's Chi-Square found no significant difference between groups in the numbers of participants who had notified their drinkers that they were seeking help.

Multivariate data were subjected to a one way, between subjects MANOVA. Because both sexual and physical abuse mean scores violated the assumption of homogeneity of variance-covariance, they were also analysed by the Mann-Whitney *U*

[11] Eleven to the Immediate Entry group and 4 to the Waitlist group

Test. No significant differences were found between the Non Starter group and the Composite Treatment group (n=68) on participants' mental health, coping status, or drinkers' consumption patterns (see Table 9.14).

Table 9.14
Comparisons between mean scores across all variables from the "Non Starter" group (n=15) and the Composite Treatment group (n=68)

Variable	Allocated "Non Starter" group (n=15) compared to Composite Treatment group (n=68)
1. Participants	
a) Mental health (CCEI)[12]	Wilks' Lambda F(5,77)=.44, $p>.05$
Depression (DPDS)	Mann-Whitney $U=236$, $p>.05$
b) Coping status	Wilks' Lambda F(3,79)=1.02, $p>.05$
2. Relationship between participants and drinkers	
a) Interactions	
-when drinking	Mann-Whitney $U=488$, $p>.05$
-when not drinking	Mann-Whitney $U=466$, $p>.05$
b) Marital discord	Mann-Whitney $U=346$, $p>.05$
c) Abuse from drinkers[13]	Wilks' Lambda F(3,79)=1.47, $p>.05$
-sex abuse	Mann-Whitney $U=475$, $p>.05$
-physical abuse	**Mann-Whitney $U=354$, $p<.01$**
d) Marital state	Mann-Whitney $U=331$, $p>.05$
3. Drinkers' consumption patterns	
a) Scores on SMAST	Mann-Whitney $U=497$, $p>.05$
b) Duration of problem[14]	Mann-Whitney $U=463$, $p>.05$
c) Consumption patterns	Wilks' Lambda F(5,77)=.41, $p>.05$

However, whilst there were no significant differences across *most* of the relationship variables, the Non Starter group mean of .80 (sd=1.1)[15] for drinkers' physical abuse was significantly higher than the Composite Treatment group mean of .16 (sd=.48).

[12] Excluding somatic anxiety
[13] Excluding physical and sex abuse
[14] From research participants' perspective
[15] A score of 1 was rated as "minimal'

Forty percent of the Non Starter group (n=6) reported physical abuse ranging between "minimal" and "severe" levels, with 27% (n=4) rating their abuse at "moderate" levels. On the other hand, only 12% (n=8) in the Composite Treatment group reported physical abuse ranging between "minimal" and "moderate" levels, and only 3 participants (4%) rated their drinkers' abuse as "moderate". Therefore, these data seem to suggest that the Non Starter group *may* have decided not to commence treatment because they were fearful of their drinkers' reactions.

9.2.4 Research question 6: A comparison between the Dropout group (n=25) and the Full Treatment group (n=43)

Were there any significant differences between the Dropout group and the Full Treatment group at pre treatment (Time 1)?

Multivariate data were subjected to a one way, between subjects MANOVA which compared the Early and Late Dropout groups (n=25) to the Full Treatment group (n=43) across all major variables; i.e. participants, their relationships with their drinkers, and drinkers' consumption patterns. Univariate analyses were conducted by Mann-Whitney *U* tests (because of unequal cell sizes).

Multivariate analyses found no significant difference between groups on mental health (Wilks' Lambda $F(4,63)=.40$, $p>.05$) and coping status (Wilks' Lambda $F(3,64)=1.40$, $p>.05$). Similarly, no significant difference was found for the quality of everyday interactions between participants and their drinkers (Wilks' Lambda $F(2,65)=.97$, $p>.05$), drinkers abusive behaviour (Wilks' Lambda $F(5,62)=.49$, $p>.05$) or drinkers' consumption patterns (Wilks' Lambda $F(5,62)=.49$, $p>.05$). Univariate analyses found no significant differences between groups on depression as measured by the DPDS, marital discord or marital state. Moreover, no significant differences were found between groups regarding age, occupations, income, drinkers' MAST score, number of years participants had found their drinkers' consumption problematic, whether participants had notified their drinkers that they were seeking help, childhood abuse or parental drinking.

The efficacy of the Holyoake intervention and the durability of its effects

To investigate the efficacy of the Holyoake intervention and the durability of its effects[16] the Full Treatment group data were subjected to a one way, within subjects, repeated measures MANOVA which compared mean scores over 5 time periods;[17] viz. pre treatment, mid treatment, end treatment, 3 months post treatment, and 6 months post treatment. Once again, the three major variable groups were examined; viz. (i) participants (ii) their relationships with their drinkers, and (iii) drinkers' consumption patterns.

Participants' data included mental health, coping, and relationship variables. Relationship data included participants' perceptions of the drinkers' abusive behaviour; and marital discord, depression (as measured by the DPDS) and marital state.[18] Drinkers' data (provided by participants) included frequency of use, effect of use on any given drinking day, and levels of consumption.

Table 9.15 presents a summary of means, standard deviations, and univariate analyses for the Full Treatment group, and identified significant end treatment effects which were sustained through 6 months post treatment within each of the 3 major variable groups.

9.2.5 The effect and durability of treatment on participants' mental health status

The intervention hypotheses as presented in Chapter 7 were grouped in two separate sections; viz. the effect of treatment (hypotheses 1-4), and the durability of treatment (hypotheses 5-8). Because the results of both the effect and durability of treatment have been presented together in this chapter, intervention hypothesis pairs have also been presented; e.g.

Intervention hypothesis 1

It was expected that there would be significant improvement in pre and post tests of participants' mental health status as a result of the intervention as evidenced

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[16] Notwithstanding threats to internal validity due to the short waiting period

[17] With the exception of control and tolerant coping strategies, and marital discord which were analysed over 6 time periods (including the end waitlist period)

[18] Only partners completed these questionnaires

Table 9.15
Summary of mean scores, standard deviations, and univariate analyses for the Full Treatment group (n=43) from pre treatment through end treatment and 3 months and 6 months post treatment across the 3 major variable groups (participants, their relationships with their drinkers, and their drinkers' consumption patterns)

Variable		Pre treatment		End waitlist		Mid treatment (5 sessions)		End treatment (10 sessions)		3 months post treatment		6 months post treatment		F	*p*	Eta^2	Observd Power
1. Participants	n	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD				
a) Mental health status (CCEI)	43																
(i) Free floating anxty.		**7.86**	**4.20**			**7.05**	**3.48**	**5.70**	**3.50**	**5.21**	**3.41**	**5.07**	**3.32**	**14.54**	**<.001**	**.26**	**1.00**
(ii) Depression		**6.09**	**3.02**			**6.28**	**3.41**	**5.30**	**3.30**	**5.31**	**3.50**	**4.81**	**3.70**	**4.43**	**<.01**	**.10**	**.93**
(iii) Somatic anxiety		**6.23**	**3.21**			**5.37**	**2.80**	**4.28**	**2.91**	**3.98**	**2.63**	**3.90**	**2.59**	**14.14**	**<.001**	**.25**	**1.00**
(iv) Obsessionality		**6.53**	**3.10**			**5.91**	**3.00**	**5.10**	**2.54**	**5.88**	**2.93**	**5.05**	**2.89**	**5.30**	**<.001**	**.11**	**.97**
(v) Emotionality		**31.37**	**13.39**			**28.60**	**11.88**	**24.23**	**11.82**	**23.84**	**12.22**	**22.79**	**11.57**	**13.93**	**<.001**	**.25**	**1.00**
b) Depression (DPDS)	**17**	**8.72**	**4.96**			**6.04**	**4.56**	**5.34**	**4.23**	**4.58**	**3.33**	**4.56**	**3.30**	**21.48**	**<.001**	**.39**	**1.00**
c) Coping strategies	17																
(i) Control		**20.30**	**8.08**	**13.83**	**8.66**	**9.41**	**6.55**	**8.82**	**4.20**	**6.80**	**4.75**	**7.88**	**4.87**	**21.35**	**<.001**	**.57**	**1.00**
(ii) Tolerant		**17.24**	**6.92**	**11.65**	**7.00**	**9.65**	**6.18**	**9.59**	**5.32**	**9.36**	**5.23**	**7.41**	**3.26**	**11.88**	**<.001**	**.43**	**1.00**
(iii) Assertive		22.26	6.34	*		23.21	6.50	21.95	7.26	23.26	6.85	23.05	5.90	.87	>.05	.02	.27

cont…

* No change in assertive coping strategies during the waitlist period

Table 9.15 cont…

Variable		Pre treatment		End waitlist		Mid treatment		End treatment		3 months post treatment		6 months post treatment		F	*p*	Eta^2	Observd Power
2. Relationships	n	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD				
a) Quality of interactions	43																
(i) When drinking		**3.86**	**1.10**			**3.56**	**1.10**	**3.21**	**1.06**	**3.23**	**1.31**	**3.12**	**1.10**	**3.67**	**<.01**	**.16**	**1.00**
(ii) When not drinking		**2.70**	**1.01**			**2.53**	**.94**	**2.37**	**1.07**	**2.35**	**1.04**	**2.14**	**1.01**	**7.87**	**<.001**	**.08**	**.87**
b) Marital discord	**17**	**8.75**	**2.86**	**6.24**	**3.24**	**4.73**	**2.28**	**4.61**	**3.27**	**4.39**	**2.92**	**3.95**	**2.09**	**10.79**	**<.001**	**.82**	**1.00**
c) Levels of abuse	43																
(i) Verbal		**1.35**	**1.31**			**.79**	**1.17**	**.91**	**1.19**	**.81**	**1.10**	**.56**	**.91**	**4.34**	**<.01**	**.09**	**.93**
(ii) Emotional		1.28	1.47			.95	1.41	.79	1.08	.95	1.25	.58	1.07	2.70	.03*	.06	.74
d) Marital state #	**36**	**46.77**	**10.04**			**44.80**	**11.22**	**43.46**	**14.27**	**41.71**	**13.24**	**42.11**	**12.42**	**3.29**	**<.05**	**.30**	**.78**
3. Drinkers' consumption patterns	43																
(i) Drinks on drinking day		**4.58**	**1.10**			**4.33**	**1.06**	**3.91**	**1.27**	**3.77**	**1.43**	**3.70**	**1.42**	**11.52**	**<.001**	**.22**	**1.00**
(ii) Drinking days past mo.		4.74	1.35			4.58	1.55	4.63	1.72	4.30	1.77	4.23	1.99	1.60	>.05	.04	.49
(iii) Drinking days past wk		2.81	1.28			2.86	1.26	2.81	1.33	2.53	1.56	2.58	1.48	1.14	>.05	.03	.35
(iv) Frequency of use		3.33	0.87			3.00	1.22	2.93	1.20	2.81	1.38	3.05	1.23	1.75	>.05	.04	.53
(v) Effect on drinking day		2.81	1.28			2.72	1.24	2.60	1.26	2.62	1.25	2.56	1.20	.76	>.05	.02	.24

36 participants were in conjugal relationships

by scores from the Crown Crisp Experiential Index (CCEI) and the Drinkers' Partners' Distress Scale (DPDS); viz.

a) Significantly reduced anxiety[19] (i.e. free floating, somatic, and obsessionality);

b) Significantly reduced depression as measured by: (i) the CCEI; and (ii) the DPDS; and therefore,

c) Significantly reduced emotionality (CCEI total mean score).

Intervention hypothesis 5

It was expected that there would be no significant decrement of treatment effect on participants' post intervention mental health status when post treatment tests were compared to tests at both 3 months post treatment and 6 months post treatment as evidenced by:

a) No significant decrement of effect on anxiety;

b) No significant decrement of effect on depression as measured by the Crown Crisp Experiential Index (CCEI) and the Drinkers' Partners' Distress Scale (DPDS); and therefore,

c) No significant decrement on emotionality (total CCEI mean score).

According to Jaccard and Becker (1983, p 233), research in the behavioural sciences typically produces relatively small values of intervention effect; i.e. eta-squared (or eta^2). They suggest interpreting an eta-squared of <.10 as constituting a weak intervention effect, an eta-squared between .10 and .25 as constituting a moderate effect, and an eta-squared >.25 as a strong effect. This suggestion has been followed in this research.

The MANOVA found a significant, strong multivariate effect of the intervention on participants' mental health status as measured by the CCEI from pre treatment through 6 months post treatment (Wilks' Lambda $F(16,505)=5.10$, $p<001$, $eta^2=.11$, observed power=1.00). **Further univariate analyses revealed all variables had received a significant intervention effect; viz. free floating anxiety, depression,**

[19] Because phobic anxiety remained at normal levels throughout the intervention (according to the CCEI's normative data) it was removed due to the small sample size and the number of mental health variables. Despite the reliability problem with the obsessionality subscale, it was retained for clinical interest

somatic anxiety, obsessionality, and thus, participants' emotionality (see Table 9.15).

Subsequent tests of within subjects contrasts (see Table 9.16) were planned to compare mean scores from 1) pre treatment to mid treatment, 2) pre to end treatment, and 3) end treatment to 6 months post treatment. As Table 9.16 and Figure 9.1 have illustrated, although somatic anxiety, obsessionality, and emotionality had significantly reduced by mid treatment, these effects were weak and could not be generalised beyond this sample. There was no significant reduction in free floating anxiety or depression mean scores by mid treatment (5 sessions). By the end of treatment (10 sessions), the reduction in somatic anxiety and obsessionality mean scores had increased in significance and effect, and free floating anxiety and depression mean scores had also significantly reduced. Moreover, by the end of treatment, the emotionality mean score had reduced to below the CCEI normative data mean[20] of 27.6 (sd=18.6). All reductions in mental health variables were sustained through 6 months post treatment.

When 6 month post treatment mean scores were compared to the CCEI normative data (see Table 9.9), the female (n=40) score for free floating anxiety (5.23) and somatic anxiety (3.99) had reduced to *below* the mean for urban women. Similarly, the male mean scores (n=3) for somatic anxiety (2.67) and depression (1.66) had also reduced to below the mean.

On the other hand, the MANOVA found a strong, significant effect on depression as measured by the DPDS (defined as embarrassment, loneliness, lack of stimulating company, worry, unsatisfactory sex, and insecurity) from pre treatment through 6 months post treatment (see Table 9.15). Subsequent tests of within subjects contrasts (see Table 9.16) revealed that the depression mean score had significantly and strongly reduced by mid treatment, and sustained through 6 months post treatment.

Thus, given the significant reduction in participants' anxiety and depression by the end of treatment, which resulted in significantly reduced emotionality, intervention hypothesis 1 was supported. Given no significant decrement of effect on participants' mental health status from the end of treatment through 6 months post treatment, the durability of treatment was demonstrated. Therefore, intervention hypotheses 5 was also supported.

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[20] For urban women

Table 9.16
Changes in participants' mental health mean scores between measurement periods from pre treatment through 6 months post treatment and between end treatment and 6 months post treatment for the Full Treatment group (n=43)

Variable	Measurement periods	Change in mean scores	F	*p*	Eta^2	Observed power
Somatic anxiety	**Pre to mid**	**7.86 to 5.37**	**4.41**	**<.05**	**.10**	**.54***
	Pre to end	**7.86 to 4.28**	**25.35**	**<.001**	**.38**	**1.00**
	End to 6 mo post trt	4.28 to 4.00	1.35	>.05	.03	.21
Obsessionality	**Pre to mid**	**6.53 to 5.91**	**4.51**	**<.05**	**.10**	**.55***
	Pre to end	**6.53 to 5.09**	**16.57**	**<.001**	**.28**	**.98**
	End to 6 mo post trt	5.09 to 5.04	.02	>.05	.00	.05
Free floating anxiety	Pre to mid	7.86 to 7.04	3.67	>.05	.08	.46
	Pre to end	**7.86 to 5.70**	**22.48**	**<.001**	**.35**	**1.00**
	End to 6 mo post trt	5.70 to 5.07	2.28	>.05	.05	.32
Depression	Pre to mid	6.09 to 6.28	.18	>.05	.00	.07
	Pre to end	**6.09 to 5.30**	**4.36**	**<.05**	**.09**	**.53**
	End to 6 mo post trt	5.30 to 4.81	1.94	>.05	.04	.27
Emotionality	**Pre to mid**	**31.37 to 28.60**	**5.37**	**<.05**	**.11**	**.62**
	Pre to end	**31.37 to 24.23**	**29.51**	**<.001**	**.41**	**1.00**
	End to 6 mo post trt	24.23 to 22.79	1.78	>.05	.04	.26
Depression (DPDS)	**Pre to mid**	**8.72 to 6.04**	**19.45**	**<.001**	**.32**	**.99**
	Pre to end	**8.72 to 5.31**	**26.72**	**<.001**	**.39**	**1.00**
	End to 6 mo post trt	5.31 to 4.46	2.22	>.05	. 05	.31

9.2.6 The effect and durability of treatment on participants' coping status

Intervention hypothesis 2

It was expected that there would be significant changes in pre and post tests of participants' coping status as a result of the intervention as evidenced by:

a) Significantly reduced control coping strategies;

b) Significantly reduced tolerant coping strategies; and

d) Significantly increased assertive coping strategies.

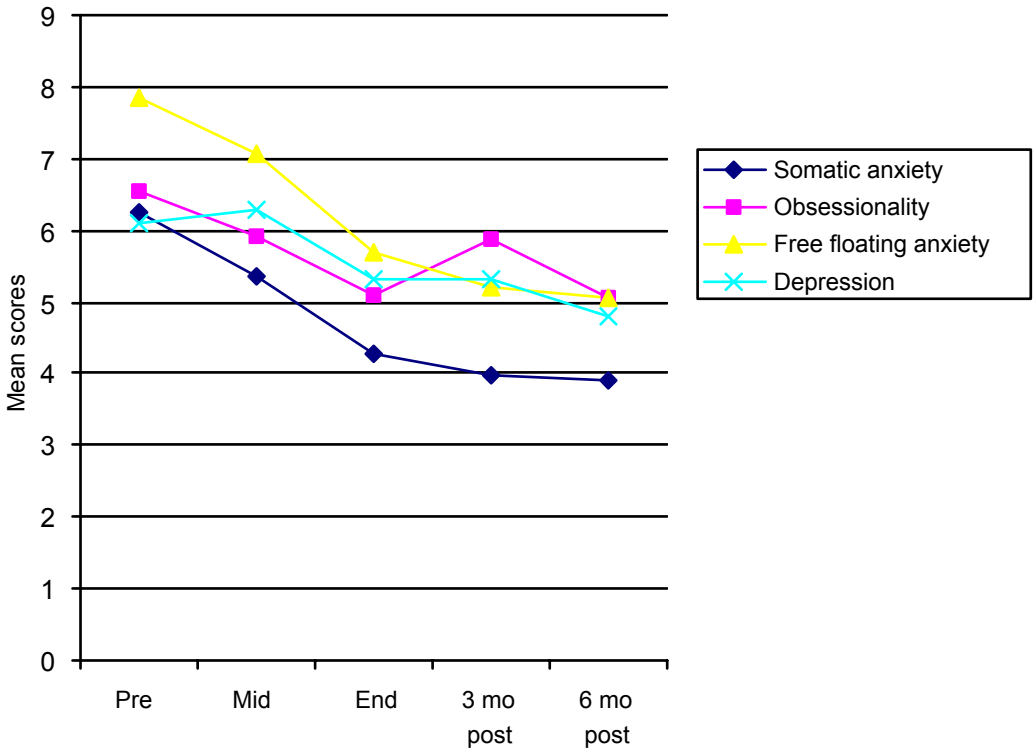

Figure 9.1 The durability of intervention effect on participants' mental health status from end treatment through 6 months post treatment

Intervention hypothesis 6

It was expected that there would be no significant decrement of treatment effect on participants' post intervention coping status when post treatment tests were compared to tests at 6 months post treatment as evidenced by:

a) No significant decrement of effect on control coping strategies; and

b) No significant decrement of effect on tolerant coping strategies.

Because there were significant reductions in both the control coping and tolerant coping mean scores during the waitlist period, the data were analysed over 6 treatment periods (i.e. pre treatment, end waitlist period, mid treatment, end treatment, 3 months post treatment, and 6 months post treatment) so that the impact of both the waitlist period and the intervention could be mapped more accurately. Given these significant reductions in mean scores during the waitlist period, it was important to recognise that any *further* significant reductions during treatment could not be attributed to the

intervention[21] because these may have merely have been an extension of the reductions achieved during the waiting period.

As Table 9.15 and Figure 9.2 have illustrated, the MANOVA found a significant multivariate effect on coping strategies from pre treatment through 6 months post treatment (Wilks' Lambda $F(15,240)=4.74$, $p<.001$, $eta^2=.23$, observed power=1.00). Further univariate analyses revealed a significant effect on 2 of the 3 coping variables; viz. control coping and tolerant coping. There was no significant effect on assertive coping.

Subsequent tests of within subject contrasts (see Table 9.17) identified that the significant reduction in the control coping mean score which had occurred between pre and end waitlist period was followed at mid treatment by an *additional* significant, strong reduction in mean score which was sustained through 6 months post treatment with augmented effect.

Whilst the tolerant coping mean score had significantly and moderately reduced during the waitlist period, there was no additional reduction between the end waitlist period and mid treatment, which was sustained through 6 months post treatment.

According to participants' ratings on the Likert scale, their utilisation of both control coping and tolerant coping strategies had reduced from within the "often" range at pre treatment, to within the "sometimes" range by the end of treatment. This was sustained through 6 months post treatment.

On the other hand, participants had maintained their use of assertive coping strategies within the "sometimes" range (as measured by the Drinkers' Partners' Coping Questionnaire: DPCQ).

Although control and tolerant coping mean scores had indeed significantly and strongly reduced during treatment, these data must be viewed with caution due to the significant reduction in these variables during the waitlist period. Whilst it was tempting to claim an intervention effect on the *further* significant reduction in control coping mean scores between the end of the waitlist period and mid treatment and the maintenance of the reduction in tolerant mean scores, it was not prudent to do so.

Therefore, intervention hypothesis 2a and 2b could only be <u>partially</u> supported. Given no significant increase in assertive coping strategies during

[21] Even in the absence of internal validity problems due to the short waitlist period

treatment, intervention hypothesis 2c was not supported. Given no significant decrement of effect on participants' control or tolerant coping status from the end of treatment through 6 months post treatment, the durability of treatment was demonstrated. Therefore, intervention hypothesis 6 was also supported.

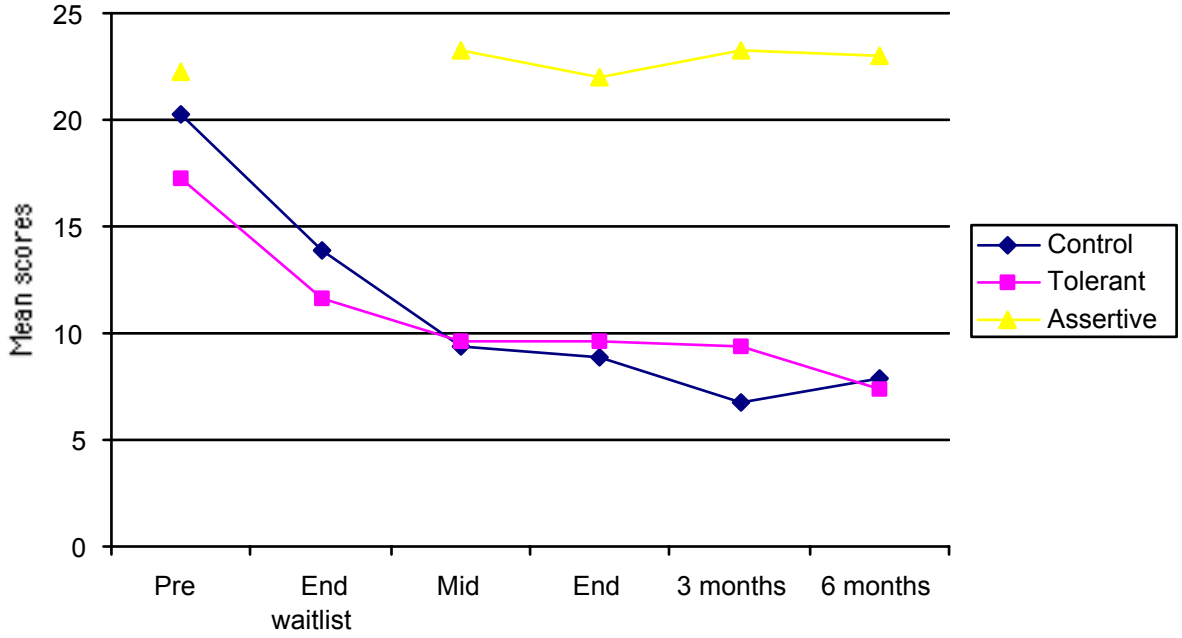

Figure 9.2 The durability of the intervention effect on participants' coping status from end treatment through 6 months post treatment
(scores reversed for assertive: high scores = less assertive)

Table 9.17
Changes in participants' coping mean scores between measurement periods throughout treatment and between end treatment and 6 months post treatment for the Full Treatment group (n=17)[22]

Coping Variable	Measurement periods	Change in mean scores	F	*p*	Eta^2	Observ'd power
Control	**Pre to end waitlist**	**20.30 to 13.82**	**23.91**	**<.001**	**.60**	**.99**
	End waitlist to mid	**13.83 to 9.41**	**10.42**	**<.01**	**.39**	**.86**
	Pre to end	**20.30 to 8.82**	**69.87**	**<.001**	**.81**	**1.00**
	End to 6 mo post	8.82 to 7.88	.90	>.05	.05	.15
Tolerant	**Pre to end waitlist**	**17.24 to 11.65**	**13.10**	**<.01**	**.45**	**.83**
	Pre to mid	**17.24 to 9.65**	**43.74**	**<.001**	**.73**	**1.00**
	Pre to end	**17.24 to 9.59**	**39.19**	**<.001**	**.71**	**1.00**
	End to 6 mo post trt	17.24 to 7.41	3.23	>.05	.17	.39

[22] There were only 17 participants in the Waitlist group

9.2.7 The "spin off" effect of the intervention on participants' relationships with their drinkers

Intervention hypothesis 3

It was expected that there would be significant changes in pre and post tests of participants' relationship status as a result of the intervention and evidenced by:

a) Significantly improved quality of everyday interactions between participants and their drinkers;
b) Significantly reduced marital discord;
c) Significantly reduced abusive behaviour from drinkers; and
e) Significantly improved marital state for participants.

Intervention hypothesis 7

It was expected that there would be no significant decrement of treatment effect on participants' relationship status when post treatment tests were compared to tests at 6 months post treatment as evidenced by:

a) No significant decrement of effect on the quality of everyday interactions between participants and drinkers;
b) No significant decrement of effect on marital discord;
c) No significant decrement of effect on drinkers' abusive behaviour; and
d) No significant decrement of effect on participants' marital state.

Quality of everyday interactions between participants and their drinkers

The MANOVA found a significant multivariate effect on the quality of everyday interactions between participants and their drinkers from pre treatment through 6 months post treatment (Wilks' Lambda F(8,334)=4.30, p<.001, eta^2=.09, observed power=1.00). Further univariate analyses revealed significant effects on the quality of interactions when drinkers were drinking *as well as* when they were not drinking (see Table 9.15).

Subsequent tests of within subject contrasts (see Table 9.18) identified a significant *mid treatment* reduction in mean scores in the quality of everyday interactions between participants and their drinkers *when drinkers were drinking* (as opposed to not drinking); i.e. the quality of interactions had improved. Moreover, this reduction was sustained through 6 months post treatment with augmented effect.

According to participants' ratings, the quality of interactions *when their drinkers were drinking* had improved from an average of "poor" at pre treatment to "so-so".

Table 9.18
Changes in participants' perception of the quality of everyday interactions mean scores when drinkers were drinking (or not drinking) between measurement periods throughout treatment and between end treatment and 6 months post treatment for the Full Treatment group (n=43)

Variable	Measurement periods	Change in mean scores	F	*p*	Eta^2	Observd power
Interactions when drinkers were drinking	**Pre to mid**	**3.86 to 3.56**	**4.99**	**<.05**	**.11**	**.59***
	Pre to end	**3.86 to 3.21**	**20.28**	**<.001**	**.33**	**.90**
	End to 6 mo post trt	3.21 to 3.12	.47	>.05	.01	.10
Interactions when drinkers were not drinking	Pre to mid	2.70 to 2.53	1.41	>.05	.03	.21
	Pre to end	2.70 to 2.37	3.72	>.05	.08	.47
	Pre to 6 mo post	**2.70 to 2.14**	**8.45**	**<.01**	**.17**	**.81**
	End to 6mo post trt	2.37 to 2.14	2.34	>.05	.05	.32

- Observed power too low to generalise beyond this sample

Regarding the quality of interactions between participants and their drinkers when drinkers were *not drinking*, the significance of the steady decrease in pre treatment mean scores was not evident until 3 months post treatment (F=4.42, p=<.05, eta^2=.10, observed power=.54). However, by 6 months post treatment, the reduction in pre treatment mean scores was accompanied by augmented effect and observed power (see Table 9.18). According to participants' ratings, the quality of their everyday interactions when their drinkers were *not drinking* had improved from an average of "so-so" at pre treatment to "good" by 3 months post treatment and was sustained through 6 months post treatment.

Therefore, given the significant improvement in the quality of participants' interactions with their drinkers between pre treatment and end treatment occurred only when drinkers were drinking (as opposed to not drinking), hypothesis 3a was only partly supported. However, the quality of participants' everyday interactions with their drinkers had significantly improved by 3 months post treatment. Given no significant decrement of these effects from the end of treatment through 6 months post treatment, the durability of treatment was demonstrated. Therefore, hypothesis 7 was supported.

Marital discord

The marital discord subscale of the Drinkers' Partners' Distress Scale (DPDS) measured partners' irritability and anger due to their drinkers' behaviour, money shortages; and verbal and physical abuse from their heavy drinking associates. Because marital discord significantly reduced during the waitlist period, data was analysed over 6 time periods; viz. pre treatment, end waitlist, mid treatment, end treatment, 3 months post treatment and 6 months post treatment. This was done so the impact of the waiting period (and the intervention) could be more thoroughly mapped.

The MANOVA found a strong, significant effect on marital discord from pre treatment through 6 months post treatment (Wilks' Lambda F(5,12)=10.79; *p*<.001, eta^2=.82, observed power=.99). Subsequent tests of within subject contrasts identified a significant, strong, reduction in marital discord during the waitlist period. This reduction in mean scores was sustained through end treatment, and 6 months post treatment (see Table 9.19).

Whilst it is tempting to claim an intervention effect on the additional reduction in marital discord mean scores between end waitlist and mid treatment, it is not prudent to do so. Therefore, intervention hypothesis 3b was only partially supported. Given no significant decrement of treatment effect on marital discord from end treatment through 6 months post treatment, the durability of treatment has been demonstrated. Therefore, intervention hypothesis 7b was supported.

Table 9.19
Changes in marital discord mean scores between measurement periods throughout treatment and between end treatment and 6 months post treatment for the Full Treatment group (n=43)

Variable	Measurement periods	Change in mean scores	F	*p*	Eta^2	Observed power
Marital discord	**Pre to end waitlist**	**8.75 to 6.24**	**9.07**	**<.05**	**.37**	**.72**
	Pre to mid	**8.75 to 4.73**	**44.56**	**<.001**	**.77**	**1.00**
	Pre to end	**8.75 to 4.61**	**29.75**	**<.001**	**.70**	**1.00**
	End to 6 mo post trt	4.61 to 3.95	.89	>.05	.05	.09

Abuse from drinkers towards participants

The "abuse from drinkers" variable included verbal abuse and emotional abuse.[23] Participants rated their experience of both emotional and verbal abuse between the "minimal" and "moderate" ranges prior to treatment**.**

The MANOVA found a significant multivariate effect of treatment on drinkers' abusive behaviour from pre treatment through 6 months post treatment (Wilks' Lambda F(8,334)=2.57; p<.05, eta^2=.06, observed power=.91). Further univariate analyses revealed that verbal abuse was the major contributor to the multivariate effect (see Table 9.15).

Subsequent tests of within subjects contrasts (see Table 9.20) revealed that whilst verbal abuse mean scores had indeed significantly reduced by mid treatment, this reduction had not been maintained by the end of treatment. However, by 3 months post treatment, verbal abuse mean scores had significantly reduced *with augmented effect*, and this was sustained through 6 months post treatment. According to participants' ratings, their drinkers' verbal abuse had reduced from the "moderate" range to the "minimal" range.

The MANOVA also identified a significant reduction in emotional abuse mean scores through 6 months post treatment (Wilks' Lambda F(4,168)=2.70; p<.05, eta^2=.06, observed power=.74). Although the conservative Bonferroni correction deemed the significance of this reduction to be non significant (because a p level of .025 was required), the reduction in drinkers' emotional abuse through 6 months post treatment very closely approached statistical significance. However, this reduction was unequivocally *clinically* significant. According to participants' ratings, their drinkers' emotional abuse had also reduced from the "moderate" range to the "minimal" range.

Subsequent tests of within subjects contrasts (see Table 9.20) revealed that although emotional abuse mean scores had steadily reduced during treatment no *statistically* significant reduction had occurred even by 3 months post treatment. It was not until 6 months post treatment that a significant reduction in drinkers' emotional abuse had occurred.

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[23] Emotional abuse refers to manipulative, guilt provoking, and/or passive aggressive behaviour

Table 9.20
Changes in drinkers' verbal abuse mean scores between measurement periods during treatment and between end treatment and 6 months post treatment for the Full Treatment group (n=43)

Variable	Measurement periods	Change in mean scores	F	*p*	Eta^2	Observed power
Verbal abuse from drinkers towards participants	**Pre to mid**	**1.35 to .79**	**6.35**	**<.05**	**.13**	**.69***
	Pre to end	1.35 to .91	2.92	>.05	.07	.39
	Pre to 3 mo post trt	**1.35 to .81**	**12.30**	**<.05**	**.11**	**.62***
	3 mo to 6 mo post trt	.81 to .56	2.68	>.05	.13	.70
Emotional abuse from drinkers towards participants	Pre to mid	1.28 to .95	2.70	>.05	.06	.74
	Pre to end	1.28 to .79	3.51	>.05	.08	.45
	Pre to 3 mo post trt	1.28 to .95	1.66	>.05	.04	.24
	Pre to 6 mo post trt	**1.28 to .58**	**11.12**	**<.01**	**.21**	**.90**

* Observed power too low to generalise beyond this sample

Although no significant reduction in drinkers' verbal and emotional abuse mean scores had occurred by the end of treatment, participants' ratings indicated that the reduction in mean scores was perhaps clinically significant. Therefore, intervention hypothesis 3 was partially supported. Given no significant <u>decrement</u> of treatment effect on drinkers' abusive behaviour towards participants from the end of treatment through 6 months post treatment, the durability of treatment effect has been demonstrated. Therefore, intervention hypothesis 7c was also supported.

Marital state

The marital state data (GRIMS) "tapped" participants' beliefs, attitudes and feelings about their relationships with their drinkers; viz. (i) shared interests; (ii) communication; (iii) warmth, love, or hostility; (iv) trust and respect; (v) roles expectations and goals; (vi) decision making; and (vii) coping with problems.

The MANOVA found a significant, moderately strong effect on participants' marital state from pre treatment through 6 months post treatment;

viz. Wilks' Lambda F(4,31)=3.29; $p<.05$, $eta^2=.30$, observed power=.78 (see Table 9.15). Subsequent tests of within subject contrasts identified that the mean score had significantly reduced from 46.77 at pre treatment to 42.11 by 3 months post treatment and was sustained through 6 months post treatment. However, although statistically significant improvement had indeed occurred, it was not likely to have been clinically significant as scores indicated that participants' marital state had merely reduced from "very severe problems" to "severe problems".

Therefore, given the steady reduction in marital state scores during the intervention did not become significant until 3 months post treatment, intervention hypotheses 3d was only partially supported. Given no significant decrement in end treatment mean scores (or in this case 3 month post treatment mean scores), durability of treatment effect was demonstrated. Therefore, intervention hypothesis 7d was supported.

9.2.8 The "spin off" effect and durability of effect of participants' treatment on their drinkers' consumption patterns

Intervention hypothesis 4

It was expected that there would be significant changes in pre and post tests of drinkers' consumption behaviour as a result of the intervention with their relatives as evidenced by:

a) Significant reductions in drinkers' consumption patterns; and

b) Drinkers' increased help seeking behaviour.

Intervention hypothesis 8

It was expected that there would be no significant decrement of treatment effect on drinkers' consumption behaviour when post treatment tests were compared to tests at 6 months post treatment as evidenced by no significant decrement of effect on drinkers' consumption patterns.

All data concerning drinkers was provided by research participants. Although collaterals' estimates of their drinkers' consumption patterns have been found to correlate well with drinkers' own estimates (Jarmas & Kazak, 1992; McAuley, Longbraugh, & Gross, 1978; Meyers, Miller, Hill & Tonigan, 1999), it was important to

recognise that conclusions regarding drinkers' consumption needed to be interpreted with caution.

Drinkers' consumption patterns

The consumption group of variables included the number of drinking days over the past month, the number of drinking days over the past week, and the number of drinks on any given drinking day. **The MANOVA found a significant multivariate treatment effect on consumption from pre treatment through 6 months post treatment (Wilks' Lambda $F(12,439)=3.84$, $p<.001$, $eta^2=.08$, observed power =1.00).** Further univariate analyses (see Table 9.15) revealed that the "number of drinks on any given drinking day" variable was the major contributor to the multivariate effect

Subsequent tests of within subject contrasts revealed that a significant reduction (with moderate effect) in mean scores had occurred by mid treatment, which was followed by an *additional* significant reduction by the end of treatment (with increased effect). This reduction in amount consumed on any given drinking day was sustained 6 months post treatment, accompanied by strong effect (see Table 9.21). According to participants' ratings, their drinkers had reduced their pre treatment consumption on any given drinking day from 9-12 drinks to 5-8 drinks by end treatment through 6 months post treatment.

Table 9.21
Changes in participants' perceptions of reductions in drinkers' consumption on any given drinking day between measurement periods throughout treatment and between end treatment and 6 months post treatment for the Full Treatment group (n=43)

Variable	Measurement periods	Change in mean scores	F	*p*	Eta^2	Observed power
Number of drinks on any given drinking day	**Pre to mid**	**4.58 to 4.33**	**4.51**	**<.05**	**.10**	**.55**
	Mid to end	**4.33 to 3.91**	**6.53**	**<.05**	**.14**	**.70**
	End to 6 mo post trt	**3.91 to 3.70**	**2.13**	>.05	.05	.30

Frequency and effect of use

The MANOVA found no significant effect of treatment on participants' perceptions of drinkers' frequency of use, and effect of use on any given drinking day.

Therefore, given the significant reduction in drinkers' consumption patterns by the end of participants' treatment, intervention hypothesis 4a was supported. Given no significant decrement of effect on drinkers' consumption

from the end of treatment through 6 months post treatment, intervention hypothesis 8 was also supported.

9.2.9 Changes in drinkers' consumption patterns and help seeking behaviour through 6 months post treatment: the raw data

It was illuminating to examine the raw data provided by participants who had completed 10 sessions to investigate the pattern of changes in their drinkers' consumption and help seeking behaviour from pre treatment through 6 months post treatment. As Table 9.22 has illustrated, by mid treatment (5 sessions), 27 participants (63%) had reported that their drinkers had either sought help (n=7), ceased consumption (n=2), or reduced to varying degrees. Those who sought help did so at drug and alcohol agencies (n=4), a medical practitioner (n=1), Alcoholics Anonymous (n=1), or a psychologist (n=1). By the end of treatment, the same number of participants (n=27, 63%) had reported positive change in their drinkers' behaviour: 78% of these drinkers (n=21) had sustained their mid treatment change, and this was sustained through 6 months post treatment.

However, 16 drinkers (37%) had made no change by mid treatment (or had actually increased their consumption) and this was also sustained through 6 months post treatment.

Therefore, given the intervention resulted in an increase in drinkers' help seeking behaviour hypothesis 4b was supported.

A more conservative figure regarding the number of drinkers who sought help or reduced their consumption as a "spin off" of their relatives' treatment was obtained by removing from the calculations those drinkers who had only reduced "a little". Thus, after 5 treatment sessions, 14 participants (30%) had reported positive change in their drinkers' behaviour. By the end of treatment, this had increased to 20 participants (47%) whose drinkers had made substantial change.

9.3 The effect and durability of partial treatment (5 treatment sessions) for the Late Dropout group who were available for follow up (n=13)

This section has investigated the effect of the Holyoake intervention on the 13 participants from the Late Dropout group (n=20) who were available for follow up 5 weeks after they had completed 5 treatment sessions; i.e. *as if* they had completed the 10 treatment sessions. Given the significant reduction in mean scores during the waitlist period for control and tolerant coping strategies, and marital discord, it has been customary in this research to focus the analyses for these variables on the waitlist group so that the effect of the waiting period could be more thoroughly mapped. Given the small sample size in the Late Dropout group, this procedure has been omitted.

Table 9.22
Participants' reports (raw data) of drinkers' help seeking behaviour, reduced consumption, no change or increased consumption from pre treatment through 6 months post treatment for the Full Treatment group (n=43)

Drinkers' help seeking behaviour, reduced consumption, no change, or increased consumption	Mid treatment (5 sessions)	End treatment (10 sessions)	6 months post treatment
Sought help	7	7	4
Ceased	2	4	1
Reduced dramatically	2	1	2
Reduced considerably	2	8	7
Reduced a little	14	7	13
Total help seeking behaviour or reduced consumption	**27 (63%)**	**27 (63%)**	**27 (63%)**
No change	12	8	9
Increased a little	2	3	3
Increased considerably	1	4	2
Increased dramatically	1	1	2
Total no change or increased consumption	**16 (37%)**	**16 (37%)**	**16 (37%)**

Notwithstanding the small number of participants, data were subjected to a one way, within subjects, repeated measures MANOVA which compared variables across 3 periods, viz. pre treatment, 5 treatment sessions, and 5 weeks later *as if* participants were still in treatment. Once again, the three major variable groups were examined; viz.

(i) participants, (ii) their relationships with their drinkers, and (iii) drinkers' consumption patterns.

Subsequent tests of within subjects contrasts were planned to compare mean scores across all variables from pre treatment to 5 treatment sessions and from pre treatment to 5 weeks post treatment. If significant reductions in mean scores had occurred between pre treatment and 5 treatment sessions, another comparison was done which compared mean scores at 5 treatment sessions with scores at 5 weeks post treatment.

A summary of means, standard deviations and univariate analyses have been presented in Table 9.23. Despite the small sample size, the MANOVA identified significant reductions in mean scores within each of the 3 variable groups which were sustained through 5 weeks post treatment.

It was interesting to note that the effect of the Holyoake intervention on these 13 participants' mental health, coping and relationship status was similar *in most respects* to that identified for the Full Treatment group (n=43) over the same time periods - even though the Late Dropout group had only received 5 treatment sessions and the Full Treatment group had received 10 treatment sessions. However, as a comparison between Tables 9.23 and 9.24 (i.e. summary analyses for the full Treatment group) has illustrated, the effect of the intervention on the Late Dropout group's drinkers seemed to be more pervasive.

9.3.1 The effect and durability of partial treatment (5 treatment sessions) on participants' mental health status (n=13)

The mental health group of variables (as measured by the CCEI) included free floating anxiety, somatic anxiety and depression. Given the small sample size in the Late Dropout group, obsessionality scores were not included.

The MANOVA found a significant, strong, multivariate effect on participants' mental health status after 5 treatment sessions through 5 weeks post treatment (Wilks' Lambda $F(6,44)=2.78$, $p<.05$, $eta^2=.28$, observed. power=.83). Further univariate analyses revealed that the significant reduction in somatic anxiety mean scores was the major contributor to this effect (see Table 9.23).

Subsequent tests of within subjects contrasts (see Table 9.25) revealed that the significant reduction in the somatic anxiety mean score achieved after 5 treatment

sessions was sustained through 5 weeks post treatment. However, despite the steady reduction in free floating anxiety mean scores (from 7.08 to 6.54 to 5.31), no significant effect was found. Moreover, no significant reduction in depression mean scores had occurred after 5 treatment sessions through 5 weeks post treatment. These results were consistent with those obtained from the Full Treatment group where somatic anxiety had reduced after 5 treatment sessions, and free floating anxiety and depression mean scores had not significantly reduced until participants had completed 10 sessions.

However, as Table 9.23 has illustrated, when the total CCEI mean score (i.e. emotionality) was subjected to a MANOVA, a significant, very strong effect on the Late Dropout group's emotionality after 5 treatment sessions through 5 weeks post treatment was found (Wilks' Lambda F(2,11)=5.68, p<.05, eta^2 =.51, observed. power=.75).

Subsequent tests of within subjects contrasts (see Table 9.25) identified that the reduction in emotionality mean score had reached significance by 5 weeks *post treatment*. Whilst these results were consistent with those from the Full Treatment group (see Tables 9.23 & 9.24), emotionality had reduced significantly earlier for the Full Treatment group; i.e. at the 5 session point (see Table 9.16). Perhaps a larger sample size may have increased the significance of the reduction in mean score at the 5 session point for the Late Dropout group.

Regarding depression (as measured by the DPDS), the MANOVA found a significant, very strong effect after 5 treatment sessions through 5 weeks post treatment (Wilks' Lambda F(2,11)=7.69, p<.01, eta^2 =.58, observed. power=.87). These results were consistent with those obtained from the Full Treatment group (see Tables 9.23 & 9.24). Subsequent tests of within subjects contrasts (see Table 9.25) revealed that the significant reduction in mean score which had occurred after 5 treatment sessions was sustained through 5 weeks post treatment

9.3.2 The effect and durability of partial treatment (5 sessions) on participants' coping status (n=13)

Given the small sample size (and no significant change in assertive mean scores in any previous analyses), only control coping and tolerant coping scores were entered into the MANOVA. **A significant, very strong multivariate effect on coping status was found after 5 treatment sessions through 5 weeks post treatment (Wilks'**

Lambda $F(4,46)=5.95$, $p<.01$, $eta^2=.34$, observed power=.97). Further univariate analyses identified a significant effect on both control coping and tolerant coping mean scores. These results were consistent with those obtained from the Full Treatment group (see Tables 9.23 & 9.24).

Table 9.23
Summary of means, standard deviations and univariate analyses for the Late Dropout group from pre treatment through 5 treatment sessions and 5 weeks post treatment (n=13)

Variable		Pre treatment		5 treatment sessions		5 weeks post treatment		F	*p*	Eta^2	Observed Power
1. Participants	n	M	SD	M	SD	M	SD				
a) Mental health	13										
(i) Free floating anxiety		7.08	3.35	6.54	4.41	5.31	4.17	2.45	>.05	.17	.45
(ii) Somatic anxiety		**5.85**	**2.79**	**3.69**	**2.93**	**2.85**	**2.82**	**8.50**	**<.01**	**.42**	**.94**
(iii) Depression		4.62	3.01	5.08	3.71	4.31	3.28	.77	>.05	.06	.03
(iv) Emotionality (CCEI total)		**26.15**	**12.30**	**24.92**	**15.12**	**20.54**	**12.82**	**5.68**	**<.05**	**.51**	**.75**
(v) Depression (DPDS)		**7.61**	**2.76**	**4.15**	**1.29**	**3.07**	**2.02**	**10.72**	**<.05**	**.66**	**.96**
b) Coping strategies	13										
(i) Control		**19.23**	**5.90**	**9.08**	**6.82**	**7.08**	**6.01**	**8.98**	**<.01**	**.43**	**. 95**
(ii) Tolerant		**15.62**	**8.53**	**7.15**	**5.32**	**5.85**	**4.62**	**15.52**	**<.001**	**.56**	**1.00**

cont…

* Only 10 participants were in conjugal relationships

Table 9.23 cont…

Variable		Pre treatment		5 treatment sessions		5 weeks post treatment		F	*p*	Eta^2	Observed Power
2. Relationships											
a) Quality of interactions #	13	M	SD	M	SD	M	SD				
-when drinking		**3.46**	**.97**	**3.38**	**.96**	**2.85**	**1.14**	**3.17**	**.06**	**.21**	**.55**
-when not drinking		2.31	1.11	1.93	.64	1.92	.64	1.44	>.05	.11	.28
b) Marital discord	**13**	**7.44**	**3.26**	**4.00**	**.95**	**3.15**	**2.11**	**7.69**	**.01**	**.58**	**.87**
c) Levels of abuse#	13										
(i) Verbal abuse		**1.15**	**1.21**	**.62**	**.96**	**.15**	**.55**	**4.31**	**.025**	**.26**	**.69**
(ii) Emotional abuse		**1.08**	**1.26**	**.46**	**.97**	**.15**	**.55**	**4.62**	**<.025**	**.28**	**.73**
d) Marital state (n=10)	10*	43.20	9.13	38.10	7.64	35.00	11.72	2.27	>.05	.36	33
3. Drinkers' consumption patterns (n=13) ##											
(i) Drinks on a drinking day		**5.08**	**.86**	**4.69**	**.95**	**3.62**	**1.98**	**7.46**	**.04**	**.28**	**.59**
(ii) Drinking days past mo.		**4.62**	**1.76**	**3.85**	**2.12**	**2.77**	**2.24**	**5.13**	**.01**	**.30**	**.77**
(iii) Drinking days past wk.		**2.92**	**1.61**	**2.38**	**1.76**	**1.46**	**1.66**	**5.36**	**.01**	**.31**	**.79**
(iv) Frequency		**3.38**	**0.87**	**2.62**	**1.61**	**2.15**	**1.68**	**4.03**	**.03**	**.25**	**.53**
(v) Effect on a drinking day		**3.15**	**1.14**	**2.54**	**1.20**	**2.08**	**1.55**	**8.75**	**<.01**	**.42**	**.87**

* Only 10 participants were in conjugal relationships
\# The Bonferroni correction required a significance level of .025
\# \# The Bonferroni correction required a significance level of .01

Table 9.24
Summary of means, standard deviations, and univariate analyses for the Full Treatment group (n=43) from pre treatment, end waitlist period, through mid treatment (5 sessions) and end treatment (10 sessions) across the 3 major variables groups (participants, their relationships with their drinkers, and their drinkers' consumption patterns)

Variable		Pre treatment		End waitlist[24]		Mid treatment (5 sessions)		End treatment (10 sessions)		F	*p*	Eta^2	Observed Power
1. Participants	n	M	SD	M	SD	M	SD	M	SD				
a) Mental Health (CCEI)	43												
(i) Free floating anxiety		**7.86**	**4.20**			**7.05**	**3.48**	**5.70**	**3.50**	**13.93**	**<.001**	**.25**	**1.00**
(ii) Somatic anxiety		**6.23**	**3.21**			**5.37**	**2.80**	**4.28**	**2.91**	**13.04**	**<.001**	**.24**	**1.00**
(iii) Depression		6.09	3.02			6.28	3.41	5.30	3.30	3.39	.04*	.08	.62
(iv) Emotionality (CCEI total)		**31.37**	**13.39**			**28.60**	**11.88**	**24.23**	**11.82**	**1.39**	**<.001**	**.39**	**1.00**
***(v)* Depression (DPDS)**	**43**	**8.72**	**4.96**			**6.04**	**4.56**	**5.31**	**4.34**	**8.44**	**<.01**	**.70**	**.95**
b) Coping strategies													
(i) Control	**17**	**20.30**	**8.08**	**13.83**	**8.66**	**9.41**	**6.55**	**8.82**	**4.20**	**29.42**	**<.001**	**.65**	**1.00**
(ii) Tolerant	**17**	**17.24**	**6.92**	**11.65**	**7.00**	**9.65**	**6.18**	**9.59**	**5.32**	**14.49**	**<.001**	**.48**	**1.00**
(iii) Assertive	43	22.26	6.34			23.21	6.50	21.95	7.26	1.15	>.05	.03	.25

cont...

* After applying the Bonferroni correction, a significance level of .01 was required

[24] Only control coping, tolerant coping, and marital discord were included in the end waitlist data

Table 9.24 cont...

Variable		Pre treatment		End waitlist		Mid treatment (5 sessions)		End treatment (10 sessions)		F	*p*	Eta^2	Observed Power
2. Relationships between participants and drinkers	n	M	SD	M	SD	M	SD	M	SD				
a) Quality of interactions	43												
(i) When drinking		**3.86**	**1.10**			**3.56**	**1.10**	**3.21**	**1.06**	**11.21**	**<.001**	**.20**	**.98**
(ii) When not drinking		2.70	1.01			2.53	0.94	2.37	1.07	2.41	>.05	.05	.47
b) Marital discord	**17**	**10.55**	**4.47**	**8.52**	**3.65**	**6.34**	**4.56**	**5.49**	**4.23**	**8.44**	**<.01**	**.70**	**.95**
c) Abuse from drinkers	43												
(i) Verbal abuse		1.35	1.31			.79	1.17	.91	1.19	3.30	.04**	.07	.61
(ii) Emotional abuse		1.28	1.47			.95	1.41	.79	1.08	2.13	>.05	.05	.43
d) Marital state#	36	47.31	10.55			45.08	11.19	43.44	14.01	2.17	>.05	.11	.41
3. Drinkers' consumption patterns	43												
(i) Drinks on drinking day		**4.58**	**1.10**			**4.33**	**1.06**	**3.91**	**1.27**	**9.10**	**<.001**	**.18**	**.97**
(ii) Drinking days past month		4.74	1.35			4.58	1.55	4.63	1.72	.32	>.05	.04	.07
(iii) Drinking days past week		2.81	1.28			2.86	1.26	2.81	1.33	.95	>.05	.03	.06
(iv) Frequency of use		3.33	0.87			3.00	1.22	2.93	1.20	2.64	>.05	.05	.46
(v) Effect on drinking day		2.81	1.28			2.72	1.24	2.60	1.26	1.05	>.05	.04	.35

** After applying the Bonferroni correction, a significance level of .025 was required
# 36 participants in the Full Treatment group were in conjugal relationships

Table 9.25
Changes in participants' mental health and coping mean scores between pre treatment and 5 treatment sessions through 5 weeks post treatment for the Late Dropout group (n=13)

Variable	Change in mean scores	*F*	*p*	Eta^2	Observed power
Participants' mental health status					
Somatic anxiety					
Pre to 5 sessions	**5.85 to 3.69**	**8.44**	**<.05**	**.41**	**.76**
Pre to 5 weeks post trt	**5.85 to 2.85**	**11.70**	**<.01**	**.49**	**.88**
5 sessions to 5 wks post trt	3.69 to 2.85	1.94	>.05	.14	.25
Emotionality (total CCEI)					
Pre to 5 sessions	26.15 to 24.92	.23	>.05	.02	.07
Pre to 5 weeks post trt	**26.15 to 20.54**	**9.59**	**<.01**	**.44**	**.81**
Depression (DPDS)					
Pre to 5 sessions	**7.61 to 4.15**	**23.38**	**<.001**	**.66**	**.92**
Pre to 5 weeks post trt	**7.61 to 3.07**	**9.41**	**<.05**	**.51**	**.78**
5 sessions to 5 wks post trt	4.15 to 3.07	2.70	>.05	.18	.33
Participants' coping strategies					
Control					
Pre to 5 sessions	**19.23 to 9.08**	**8.59**	**<.05**	**.42**	**.77**
Pre to 5 weeks post trt	**19.23 to 7.08**	**11.54**	**<.01**	**.49**	**.88**
5 sessions to 5 wks post trt	9.08 to 7.08	1.18	>.05	.09	.16
Tolerant					
Pre to 5 sessions	**15.62 to 7.15**	**14.67**	**<.01**	**.55**	**.94**
Pre to 5 weeks post trt	**15.62 to 5.85**	**21.02**	**<.01**	**.64**	**.99**
5 sessions to 5 wks post trt	7.15 to 5.85	1.18	>.05	.09	.17

Subsequent tests of within subjects contrasts (see Table 9.25) revealed that strong significant reductions in both control and tolerant coping mean scores had occurred by the end of 5 sessions and were sustained 5 weeks post treatment. However, given the significant reduction in both control and tolerant coping mean scores during the waitlist period, this could not prudently be attributed to the intervention.

9.3.3 The effect and durability of partial treatment (5 treatment sessions) on participants' relationships with their drinkers (n=13)

Quality of every day interactions between participants and their drinkers

The MANOVA found no significant effect of the intervention on the quality of everyday interactions between participants and their drinkers (Wilks' Lambda $F(4,46)=2.04$, $p>.05$). However, further univariate analyses (see Table 9.23) were investigated which identified that the reduction in mean scores for the quality of everyday interactions *when drinkers were drinking* (as opposed to when they were not drinking) had approached significance (Wilks' Lambda $F(2,24)=3.17$, $p=.06$, $eta^2=.21$, observed power=.55). These results were consistent with the Full Treatment group where the quality of everyday interactions between participants and their drinkers *when drinkers were drinking* had significantly improved after 5 treatment sessions (see Tables 9.23 & 9.24 & 9.18).

Marital discord

The MANOVA found that the steady reduction in marital discord mean scores after 5 treatment sessions through 5 weeks post treatment approached significance with very strong effect; viz. Wilks' Lambda $F(2,8)=4.47$, $p=.05$, $eta^2=.53$, observed power=.59 (see Table 9.23)**.** Subsequent tests of within subjects contrasts revealed that the marital discord mean score had strongly and significantly reduced after 5 treatment sessions and was sustained through 5 weeks post treatment. These results were consistent with those obtained from the Full Treatment group (see Tables 9.26 & 9.19).

Abuse from drinkers towards participants and participants' marital state

The MANOVA found an effect on drinkers' abusive behaviour after 5 treatment sessions through 5 weeks post treatment which approached significance (Wilks' Lambda $F(4,46)=2.45$, $p=.06$, $eta^2=.18$, observed power=.66). Further univariate analyses identified significant reductions in both verbal and emotional abuse (see Table 9.23). Subsequent tests of within subjects contrasts (see Table 9.26) revealed that both verbal and emotional abuse mean scores had significantly reduced at the 5 weeks post treatment point for the Late Dropout group.

These results were inconsistent with the Full Treatment group which found no significant reduction in either verbal or emotional abuse until 3 months and 6 months post treatment respectively. However, the MANOVA found no significant effect of partial treatment on participants' marital state which was consistent with the Full Treatment group (see Tables 9.23 & 9.24).

Table 9.26
Changes in participants' relationship mean scores after 5 treatment sessions through 5 weeks post treatment for the Late Dropout group (n=13)

Variable	Change in mean scores	*F*	*p*	Eta^2	Observed power
Marital discord					
Pre to 5 sessions	**7.44 to 4.00**	**12.84**	**<.01**	**.52**	**.91**
Pre to 5 weeks post trt	**7.44 to 3.15**	**16.72**	**<.01**	**.58**	**.96**
5 sessions to 5 wks post trt	4.00 to 3.15	2.26	>.05	.16	.28
Drinkers' abusive behaviour (n=13)					
Verbal abuse					
Pre to 5 sessions	1.15 to .62	2.35	>.05	.16	.19
Pre to 5 weeks post trt	**1.15 to .15**	**6.00**	**<.05**	**.37**	**.68**
Emotional abuse					
Pre to 5 sessions	1.08 to .46	3.46	>.05	.22	.21
Pre to 5 weeks post trt	**1.08 to .15**	**7.02**	**<.05**	**.37**	**.68**

9.3.4 The "spin off" effect of participants' partial treatment on their drinkers' consumption patterns (n=13)

The consumption group of variables (provided by participants) included frequency of use, effect of use, the number of drinking days over the past month, the number of drinking days over the past week, and the number of drinks consumed on any given drinking day.

Despite the small sample size, the MANOVA found a strong, multivariate effect on drinkers' consumption patterns after 5 treatment sessions through 5 weeks post treatment (Wilks' Lambda $F(10,40)=2.43$, $p<.05$, eta^2=.38, observed

power=.88). Further univariate analyses identified significant reductions in mean scores for all consumption variables accompanied by strong effect.

However, when the Bonferroni correction was applied (which required a significance level of .01), only the reduction in mean score for "the effect of use" was deemed to be significant (see Table 9.23). Given a larger sample size, the reductions in mean scores for the other consumption variables may have become more statistically significant.

Subsequent tests of within subjects contrasts (see Table 9.27) revealed significant reductions (accompanied by strong effect) in mean scores after 5 sessions for frequency of use, effect of use, and the number of drinking days in the past month. Moreover, all of these reductions were sustained through 5 weeks post treatment. Whilst there were no significant reductions in mean scores after 5 treatment sessions for the number of drinking days in the past week or the number of drinks consumed on any given drinking day, both mean scores had reduced significantly (with strong effect) through 5 weeks post treatment.

These results were *inconsistent* with those from obtained from the Full Treatment group which found only a significant, sustained reduction in the number of drinks drinkers consumed on any given drinking day (see Tables 9.23 & 9.24).

Thus, these data have tended to indicate that whilst the Late Dropout group had demonstrated similar treatment gains to the Full treatment group in terms of mental health and coping status, the degree of positive change in their drinkers' abusive behaviour and consumption patterns seemed to be superior to the Full Treatment group.

9.4 A comparison between the Late Dropout group and the Full Treatment group

Despite the small sample size of the Late Dropout group who were available for follow up (n=13), statistical analyses identified significant intervention effects between pre treatment through 5 treatment sessions across all variable groups; i.e. participants' mental health and coping status, their relationships with their drinkers, and their drinkers' consumption patterns.

For instance, a similar pattern of effect on mean scores was evident between the two groups after 5 treatment sessions; viz.

- Significantly reduced somatic anxiety

- Significantly reduced depression (as measured by the DPDS)
- Significantly reduced control and tolerant coping strategies
- Significantly reduced marital discord
- No significant reduction in free floating anxiety
- No significant reduction in depression (as measured by the CCEI)

Table 9.27
Changes in participants' mean scores of drinkers' consumption mean scores after 5 treatment sessions through 5 weeks post treatment for the Late Dropout group (n=13)

Variable	Change in mean scores	*F*	*p*	Eta^2	Observed power
Frequency					
Pre to 5 sessions	**3.38 to 2.62**	**7.50**	**<.05**	**.39**	**.71**
Pre to 5 weeks post trt	**3.38 to 2.15**	**8.35**	**<.05**	**.41**	**.76**
5 sessions to 5 wks post trt	2.62 to 2.15	.68	>.05	.05	.12
Effect of use					
Pre to 5 sessions	**3.15 to 2.54**	**11.64**	**<.01**	**.49**	**.88**
Pre to 5 weeks post trt	**3.15 to 2.08**	**10.69**	**<.01**	**.47**	**.85**
5 sessions to 5 wks post trt	2.54 to 2.08	3.60	>.05	.23	.42
Drinking days past mo					
Pre to 5 sessions	**4.62 to 3.85**	**4.55**	**.054**	**.28**	**.50**
Pre to 5 weeks post trt	**4.62 to 2.77**	**8.35**	**<.05**	**.40**	**.74**
5 sessions to 5 wks post trt	3.85 to 2.77	2.55	>.05	.18	.31
Drinking days past week					
Pre to 5 sessions	2.92 to 2.38	2.63	>.05	.18	.32
Pre to 5 weeks post trt	**2.92 to 1.46**	**8.08**	**<.05**	**.40**	**.74**
5 sessions to 5 wks post trt	2.38 to 1.46	3.60	>.05	.23	.42
Drinks on drinking day					
Pre to 5 sessions	5.08 to 4.69	2.54	>.05	.18	.31
Pre to 5 weeks post trt	**5.08 to 3.62**	**6.77**	**<.05**	**.36**	**.67**
5 sessions to 5 wks post trt	4.69 to 3.62	3.29	>.05	.22	.39

On the other hand, (making due allowance for the small sample size) there were inconsistencies between the Late Dropout group and the Full Treatment group particularly in terms of drinkers' abusive behaviour and consumption patterns (see

Table 9.28). Notwithstanding the Bonferroni challenge to the significance of some of these data, they tend to suggest that the Late Dropout group may have decided to terminate their treatment because their situations had improved.

9.4.1 The "spin off" effect of participants' partial treatment (5 sessions) on their drinkers' consumption patterns and help seeking behaviour: the raw data

This section has examined the raw data relating to participants' reports of changes in their drinkers' help seeking behaviour or consumption patterns. Positive change in drinkers' behaviour has been reported in terms of (i) *substantial change* (i.e. drinkers sought help, ceased consumption, reduced "dramatically", or reduced "considerably"), or (ii) *some degree of change* (which also included those drinkers who had reduced "a little"). The raw data have been presented in 6 ways; viz.

1. Estimates of drinkers' positive change from the Late Dropout group (n=20) who had completed 5 treatment sessions
2. Estimates of drinkers' positive change from 13 participants from the Late Dropout group who were available for follow up 5 weeks after completing their 5 treatment sessions (i.e. *as if* they had completed 10 treatment sessions).
3. Estimates of drinkers' positive change from the Early Dropout group (n=5) *as if* they had completed the intervention (i.e. at both the 5 session and 10 sessions measuring points).
4. Estimates of drinkers' positive change from the combined Early and Late Dropout groups (n=25)
5. Estimates of drinkers' positive change based on *all* participants who commenced treatment (n=68) regardless of whether or not they completed treatment (i.e. the Full Treatment group combined with the Dropout group)
6. Estimates of drinkers' positive change based on *all* participants who were allocated to treatment (n=83); i.e. including the Non Starter group (n=15).

The Late Dropout group (n=20)

The Late Dropout group's raw data were examined to investigate the pattern of drinkers' help seeking behaviour and consumption patterns which had occurred after 5 treatment sessions. As Table 9.28 has illustrated, 12 participants (60%) from the Late Dropout group reported that their drinkers had sought help (n=5), ceased consumption

Table 9.28
Inconsistent results between the Late Dropout group (n=13) and the Full Treatment group (n=43) for participants' mental health, coping, and relationship status, and drinkers' consumption patterns

Variable	Late Dropout group (n=13)	Full Treatment group (n=43)
Participants' free floating anxiety	Insignificant reduction in mean score (7.08 to 6.54) after 5 sessions. **Significant reduction achieved 5 weeks post treatment** (see Table 9.25)	Significant reduction in mean score (7.86 to 7.04) after 5 sessions. Sustained through 6 months post treatment
Participants' emotionality (sum of CCEI mean scores)	Insignificant reduction in mean score (26.15 to 24.92) after 5 sessions. **Significant reduction achieved 5 weeks post treatment** (see Table 9.25)	Significant reduction in mean score (31.37 to 28.60) after 5 sessions. Sustained through 6 months post treatment (see Table 9.16)
Quality of everyday interactions between participants and drinkers	Insignificant reduction in mean scores for quality of interactions when drinkers were drinking or not drinking	**Significant reduction in mean scores after 5 sessions for quality of interactions only when drinkers were drinking.** Sustained through 6 months post treatment (see Table 9.18)
Drinkers' abusive behaviour	**Significant reduction in both verbal and emotional abuse after 5 sessions** Sustained through 5 weeks post treatment (see Table 9.26)	No significant reduction in verbal and emotional abuse after 10 sessions. Significant reductions at 3 and 6 months post treatment respectively (see Table 9.20)

cont…

Table 9.28 cont…

Drinkers' consumption patterns **(see Tables 9.15 & 9.27)**	**Significant reduction in mean scores for <u>effect of use</u> after 5 sessions** Sustained through 5 weeks post treatment	No significant reduction in effect of use through 6 months post treatment
	Significant reduction in mean scores for <u>frequency of use</u> after 5 sessions. Sustained through 5 weeks post treatment. Deemed insignificant by Bonferroni correction	No significant reduction in frequency of use through 6 months post treatment
	Significant reduction in mean scores for the <u>number of drinking days in the past month</u> after 5 sessions Sustained through 5 weeks post treatment. Deemed insignificant by Bonferroni correction	No significant reduction in number of drinking days over the past month through 6 months post treatment
	Significant reduction in mean scores for the <u>number of drinking days in the past week</u> after 5 sessions. Sustained through 5 seeks post treatment Deemed insignificant by Bonferroni correction	No significant reduction in number of drinking days over the past week through 6 months post treatment
	Significant reduction in mean scores for the <u>number of drinks on a drinking day</u> through 5 weeks post treatment. Deemed insignificant by Bonferroni correction	**Significant reduction in number of drinks on a drinking day after 5 sessions.** Sustained through 6 months post treatment

(n=3), or reduced to some degree. However, when those drinkers who had only reduced "a little" (n=3) were removed from the calculations, the number of drinkers who had made *substantial* change in their behaviour fell to 9 (45%).

Follow up of 13 participants from the Late Dropout group

Further data were obtained from the 13 participants who were available for follow up 5 weeks post treatment. As Table 9.29 has illustrated, by 5 weeks post treatment, another drinker had sought help, 2 others had ceased consumption, and another had "reduced considerably". Thus, by 5 weeks post treatment, 16 participants (80%) from the Late Dropout group had reported that their drinkers had sought help (n=6), or had reduced to *some degree.* When those drinkers who had only reduced "a little" (n=3) were removed from the calculation, the number of drinkers who had made *substantial* change in their behaviour fell to 13 (65%).[25]

Table 9.29
Participants' cumulative reports (raw data) of drinkers' help seeking behaviour and reduced consumption after 5 treatment sessions through 5 weeks post treatment for the Late Dropout group (n=20)

Drinkers' help seeking behaviour or reduced consumption	5 sessions	5 weeks post treatment
Sought help	5	6
Ceased	3	5
Reduced dramatically	0	0
Reduced considerably	1	2
Reduced a little	3	3
Total help seeking behaviour or reduced consumption	**12 (60%)**	**16 (80%)**

The Early Dropout group (n=5)

Data was also available from 3 participants from the Early Dropout group (n=5). When these participants were assessed at the 5 session point (*as if* they had completed 5 sessions), 2 reported that their drinkers had reduced " a little". Five weeks later (i.e. at the 10 session measuring point), another participant reported that her drinker had reduced "a little" and another reported that his drinker had sought help. Thus, at the 10

[25] Percentage was calculated using n=20

session point, 3 participants had reported their drinkers had reduced "a little" and one had reported that his drinker had sought help.

The combined Dropout groups (n=25)

As Table 9.30 has illustrated, when the two Dropout groups were combined, after 5 sessions (or at the 5 session point), 14 participants (56%) had reported that their drinkers had either sought help (n=5) or had reduced their consumption to some degree When those drinkers who had only reduced "a little" (n=5) were removed from the calculation, the number of drinkers who had made *substantial* change in their behaviour fell to 9 (36%).

Similarly, at the 10 session point, a total of 20 (80%) drinkers had either sought help (n=7) or reduced their consumption *to some degree.* When those drinkers who had only reduced "a little" (n=6) were removed from the calculation, the number of drinkers who had made *substantial* change in their behaviour fell to 14 (56%).

Table 9.30
Participants' cumulative reports (raw data) of drinkers' help seeking behaviour or reduced consumption after 5 treatment sessions through 5 weeks post treatment for the combined Dropout groups (n=25)

Drinkers' help seeking behaviour or reduced consumption	5 sessions	5 weeks post treatment
Sought help	5	7
Ceased	3	5
Reduced dramatically	0	0
Reduced considerably	1	2
Reduced a little	5	6
Total help seeking behaviour or reduced consumption	**14 (56%)**	**20 (80%)**

The Dropout groups combined with the Full Treatment group (n=68)

When the 2 Dropout groups (n=25) were combined with the Full Treatment group (n=43: see Table 9.22), 41 participants (60%) had reported that their drinkers had either sought help (n=12) or reduced their consumption *to some degree* at the 5 session

point. When those drinkers who had only reduced "a little" (n=19) were removed from the calculation, only 22 drinkers (32%) had made *substantial* change in their behaviour.

By the 5 weeks post treatment point (or 10 treatment sessions for the Full Treatment group), 47 participants (69%) had reported that their drinkers had either sought help (n=14) or reduced to some degree. When those drinkers who had only reduced "a little" (n=13) were removed from the calculation, the number of drinkers who had made *substantial* change fell to 34 (50%).

Estimates of change in drinkers' behaviour based on all participants allocated to treatment (n=83)

Although 83 research participants were allocated to treatment, 15 did not commence. Because every attempt has been made to be mindful of the intention to treat principle, calculations regarding participants' reports regarding changes in their drinkers' behaviour have also been based on *all* participants who were allocated to treatment (n=83). Table 9.31 has presented comparisons between participants' reports regarding the number of drinkers who had made positive change in the combined Full Treatment and Dropout groups (n=68), and the group who were allocated to treatment (n=83).

Thus, the most favourable "spin off" effect of the Holyoake intervention on the 68 participants who had commenced treatment was to facilitate 69% (n=47) of their treatment resistant drinkers to seek help or reduce their consumption *to some degree*. However, when those drinkers who had only reduced their consumption "a little" were removed from the calculations, only 50% of drinkers (n=34) had made *substantial* change in their behaviour.

On the other hand, the least favourable effect of the Holyoake intervention on drinkers' behaviour was calculated including all those who were allocated to treatment, *regardless of whether they commenced or completed treatment* (n=83). Thus, the least favourable "spin off" effect of the Holyoake intervention was to facilitate 57% of drinkers (n=47) to either seek help or reduce their consumption to some degree. However, when those drinkers who had only reduced their consumption "a little" were removed from the calculations, only 41% of drinkers (41%) had made *substantial* change in their behaviour.

Table 9.31
Comparisons between participants' reports of change in drinkers' help seeking behaviour and consumption patterns (raw data) for the Full Treatment group, the Late Dropout group (n=20), the combined Full Treatment and Dropout group (n=68), and the group were allocated to treatment (n=83)

Degree of change	Full Treatment group (n=43)		Late Dropout group (n=20)		Combined Full Treatment and Dropout group (n=68)		Allocated to treatment group (n=83)	
	5 treatment sessions	10 treatment sessions	5 treatment sessions	10 session point	5 treatment sessions	10 session point	5 session point	10 session point
Substantial change (sought help, ceased consumption, reduced dramatically or considerably)	13 (30%)	20 (47%)	9 (45%)	13 (65%)	22 (32%)	34 (50%)	22 (27%)	34 (41%)
Reduced a little	14	7	3	3	19	13	19	13
Some degree of positive change	27 (63%)	27 (63%)	12 (60%)	16 (80%)	41 (60%)	47 (69%)	41 (49%)	47 (57%)
Sought help (included in substantial change)	*7 (16%)*	*7 (16%)*	*5(25%)*	*6(30%)*	*12(18%)*	*13(19%)*	*12(14%)*	*13 (16%)*

CHAPTER 10

Discussion

The effect and durability of the Holyoake intervention: the quantitative data

The significant changes for participants, their relationships with their drinkers, and their drinkers' consumption patterns which were identified during treatment, and sustained through 6 months post treatment, have been discussed in terms of the transtheoretical model of change developed by DiClemente and Prochaska, (1982); Prochaska (1979); Prochaska and DiClemente (1984, 1988), and Prochaska, Norcross and DiClemente (1994) as outlined in Chapter 5.

Although Prochaska, et al's. (1994) suggestions for maintaining changed behaviours arose from researching how people successfully changed their addictive behaviours (e.g. smoking, alcohol abuse, eating disorders), they claimed (p.15) that their model was likely to be applicable "to individuals in any stage of problematic behaviour." Therefore, it was reasonable to assume that the same stages and processes of change, and maintenance strategies may have been used by participants in the current study to sustain and strengthen the gains they had made during treatment. Moreover, the "spin off" effect of participants' treatment on their drinkers has been discussed not only in terms of the stages and processes of change, but also in terms of the motivational elements (the "why" of change) proposed by Miller (1998) as outlined in Chapter 5.4.

The discussion regarding the effect and durability of the Holyoake intervention has been dealt with in four sections; viz.

1. Discussion regarding the significant reduction during the waitlist period in control and tolerant coping strategies, and marital discord

2. Discussion regarding the effect of the Holyoake intervention on participants' mental health, coping, and relationship status
3. Discussion regarding the "spin off" effect of participants' treatment on their drinkers' consumption patterns and help seeking behaviour
4. Discussion of the durability of effects of the intervention on participants, their relationships with their drinkers, and their drinkers' consumption patterns

10.1 Discussion regarding the significant reduction in participants' control and tolerant coping strategies and marital discord during the waitlist period

Control coping strategies were defined as participants' attempts to directly control their drinkers' consumption or the expression of strong emotion due to drinkers' unacceptable behaviour. Tolerant coping strategies were defined as participants' attempts to protect their drinkers from the consequences of their excessive consumption. Depression (as described by the Drinkers' Partners' Distress Scale: DPDS) was defined as participants' feelings and experiences in relation to their drinkers' behaviour (i.e. embarrassment, loneliness, neglect, lack of stimulating company, worry about leaving drinkers in charge of household responsibilities, unsatisfactory sex, and insecurity about the relationship). Marital discord was defined as (i) participants' irritability and anger *in reaction* to their drinkers' behaviour; (ii) money shortages; and (iii) drinkers' verbal and/or physical abuse.

The significant correlation between control coping, tolerant coping, and marital discord found in this study makes good clinical sense. This suggested that although drinkers' destructive behaviour was the *major* contributor to the level of marital discord, participants' *reactions* to their drinkers' behaviour was also likely to be an important factor. For instance, control coping strategies were comprised of emotional outbursts and/or attempts to control drinkers' consumption and/or behaviour. Therefore, it was reasonable to assume that the significant reduction in control coping strategies reduced participants' *contribution* to marital discord during the waitlist period (especially as drinkers' abusive behaviour did not correspondingly reduce).

Moreover, the significant correlation between control coping strategies in particular and marital discord was supported by participants' qualitative interviews (see Chapter 11)

which revealed that many participants were aware that these strategies were not helpful and in fact sometimes exacerbated their situations. However, despite many varied and abortive attempts to control their drinkers' consumption and/or behaviour and fix the family problems (Velleman et al. 1993), the excessive drinking continued and participants became more and more helpless and trapped.

Thus, it was not surprising that 70% of participants (n=58) in this study identified the need for therapy for themselves (to help them deal with their emotional reactions to their drinkers' behaviour), and the need to learn more effective coping strategies as their main reasons for seeking help. Given the common belief (even amongst addiction workers) that no one can help treatment resistant drinkers until they decide to present for help themselves (Yates, 1988; Garrett, Stanton, et al. 1999), it was also not surprising to find that only 10% (n=7) of participants identified the encouragement of their drinkers into treatment as their main reason for seeking help.

Given participants in the Waitlist group (n=25)[1] were to join the Holyoake intervention very soon, they *may* have placed a moratorium on their control and tolerant coping strategies during the waitlist period. Moreover, 76% of these participants had already informed their drinkers that they were seeking help. By taking this very difficult (and often very brave) step, participants were clearly demonstrating (to themselves as well as their drinkers) that they were no longer willing to tolerate their drinkers' unacceptable behaviour. Similarly, participants were no longer willing to tolerate their own emotional pain and reactive behaviour towards their drinkers, or the deleterious impact upon the family.

Thus, participants' determination to contend more effectively with their problems may have unleashed the necessary emotional energy and resolve required to propel themselves into the action stage of change (Prochaska, Norcross & DiClemente, 1994). Moreover, given participants were likely to be well into the preparation stage of change during the waitlist period, they would have been involved in decision making and thorough preparation for the additional changes they knew they would make during their treatment program.

[1] Whilst 29 participants were originally allocated to the Waitlist group, only 25 presented for their end waitlist interview

It was reasonable to assume that the preliminary information participants received about the intervention program, coupled with the process of completing the various questionnaires and the qualitative interview (see Appendix 2), may have increased their awareness of the seriousness of their plight, validated their experiences, and reinforced their resolve to take action. Moreover, some of the areas relevant to coping strategies and marital discord may have been highlighted. Thus, participants may have been provided with hints regarding what they needed to *stop* doing. For instance, Batel, Pessione, Bouvier and Rueff (1995) found dependent drinkers changed their behaviour after exposure to a simple letter. As a result, participants may have increased their self monitoring behaviour, and decided to tackle some of their issues before they commenced the intervention.

For example, the Drinkers' Partners' Coping Questionnaire (DPCQ: see Appendix 1) specifically asked about the incidence of control coping strategies (e.g. covering up the seriousness of the drinking, quarrelling about the drinking, emotional outbursts, making threats). Thus, if participants in the Waitlist group had indeed decided to place a moratorium on their unhelpful coping strategies pending their attendance at the intervention program, the pre intervention assessment process was likely to have been an important reinforcing factor.

The Holyoake intervention which participants had decided to attend had an excellent reputation. Thus, the crucial hope and belief that participants could indeed learn to handle their situations more effectively and reduce the harm to themselves and their families had already been created (Miller et al. 1999; Miller & Rollnick, 1991; Prochaska, Norcross & DiClemente, 1994).

Notwithstanding the significant reduction in participants' control and tolerant coping strategies and marital discord during the waitlist period, no significant increase had occurred in participants' assertive coping strategies (as measured by the DPDQ), mental health, relationships with their drinkers, nor reductions in their drinkers' consumption patterns.

Thus, participants needed to do much more than just *reduce* their control and tolerant coping strategies to improve their situations. Obviously, they needed to develop additional, more successful coping strategies to counter their old behaviours (Prochaska, Norcross & DiClemente, 1994) and allow the process of more successful coping to

germinate (Cohen & Lazarus, 1979; Folkman & Lazarus, 1980; Folkman et al. 1986; Matheny et al. 1986; Moos et al. 1990; Roger, Jarvis & Najarian, 1993).

10.2 The effect of the Holyoake intervention on participants' mental health, coping and relationship status from the Full Treatment group (n=43)

Overview

Before the treatment effect on participants has been discussed in detail, it was important to reflect upon the "how" of the changes participants experienced during the intervention. Given the Holyoake intervention placed emphasis on participants' need to increase their focus on their *own* needs and issues gain more control over their *own* behaviour (something which they could control), as opposed to trying to control their drinkers' behaviour (something over which they had no control), participants' sense of personal empowerment and self efficacy seemed to increase. Moreover, according to Satir, Banmen, Gerber and Gomori (1991), the second order change involved in this process of de-enmeshment would have been likely to result in participants changing their expectations, perceptions, and feelings regarding their situations.

This process of empowerment may have begun when participants decided to enrol in the Holyoake program and inform their drinkers that they were seeking help. This powerful emotional energy may have provided the impetus and the resolve for participants to propel themselves into the action stage of change (Prochaska, Norcross & DiClemente, 1994). The Holyoake program provided the essential elements which Prochaska, Norcross and DiClemente claim are necessary to reinforce and support participants' decisions to take action. Primarily, the intervention taught participants that they were not responsible for their drinkers' behaviour, nor could they control or change it. They learned how their often overdeveloped sense of responsibility had evolved, and how to monitor and change their unhelpful thinking patterns. They learned about the process of dependency and associated family dynamics and this was likely to enhance their understanding, awareness, and acceptance of their drinkers' situation as well as their own.

Participants were encouraged to divert the disproportionate attention they were allocating to their drinkers' feelings, needs, and problems and to focus on their *own* instead

(often for the first time in their lives). Slowly they began to communicate their feelings and needs to their drinkers ("...and the roof didn't fall in!", one participant commented) and develop their own independent interests and friendships. Thus, participants were encouraged to i) let go of their need to control their drinkers' behaviour; (ii) develop more control over their *own* feelings, reactions, and behaviour; (iii) live more in accordance with their personal value systems; and (iv) increase their emotional independence.

The group therapy sessions were likely to have provided the helping relationships so important in each stage of change (Prochaska, Norcross & DiClemente, 1994). This may have given participants the opportunity to share their pain, fears, grief, hope, *and successes* in an accepting, supportive, confidential environment. Thus, participants were encouraged to accept their personal human frailties (and also those of others, particularly their drinkers), develop trust in their own feelings and judgments, and begin to trust others in their therapy group. Thus, the initial process of participants' empowerment was likely to have been enabled and supported by the Holyoake intervention which then permitted further progress to occur.

10.2.1 The effect of the Holyoake intervention on participants' mental health (i.e. anxiety and depression)

The Holyoake intervention aimed to:

- Minimise the harm experienced by relatives of excessive drinkers;
- Improve relatives' emotional well-being and coping; and
- Assist relatives to recognise behaviours that might unwittingly enable their drinkers' alcohol/other drug problems to continue.

Although the Holyoake FOCUS program consisted of 12 sessions, research participants were assessed after completing 10 sessions (for ease of data collection). Given the ongoing, revolving structure of the program, research participants were able to commence their 10 sessions at any one of the sessions described in Table 8.3.

The majority of participants had identified therapy for themselves and strategies to more effectively handle their situations as what they most wanted to achieve from their

treatment program. Therefore, given the hope that they would indeed achieve these goals, participants were likely to have emitted a collective sigh of relief when they embarked upon their program. At last participants were doing something constructive for themselves.

Intervention hypothesis 1a: supported

- That the intervention would result in significantly reduced anxiety (i.e. free floating, somatic and obsessionality).

It was reasonable to assume that the educational component of the intervention fulfilled participants' need for information and the regular relaxation component may have assisted them to calm down enough to think more clearly. Predominant themes in the Holyoake intervention which directly targeted stress/anxiety were the relationship between thoughts, feelings and behaviour, the need for self care and responsibility (as opposed to assuming inappropriate care and responsibility for others), and communication of feelings, concerns and needs.

Some authors (e.g. Wegscheider, 1988) have reported patterns of obsessionality and perfectionism among partners of excessive drinkers. Given some participants may have experienced these patterns of behaviour, it was worth noting that the Holyoake intervention's focus on the relationship between thoughts, feelings and behaviour may have assisted these participants to apply the 4 Rs as suggested by Schwartz (1966) as outlined in Chapter 6.3; viz. **R**elabel, **R**eattribute, **R**efocus, and **R**evalue.

For instance, the Holyoake intervention encouraged participants to **R**elabel unwanted thoughts and urges to use ineffective coping strategies (e.g. rescuing) as merely habitual responses to severe stress. Moreover, participants were encouraged to **R**eattribute these unhelpful coping strategies as merely rigid, habitual responses because they had exhausted their "bank" of viable coping alternatives. By encouraging participants to reduce inappropriate focus on their drinkers' feelings, thoughts and behaviour, and to increase responsibility for their own instead, the intervention also may have enabled participants to **R**efocus attention on to areas which were under their control.

Thus, participants who successfully applied these strategies were no longer "stuck" in the interdependent coping patterns which had developed between themselves and their

drinkers. Instead, they were likely to have **R**evalued themselves and recognised their unhelpful coping strategies were merely the result of severe stress, and not that they were going crazy at all. As a result, participants may have been freed to choreograph the steps in their new action plan to achieve more effective, empowering outcomes.

The group therapy was likely to have provided the constructively helpful milieu which may have enabled participants to process the information they had received, apply it to their own situations, safely explore and express their feelings, and share their progress as they began to trial their new strategies with their drinkers. This was especially important for the 49% of participants who did not receive adequate support from family or friends. Given the groups were comprised of participants at various stages in their program, newcomers were given the valuable opportunity to identify with and learn vicariously from others who talked about their experiences, successes and setbacks in applying the program in their lives.

Thus, newcomers' initial hope and belief that they could indeed improve their situations was likely to be strengthened by this modelling (Bandura, 1977a; 1977b). On the other hand, participants who were at later stages of their program were given the equally valuable opportunity to "see" themselves as they were when they entered the program and to acknowledge their own improvement.

Despite the significant, moderate effect on somatic anxiety and obsessionality (and therefore emotionality) mean scores which had occurred by mid treatment (i.e. 5 sessions), these results could not be confidently be generalised beyond this sample due to low observed power. However, with a larger sample size, the effect of treatment may have been more pronounced (Jaccard & Becker, 1983). These results seemed to illustrate Prochaska, Norcross and DiClemente's (1994) assertion that early change is fragile and needs to be nurtured and maintained by reinforcing and expanding raised consciousness, and trialing effective strategies within a supportive environment.

Once participants had completed their treatment, they had received and processed information regarding the typical patterns of behaviour which develop between alcohol dependents and their families as well as effective strategies to interrupt this process. By the end of treatment, the mid treatment effect on obsessionality and somatic anxiety had considerably strengthened (see Table 9.16). Moreover, it was reasonable to assume that the

strong, significant treatment effect on the free floating anxiety mean score (dread, indefinable terror, tension without a cause, or panic) evident by the end of the intervention suggested that participants may have been calming down and assuming more control and responsibility for their *own* well-being.

Gradually as the effectiveness of the strategies participants were learning became more evident, participants may have lost their dread of the future, and fear of the consequences of their drinkers' consumption. Moreover, it was likely that participants developed more courage to gradually disengage from the interdependent stress, coping and transactional patterns which had developed between themselves and their drinkers (see Figure 2.1). Thus, participants seemed to be managing their reactions to their drinkers' behaviour more effectively and were no longer debilitated by anxiety.

The reduction in anxiety achieved by the intervention was consistent with other treatment programs which aimed to improve the mental health of relatives of excessive drinkers (as well as training them to intervene with their drinkers; e.g. Dittrich, 1993; Miller, Meyers & Tonigan, 1999: see Table 6.2). Moreover, Miller et al. found significant reductions in anxiety even when drinkers *did not present for treatment*. However, these researchers measured anxiety as an amorphous entity rather than the different expressions of anxiety dealt with in this study. For instance, whilst participants in this study were above average when compared to the normative data in free floating anxiety and somatic anxiety, they were within the average range for phobic anxiety.

10.2.2 The effect of the Holyoake intervention on participant's depression

Intervention hypothesis 1b: partially supported

- That the intervention would result in significantly reduced depression as measured by (i) the Crown Crisp Experiential Index (CCEI), and (ii) the Drinkers' Partners' Distress Scale (DPDS).

The reduction in participants' depression as measured by the CCEI

The CCEI defined depression as sadness of mood, difficulty thinking clearly, and slowed activity. Given the close relationship between anxiety and depression, it was

reasonable to assume that the positive impact of the intervention on research participants' stress/anxiety would also tend to reduce their depression. For instance, participants were provided with information which was likely to challenge their assumptions about their drinkers' behaviour. Moreover, given participants were likely to hear similar stories to their own in group, they were given the opportunity to challenge their interpretation of their drinkers' manipulative and self centred behaviour; e.g. "This stuff is happening to others too. It seemed like it's all part of the patterns of behaviour alcoholics develop to survive." This depersonalising of their drinkers' behaviour may have assisted participants to detach themselves emotionally and respond more effectively rather than merely react to their drinkers' unacceptable behaviour.

The Holyoake intervention encouraged participants to explore their feelings regarding their hopes and fears and their relationships with their drinkers during the group therapy sessions. Therefore, participants' sadness may have been exposed and focussed upon as they fully confronted the reality of their situations, and dealt with their grief and loss issues. Participants may have also been trialing ways of countering their unhelpful coping strategies, and this would have taken huge effort and energy. Moreover, some participants may have been coping with their drinkers' negative reactions to their changed behaviour and attempts to restore the status quo (as reported by the qualitative data in Chapter 11). Thus, it was not surprising to find that depression mean scores (as measured by the CCEI) did not significantly reduce until the end of treatment.

The reduction in participants' depression as measured by the DPDS

The particular patterns of depression as measured by the depression subscale of the DPDS (i.e. embarrassment, loneliness, neglect, lack of stimulating adult company, worry about leaving drinkers in charge of household responsibilities, unsatisfactory sex, and insecurity about the relationship) had strongly and significantly reduced during the waitlist period and this reduction was sustained through treatment.

Given most participants had primarily undertaken the program to seek help for themselves (and not to intervene with their drinkers), they may have put a moratorium on trying to solve their drinkers' problems, and concentrated instead on putting their own action plan into place. The reduction in depression (as measured by the DPDS) may have

suggested that participants were becoming more aware of the typical behaviour patterns associated with dependent drinking. As a result, participants may have been able to depersonalise their drinkers' behaviour as they learned to respond to their drinkers in more effective, self affirming ways.

Three of the predominant themes in the Holyoake intervention were the need for self responsibility, personal boundaries, and effective communication. Participants were encouraged to take responsibility for their own physical, mental, emotional, social, and spiritual lives, and to concentrate on changing what they *could* change rather than focussing attention on the exhausting task of trying to change their drinkers' behaviour. According to the qualitative data, many participants were putting a priority on taking care of *themselves* rather than others.

Thus, supported and encouraged by the program, and the example of others in their therapy group, participants seemed willing to begin the sometimes risky process of changing the way they related to their drinkers. It was likely that participants may have felt more empowered as they assumed more charge of their own lives. Thus, it seemed that participants increased focus on their own needs and were perhaps feeling good about that (as the qualitative data has revealed in Chapter 11).

The significant reduction in depression (as measured by the DPDS) in the current study is different from the only other group program (Barber & Crisp, 1995)[2] which used this instrument to measure the depression levels of partners of excessive drinkers. After 5 individual treatment sessions which aimed to train partners as intervention agents (with no attention to partners' separate needs), the level of partners' depression *had not significantly reduced,* despite 60% of their resistant drinkers reducing consumption or presenting for help. This was in contrast to Miller et al. (1999) who aimed to train relatives as intervention agents *as well as* improving their mental health. Miller et al. found relatives' depression significantly reduced *whether or not their drinkers had presented for treatment.* It seemed that as participants came to understand their complex emotional situations more realistically, their awareness of choice and personal power may have inevitably increased – regardless of the outcome with their drinkers.

[2] The authors of the DPDS

Thus, the Holyoake intervention (see Chapter 8.3.6. and Table 8.3) seemed consistent with the range of interventions suggested by the empirical literature as effective in reducing anxiety and depression For instance, in addition to the educational material relating to the process of dependency and relatives' stress and coping patterns, the intervention dealt with issues regarding self care and responsibility, personal boundaries, and the relationship between feelings, thoughts and behaviour. Therefore, although the Holyoake intervention had been *clinically* derived, it seemed to have demonstrated its *general* consistency with the range of elements derived from the conceptual framework underpinning the successful treatment of anxiety and depression (see Chapter 6.4; Tables 6.3 & 6.4).

However, a comparison between the range of effective interventions indicated by the literature and the Holyoake intervention suggested that the separate "grief", "self esteem" and "denial" sessions in the Holyoake intervention were superfluous and were not supported by the literature. Moreover, the concept of relatives' "denial" tended to blame relatives, where the literature would argue that relatives' "denial" was likely to demonstrate the lack of awareness characteristic of the precontemplation stage of change.

Intervention hypothesis 1c: supported

- That the intervention would significantly reduce participants' emotionality (sum of the CCEI subscale mean scores).

The significant reduction in free floating anxiety, somatic anxiety, and obsessionality mean scores was reflected by the significant reduction in participants' emotionality (from almost 1 standard deviation above average to below the CCEI normative data average score for urban women). It seemed that participants had increased their toleration of (or adjustment to) their emotional responses to their drinkers' behaviour, and had maintained their emotional equilibrium. Moreover, the group therapy sessions encouraged the sharing of thoughts and feelings, the diversion of attention from painful stimuli, and the maintenance of satisfying relationships with others. Thus, the Holyoake intervention seemed to result in participants becoming significantly more emotionally resilient.

10.2.3 Discussion of the effect of the Holyoake intervention on participants' coping status

The predominant pre treatment coping positions adopted by partners in this research as measured by the Drinkers' Partners' Coping Questionnaire (DPCQ) were engaged and tolerant positions. Within the engaged position, participants predominantly utilised control strategies (i.e. attempts to directly control use or events directly related to the drinking) or emotional strategies (i.e. the expression of strong emotion towards drinkers because of their consumption and/or behaviour). Within the tolerant position, participants utilised inactive or withdrawal strategies, or strategies which protected their drinkers from the consequences of their behaviour.

The Holyoake intervention aimed to:

- Assist participants to recognise behaviours that might unwittingly enable their drinkers' alcohol/other drug problems to continue; and
- Improve participants' coping strategies.

Therefore, participants received information from the educational segments of the program regarding the typical patterns of behaviour which develop between alcohol dependents and their relatives. Participants were encouraged to challenge their thinking regarding their drinkers' behaviour and, as a result, many participants began to develop compassion for their drinkers' plight.[3] Moreover, extensive information was presented regarding relatives' typical coping patterns. Many participants reacted emotionally to this information as they acknowledged their *contribution* to the maintenance of the excessive drinking and tension within their families. According to Prochaska, Norcross and DiClemente's (1994) processes of change, the emotional arousal which would have arisen from participants' raised awareness of their situations would have been likely to increase their resolve to maintain their action plans (see Chapter 5.2 & Table 5.2).

Thus, it was likely that the initial significant reduction in control and tolerant coping strategies during the waitlist period would have been reinforced by the Holyoake intervention program. However, the intervention did much more than encourage the *reduction* of these strategies. Rather, it provided participants with various ideas and tools

[3] Information obtained in qualitative interviews (see Chapter 11)

to *counter* their "old program" strategies and trial the effectiveness of new ones (see aims and objectives of the Holyoake intervention in Table 8.3). Moreover, the qualitative data presented in the next chapter has described some of the new ways of coping participants had adopted during their treatment program.

Once participants began to experience success with their "new program" strategies and had developed an appropriate action plan, it was reasonable to assume that their self confidence, self esteem, and sense of competency would have considerably strengthened. However, these are all important aspects of the treatment of anxiety and depression. Thus, participants' changed behavioural strategies would have been likely to powerfully and reciprocally influence their thoughts and feelings (Ellis, 1988) which would have been likely to also result in reduced levels of anxiety and depression (see Chapter 6.3).

Moreover, given the theory of cognitive dissonance (Festinger, 1957; Festinger & Carlsmith, 1959), as participants behaved in counter-attitudinal ways (perhaps doubting the efficacy of the new coping strategies?), it was likely that their beliefs and attitudes would also have been powerfully changed. Given the significant reduction in participants' ineffective coping *preceded* significant improvements in their mental health, it was reasonable to assume that participants' improved coping strategies may have indeed facilitated, and even driven, the improvements in their mental health.

The Holyoake intervention also encouraged participants to view their coping mechanisms as normal reactions to the chronic stress they had experienced and offered suggestions on how to cope more effectively and self affirmingly. Given the example and support of other participants who were already trialing their "new program" ideas and strategies, participants gradually developed the confidence to disengage from the stress, coping and transactional patterns which had developed between themselves and their drinkers.

Participants also shared in group how they had coped with the *reactions* of their drinkers as they disengaged from these interdependent coping patterns. Participants learned that it was likely that their drinkers would want to restore the status quo and recognised the crucial need to be consistent. No longer were participants likely to be swinging from one coping position to the other. Instead they were encouraged to follow their plan of action and were supported and strengthened in the process. As participants' anxiety and depression

reduced and they calmed down enough to think more clearly and rationally, it was likely that they continued to apply the more effective strategies they were learning to solve their problems. At last participants now knew what they needed to be consistent about.

Although Dittrich (1993) reported a significant reduction in the "enabling behaviours" of partners of excessive drinkers after an 8 session group intervention, there is a paucity of empirical evidence (although there could be work in progress) regarding the effect of intervention on relatives' coping strategies. Moreover, Miller et al (1999) have highlighted the need for qualitative data to describe changes in relatives' coping strategies and how they apply what they learn from treatment. Chapter 11 will help to fill this gap in the literature.

Intervention hypotheses 2a and 2b: partially supported

- That the intervention would result in participants' reduced control and tolerant coping strategies.

Given the significant reduction in participants' control and tolerant coping mean scores as measured by the Drinkers' Partners Coping Questionnaire (DPCQ) during the waitlist period, it was not prudent to totally attribute any *additional* significant, sustained reductions in mean scores to the intervention. However, the Holyoake intervention placed strong emphasis on the need for self care and self responsibility (as opposed to assuming inappropriate responsibility for controlling the behaviour of others). Given the *further* significant, strong reduction in control coping mean scores between the end of the waitlist period and mid treatment, and the maintenance of reductions in both control and tolerant coping mean scores through 6 months post treatment, it was reasonable to assume that the intervention had considerable *influence* on participants' coping strategies. This assumption was supported by the qualitative data presented in the following chapter which revealed that participants had indeed adopted new coping strategies.

For instance, by undertaking the intervention, participants were engaging in all possible efforts to reduce the harm to themselves, and enhance their prospects for survival and recovery. Therefore, they were promoting the development of successful coping in the

way the literature has suggested (see Chapter 6.3.5). For example, participants were learning to reduce their tension producing behaviours by learning to deal more effectively with their emotional reactions to their drinkers' unacceptable behaviour. Participants were also learning to become more aware of the intimate relationship between their thoughts, feelings, and behaviour and to replace their unhelpful thinking patterns with more realistic ones.

The Holyoake intervention also encouraged participants to assume greater responsibility for their own self care and to more effectively communicate their feelings, needs and concerns. This process helped to improve participants' emotional equilibrium, and reduce anxiety and depression (and therefore improve self esteem). As part of the focus on self responsibility, the intervention also encouraged participants to rekindle old relationships with friends which had been neglected due to the problem of excessive drinking in the family. Moreover, the group therapy experience enabled participants to problem solve and practice their communication and assertiveness skills within a safe environment.

The predominant elements in the Holyoake intervention which focussed upon participants' coping strategies were "codependency" and "letting go" (see Table 8.3) . Although Holyoake seemed to subscribe to the view that codependency was a set of learned behaviours, attitudes and emotional patterns that frequently manifest into other addictive behaviours (Smalley & Coleman, 1994), the codependency *label* was not supported by the literature. This was because it has been subjected to an unvalidated, exhaustive array of definitions (Hand & Dear, 1994) which have a tendency to blame and neurotocise relatives. Although the concepts presented in the codependency embodied many features which would be supported by the literature, some concepts seemed to be drawn from "pop" psychology, and did not include the more recent, empirically supported descriptions of how relatives cope with their drinkers' unacceptable behaviour (see Chapter 2.4 & 2.5). However, the "letting go" element of the Holyoake intervention encouraged participants to "let go" of their ineffective coping strategies and substitute more effective, self affirming ones; e.g. self care and responsibility, and effective communication which had been recommended by the literature for the treatment of ineffective coping. However, the

Holyoake intervention did not specifically deal with problem solving, particularly when faced with a crisis, which the literature had also deemed as important.

Therefore, whilst the Holyoake intervention (see Chapter 8.3.6 & Table 8.3) seemed *generally* consistent with the range of interventions suggested by the literature as necessary to treat ineffective coping (see Table 6.2), the codependency element needed revision, and material relating to problem solving needed to be included. Although the Holyoake intervention had been *clinically* derived, it seemed to have demonstrated its *general* consistency (with some limitations) with the range of therapeutic elements derived from the conceptual framework underpinning the successful treatment of ineffective coping (see Chapter 6.4; Table 6.3 & 6.4).

Whilst the whole coping perspective may be viewed as blaming relatives, the Holyoake stance was particularly concerned with assisting relatives to respond to their drinkers' behaviour in more effective, self affirming ways. Although the Holyoake intervention emphasised that particular ways of coping (e.g. nagging) were associated with enabling the excessive drinking to continue, this was explained within a systems framework which highlighted relatives' *contribution* to family problems rather than *responsibility* for these problems. However, the primary emphasis of the Holyoake intervention was upon how relatives could improve their situations *for themselves* and not how to influence their drinkers.

Intervention hypothesis 2c: unsupported

- That the intervention would result in participants' increased assertive coping strategies.

The assertive subscale of the Drinkers' Partners' Coping Questionnaire (DPCQ) consisted of items regarding participants' assertive *confrontation* regarding their drinkers' behaviour, independence from their drinkers, and actions which were supportive of their drinkers' reduced consumption. Interestingly, there was no significant increase in assertive coping mean scores throughout treatment. According to participants' ratings, their use of assertive coping strategies had remained within the "sometimes" range throughout treatment. This may have indicated that participants were already utilising these particular aspects of assertiveness to a sufficient degree.

The Holyoake intervention aimed to improve the well being of participants in their own right without involving their drinkers in any way. Therefore, it did not *specifically* focus on these aspects of assertiveness. Instead, the effective communication element in the treatment program aimed to increase participants' awareness of the assertive, submissive and aggressive communication styles, and to encourage them to communicate their feelings, needs and concerns without blaming.

Most people find assertive confrontation difficult. This difficulty is especially exacerbated where there is an addiction problem with associated anger and aggression (e.g. Barber & Crisp, 1995). In fact, Miller, Meyers, and Tonigan (1999), while training relatives of treatment resistant drinkers to be intervention agents, spent considerable time *tutoring* relatives on *how* to communicate their feelings, needs and concerns effectively. According to Miller et al., several role-play sessions were required before relatives thoroughly learned the principles of assertive confrontation and were confident about using them effectively in difficult situations.

The qualitative data was consistent with this. For instance, participants' use of assertive confrontation strategies (to handle their most difficult situation in relation to their drinkers' behaviour), had reduced from n=7 (16%) at mid treatment to n=2 by the end of treatment (see Chapter 11 & Appendix 6b). This reduction may have been related to the significant decrease in drinkers' consumption and the improved quality of everyday interactions between participants and their drinkers. Thus, assertive behaviour (*as measured by the DPCQ)* may not have been as necessary as it was when these participants commenced the intervention. On the other hand, assertive confrontation regarding drinkers' behaviour in particular may not have increased because the Holyoake intervention did not specifically teach it.

However, the non significant change in assertiveness as measured by the DPCQ did not mean that the Holyoake intervention did not have significant impact upon participants' assertive behaviour in other ways, as the qualitative data in Chapter 11 has revealed. Thus, it seemed that the DPCQ (which was developed by the current author) may need modification so that the assertive subscale more accurately reflects the range of participants' assertive behaviours.

Given control coping strategies were comprised of emotional outbursts and/or attempts to control drinkers' consumption and/or behaviour, it was reasonable to assume that their significant reduction had a "spin off" impact of significantly reducing participants' *contribution* to marital discord (e.g. participants' irritability and anger in *reaction* to their drinkers' behaviour) during the waitlist period (especially as drinkers' abusive behaviour did not correspondingly reduce during the waitlist).

Thus, according to the quantitative data, whilst the Holyoake intervention had demonstrated its general consistency (with some limitations) with the range of effective interventions suggested by the empirical literature as effective in the treatment of ineffective coping, this did not result in an increase in assertive coping as described measured by the DPCQ (see Chapter 6.3.5 and Table 6.3). This was likely to be due to the absence of material regarding problem solving and assertive confrontation particularly when faced with a crisis.

10.2.4 Discussion of the "spin off" effect of the Holyoake intervention on participants' relationships with their drinkers

Intervention hypothesis 3a: supported

- That the quality of interactions between participants and their drinkers would significantly improve

Intervention hypothesis 3b could not prudently be supported

- That the intervention would result in significantly reduced marital discord.

Intervention hypothesis 3c and 3d: unsupported

- That the intervention would result in significantly reduced abuse from drinkers.
- That the intervention would result in significantly improved marital state.

Quality of everyday interactions and marital discord

Given the significant treatment effect upon participants' stress/anxiety and depression (as measured by the DPDS), coupled with the significant reduction in

participants' control and tolerant coping strategies, it was not surprising that there was a corresponding treatment effect on the *quality* of everyday interactions between participants and their drinkers. However, this improvement was only evident *when drinkers were drinking* (as opposed to not drinking). This suggested that participants were gaining more control over their *own* reactions to their drinkers' behaviour. Thus, participants' *contribution* to the conflict between themselves and their drinkers was reduced.

It was important to note that this may be precisely what participants meant by "improvements" in the quality of their everyday interactions with their drinkers – merely a reduction in conflict. Whilst there was no significant treatment effect on the quality of interactions when drinkers were *not* drinking (this remained at "so-so" throughout treatment), it was likely that this is how many couples in non problem drinking relationships who have been together for many years would rate the quality of their interactions.

Although marital discord[4] reduced significantly during the waitlist period, it was indeed tempting to attribute the *additional* significant reduction which had occurred by mid treatment, and the sustainability of this reduction to the *influence* of the intervention. Moreover, the intervention program specifically focussed upon helping participants to control their emotional reactions to their drinkers' behaviour, and channel this considerable energy into taking care of their own needs. Given Velleman et al.'s (1993) finding that partners of excessive drinkers tend to swing from one unsatisfactory coping position to another, it was reasonable to assume that participants would have been unlikely to have sustained the changes they made during the waitlist period without the education, support, and encouragement (identified by Prochaska, et al., 1994 as vital) that they received from the Holyoake intervention.

Abuse from drinkers towards participants and participants' marital state

Although participants had reported a significant (albeit weak) reduction in verbal abuse mean scores (i.e. 1.35 to .91) from their drinkers by the end of treatment, when the conservative Bonferoni correction was applied, these were both deemed to be non

[4] i.e. Participants' experiences of irritability and anger due to their drinkers' consumption, money shortages, and verbal and physical abuse from their drinkers

significant (see Table 9.24). However, given a larger sample size, the statistical significance of this effect may have been enhanced (Jaccard & Becker, 1983).

On the other hand, there was no significant reduction in participants' experience of emotional abuse (i.e. manipulative, guilt provoking, and often passive aggressive behaviour) from their drinkers. Given participants' changed behaviour patterns and subsequent reduction in their contribution to family conflict, this may have reflected drinkers' attempts to provoke participants into resuming the interdependent coping patterns characteristic in families where excessive drinking is a problem. This was consistent with participants' marital state (as measured by the Golombok Rust Inventory of Marital State: GRIMS), which had remained within the "very severe problems" range throughout treatment.

Thus, whilst on the surface the relationship between participants and their drinkers had indeed improved (as evidenced by the significant reduction in conflict), participants' beliefs, attitudes and feelings about their relationships at a deeper level had not; e.g. shared interests, communication, warmth and love, trust and respect, role expectations and goals, decision making, and problem solving. These more intimate relationship abilities and skills are the very areas with which most dependent drinkers (and indeed many non-dependent males) have problems.

Given the significant correlation between the depression subscale of the Crown Crisp Experiential Index (CCEI)[5] and the GRIMS, it was reasonable to assume that participants' ongoing experience of sadness (although substantially reduced during treatment) was closely related to unsatisfactory levels of emotional sharing and intimacy in their relationships with their drinkers. According to O'Farrell and Bayog's (1983), some of their partners did not want to "invest further in the marital relationship" until their husbands had maintained longer periods of abstinence. These partners needed time to get over their bitterness regarding their drinkers' destructive behaviour, and to develop trust that they would not drink again.

Given the operation of the stress/coping/transactional model (Orford, 1994), it was reasonable to assume that initially, drinkers may attempt to restore the status quo by trying to provoke their relatives into resuming their "old program" coping patterns which had

[5] .61 at the .01 alpha level

assisted in the maintenance of excessive drinking. However, as participants maintained their improvements and become more skilled at their "new program" action plan, it was likely that drinkers began to respond more positively because it would have been very difficult to maintain the interdependent behaviour patterns without some level of co-operation.

Thus, the Holyoake intervention (see Chapter 8.3.6 & Table 8.3) seemed to have provided what Cordova and Jacobson (1993); Montgomery and Evans (1995); and Schmaling, Fruzzetti and Jacobson (1989) suggested was necessary to reduce marital discord and disturbance (see Chapter 6.3.4 and Table 6.1). For instance, participants were encouraged to "get out of the boxing ring", reduce conflict by avoiding blaming and recriminations (especially when their drinkers were drinking), and to identify and alter their unique conflict patterns. Moreover, participants were encouraged to take more responsibility for themselves (rather than their drinkers), recognise the intimate relationship between their own emotions, thoughts and behaviour and to communicate their feelings, needs and concerns more assertively.

The educational segments of the Holyoake intervention may have assisted participants to depersonalise their drinkers' destructive behaviour and perhaps develop some degree of compassion for their plight. This may have resulted in the expression of more positive feelings between participants and their drinkers. These suppositions regarding the nature of the improved relationship between participants and their drinkers were clarified by the qualitative data (see Chapter 11).

Very few researchers (e.g. Barber & Crisp, 1995; Binns, Dear, Knowles, & Hall, 1989; Dittrich, 1993; Miller, Myers, & Tonigan, 1999) have measured the impact of treatment on the marital discord and disturbance experienced by partners of treatment resistant drinkers. Moreover, the findings were equivocal. For example, both Binns et al. and Dittrich (both group programs) aimed to improve the psychological functioning of partners in their own right (see Table 4.2). However, whilst Binns et al. reported significant, durable gains in the quality of relationships (not defined) between relatives and their drinkers, Dittrich reported 39% of the partners in her sample had separated from their drinkers.

Although nearly 60% of the partners of treatment resistant drinkers in Barber and Crisp's study (1995 - see Table 3.1) reported their drinkers had made significant movement towards change, there was no *significant* reduction in marital discord. This was in direct contrast to popular belief that once the primary pathological element of excessive drinking is removed, partners' distress would correspondingly reduce.

Whilst Miller, Meyers, and Tonigan (1999) primarily trained relatives as change agents, they also aimed to improve relatives' psychological functioning. The relatives in their study (see Table 6.2) reported significant and durable improvements in "relationship cohesion" with their drinkers. Unfortunately, no definition of "relationship cohesion" was supplied. Perhaps the individualised as opposed to group intervention resulted in relatives being more thoroughly trained in effective communication with their drinkers. In addition, the different measures used to assess the quality of the relationship were likely to have compromised reliable comparisons.

The Holyoake intervention did not *specifically* aim to improve the relationship status between participants and their drinkers (see Chapter 8.3.6 & Table 8.3). However, it seemed to have demonstrated general consistency with the range of effective interventions suggested by the literature as effective in reducing relationship discord and disturbance (see Table 6.3). For instance, the "self responsibility", "codependency"[6] and "letting go" elements of the intervention encouraged participants to de-escalate conflict, identify and challenge unhelpful beliefs, set appropriate personal boundaries, and communicate their feelings and needs effectively. However, the intervention did not provide participants with specific problem solving skills and strategies which the literature had also recommended.

A comparison between the range of effective interventions deemed necessary by the literature and the Holyoake intervention suggested that the "family dynamics" and "intimacy and sexuality" elements in the Holyoake program may have been superfluous. Whilst some participants particularly related to the "family dynamics" session (particularly those who had grown up in problem drinking families), most of the concepts were covered in the "challenging beliefs", "boundaries" and "self responsibility" sessions. Given participants' reports that their drinkers' abusive behaviour had not reduced significantly until 3 months post treatment, and that participants' marital state remained within the "very

[6] Notwithstanding this inappropriate title

severe problems" range 6 months post treatment, the "intimacy and sexuality" session seemed to be not only superfluous but also inappropriate. Perhaps this element may have been more appropriate in an after care program for couples who were both ready to work on their relationships.

Therefore, although the Holyoake intervention had been *clinically* derived, it seemed to have demonstrated its *general* consistency (with some limitations) with the range of therapeutic elements derived from the conceptual framework underpinning the successful treatment of relationship discord and disturbance.

10.3 Discussion regarding the "spin off" impact of participants' intervention effect on drinkers' consumption patterns and help seeking behaviour

Participants were asked to respond to the following Change Questions at their initial interview; viz.

- Do you think your partner (or other)[7] [i.e. excessive drinker] is thinking about changing his/her drinking?;
- Is s/he actually doing something about changing his/her drinking?; or
- Is s/he not even thinking about changing his/her drinking?

Participants' responses placed 54% of their drinkers in the precontemplation stage of change and 46% (n=20) in the contemplation stage of change. By the completion of the intervention, 63% (n=27) of these previously treatment resistant drinkers had either reduced their consumption and/or sought help (n=7). However, no direct intervention was undertaken with these drinkers. Their reduced consumption and increased help seeking behaviour seemed to have occurred as a "spin off" from their relatives' (i.e. research participants') changed behaviours.

Intervention hypothesis 4: supported

- That the "spin off" from participants' treatment would result in drinkers' reduced consumption and increased help seeking behaviour.

[7] i.e. Participants' treatment resistant drinker

Participants' precontemplating drinkers would have received the essential consciousness raising process of change when they were informed that their relatives (i.e. research participants) were seeking help. Despite some drinkers' negative reactions at the time (e.g. "Why would *you* need to go there? There's no drinking problem in *this* family!"), this information would have had considerable impact on drinkers' level of awareness concerning their drinking.

As participants progressed through their treatment program, the process of drinkers' consciousness raising may have been reinforced as participants reduced their control and tolerant coping strategies, their contribution to marital discord, and their responsibility for fixing the problem of alcohol dependence in their family. The Holyoake intervention encouraged participants to return the responsibility for their drinkers' behaviour where it belonged – with their drinkers. Thus, one of the conditions so important in Miller's (1998) motivational intervention embodied in the FRAMES acronym (i.e. personal **R**esponsibility for change) would have been inadvertently met.

Without participants' inadvertent co-operation in the maintenance of the interdependent stress, coping and transactional patterns, drinkers' systems of defences would likely to be much less effective in protecting and shielding them from the reality of their situations. Moreover, it would be far more difficult for drinkers to successfully blame their relatives' nagging and controlling behaviours for their parlous plights: the controlling/denial trap (Miller & Rollnick, 1991) would be gradually dismantled. Thus, another of Miller's (1998) conditions for motivational intervention (i.e. **F**eedback) may have been inadvertently met.

Without the interdependent coping patterns which supported the status quo, a period of instability may have occurred for participants' drinkers. This may have also provided drinkers with a valuable opportunity to confront the reality and severity of their situations, and perhaps assisted them to increase the salience of various incentives to change their behaviour. Moreover, as drinkers noticed participants' ability to change their own behaviours, a belief (and indeed a hope) may have germinated in drinkers that they too may have been able to successfully tackle their own difficulties.

Thus, drinkers' belief and hope that they may indeed be able to similarly change their behaviour may have improved drinkers' sense of **S**elf efficacy so important in Miller's

motivational intervention. Therefore, this process was likely to have reduced drinkers' incentives to use and encouraged some of them to seek help.

On the other hand, this period of instability seemed to increase tension in the family and may have explained why 19% (n=8) of participants reported an *increase* in their drinkers' consumption by the end of treatment. The qualitative data presented in Chapter 11 has helped to clarify this issue.

According to Prochaska, Norcross and DiClemente (1994), constructively helpful relationships are vital to encourage movement through precontemplation to contemplation and ultimately into the action stage of change. It was likely that this process would have evolved through (i) participants' reduced attempts to force change by controlling their drinkers' behaviour; (ii) participants' increased attempts to retain focus on their own needs rather than their drinkers' behaviour and (iii) participants' resolve to maintain their own action plan. Many participants reported improved honesty, communication, warmth, enjoyment, and humour between themselves and their drinkers. Some drinkers even expressed interest in participants' treatment program, and even read the manual (see qualitative data in Chapter 11). The milieu created by these changes in participants' behaviour would have been analogous to Miller's (1998) **E**mpathic style which is so important in successful motivational interventions.

The improved relationship between drinkers and participants, reduced marital discord, and evidence of the seriousness of their drinking problem may have provided drinkers with enough emotional arousal to create the energy, resolve, and confidence to propel themselves from contemplation to action (Prochaska, Norcross & DiClemente, 1994). Moreover, it would have been likely to provide a milieu where they could regain their pride, safely re-evaluate themselves, their goals, and their future which are important processes within the preparation for action stage of change (see Table 5.2)

Although the Holyoake intervention did indeed produce an increase in participants' assertive communication with their drinkers (see qualitative data in Chapter 11), it did not produce an increase in participants' assertive *confrontation* or emotional independence from their drinkers. Whilst the intervention briefly focussed upon participants' need to emotionally "let go" of their drinkers, the intervention did not teach confrontational strategies to encourage drinkers to seek help at all. Had these been more *systematically*

dealt with (as was the case with self responsibility), the final 2 elements of Miller's (1998) **FRAMES** acronym may also have been more successfully (albeit inadvertently) met; viz. **A**dvice to change and **M**enu of approaches by which change might be achieved. In that case, the "spin off" changes in drinkers' consumption patterns may have been more comprehensive.

Thus, the processes of change and motivational milieu which have been found to be most effective in encouraging the movement from precontemplation through the action stage of change were likely to be *unintentionally* created and facilitated by participants who were working through the principles of their intervention program and focussing on their own needs, feelings and responsibilities.

As one participant commented;

- "I've been trying to get him to change for years! Now I've stopped trying to make him change, he's doing it on his own! I think it's because *I've* changed".

Perhaps this was an example of Professor Orford's (1994) stress/coping and transactional model in action.

Other researchers (e.g. Barber & Crisp, 1995; Miller, Meyers & Tonigan, 1999) have achieved a significant reduction in drinkers' consumption and/or increased help seeking behaviour through working with the relatives of treatment resistant drinkers. However, the current study is unique because it did *not* aim to intervene with resistant drinkers. Rather, it focussed exclusively on improving the mental health and coping of relatives of resistant drinkers – in their own right. Whilst Barber and Crisp, and Miller et al.'s work with relatives indeed facilitated the movement of their treatment resistant drinkers into the action stage of change (as evidenced by reduced consumption or presentation for assessment and/or treatment), the *durability* of these changes in drinkers' behaviour was not investigated.

10.4 Discussion regarding the effect of partial treatment (5 sessions) for the Late Dropout group (n=13) on participants' mental health, coping and relationship status, and the "spin off" of this on their drinkers' behaviour

This section has discussed the effect and durability of 5 treatment sessions on the Late Dropout group who were available for follow up (n=13) 5 weeks after they had completed 5 treatment sessions. The results from the Late Dropout group across all variables have been compared with those obtained from the Full treatment group (n=43) at the same time periods; i.e. after 5 treatment sessions and 5 weeks later at the 10 session point; i.e. when the Full Treatment group had received 10 treatment sessions and the Late Dropout group had had 5 weeks without treatment (see Table 9.31).

It was interesting to note that the effect of the Holyoake intervention on these 13 participants' mental health, coping and relationship status was consistent *in most respects* to that identified for the Full Treatment group (n=43) over the same time periods. However, the major *inconsistency* between the Late Dropout group and the Full Treatment group was in relation to drinkers' abusive behaviour and drinkers' consumption patterns. For instance, only participants from the Late Dropout group reported significant reductions in their drinkers' abusive behaviour, as well as significant reductions across *all* consumption variables. Notwithstanding the fact that only the significant reduction in mean scores for the "effect of use" survived the conservative Bonferroni correction, the reductions in all of the other consumption variables may have become more statistically significant given a larger sample size.

One would expect that the most favourable "spin off" effect of the Holyoake intervention on drinkers' help seeking and consumption patterns would be drawn from the Full Treatment group who had engaged fully with treatment and followed it through. Moreover, one would expect that participants who drop out of treatment *do not do so* because their situation has improved: more treatment is usually perceived as being better than less treatment. However, these data tend to suggest otherwise. Notwithstanding the small sample size and the conservative Bonferroni challenge to the significance of these data, it seemed that the Late Dropout group may have terminated their treatment because their mental health, coping and relationship status had improved, and their previously

treatment resistant drinkers had made considerable positive change in their behaviour. Thus, it was reasonable to assume that participants may had decided that it was no longer necessary to invest time and money into continuing with treatment.

10.4 Discussion regarding the *durability* of the intervention effect on participant's mental health, coping and relationship status and the "spin off" of this on their treatment resistant drinkers

Intervention hypothesis 5: supported

- That there would be no significant *decrement* of effect on participants' mental health status from the end of treatment through 3 months and 6 months post treatment as evidenced by sustained effect on anxiety, depression and therefore, emotionality.

Intervention hypothesis 6: supported

- That there would be no significant *decrement* of effect on participants' coping status from the end of treatment through 3 months and 6 months post treatment as evidenced by sustained effect on control coping strategies and tolerant coping strategies.

Intervention hypothesis 7: supported

- That there would be no significant *decrement* of effect on participants' relationship status from the end of treatment through 3 months and 6 months post treatment as evidenced by sustained effect on:
  a) The quality of interactions between participants and their drinkers;
  b) Marital discord;
  c) Drinkers' abusive behaviour; and
  d) Participants' marital state.

Intervention hypothesis 8: supported

- That there would be no significant *decrement* of effect on drinkers' consumption behaviour from the end of participants' treatment through 3

months and 6 months post treatment as evidenced by sustained effect on (i) the amount drinkers consumed on any given drinking day.

According to Prochaska, Norcross and DiClemente (1994), it is essential to maintain, expand and reinforce the raised awareness, supportive relationships, emotional arousal and self re-evaluation processes so important in creating a milieu for change. Moreover, Prochaska, Norcross and DiClemente found that certain strategies were important in assisting people to *maintain and strengthen* their changed behaviours (see Table 5.3); viz.

- The substitution of healthy responses for problem behaviours;
- The nurturing of caring and supportive relationships;
- The creation a more personally helpful environment;
- The rewarding of personal efforts to maintain change; and
- The continued re-evaluation of personal situation.

10.4.1 The substitution of healthy responses for problem behaviours

According to Prochaska, et al (1994), it is important for people wanting to maintain changed behaviours to engage in active diversion, to refocus their energies, and keep busy. During the 6 months following the completion of the intervention program, participants were likely to have become more confident and adept at maintaining their personal action plans and refining their coping strategies and therefore, they continued to improve.

The durability of intervention effect on participants' mental health

Given the maintenance of the significant reductions in free floating anxiety, somatic anxiety and depression between end treatment and 6 months post treatment, it was reasonable to assume that participants were becoming more adept in their use of the ideas and strategies they had learned in their intervention program. Therefore, it may have been likely that by the end of the intervention program, participants had become more self controlled and confident.

Given the maintenance of the significant reduction anxiety and depression, it followed that participants were likely to be refining and strengthening their skill in

monitoring and challenging their automatic thoughts. Thus, it was also likely that they were able to more successfully moderate and manage their emotional and behavioural *reactions* to their drinkers' behaviour. This supposition seemed to be supported by the maintenance of the significant reduction in depression (as measured by the Drinkers' Partners' Distress Scale) through 6 months post treatment which indicated that participants were not experiencing so such distress regarding their situations.

Moreover, given the emphasis the intervention program placed on the need for increased *self* responsibility, participants were more than likely taking much more responsibility for their own well being, and not relying so much on their drinkers for emotional support. In fact, the qualitative data presented in the next chapter has confirmed this supposition.

The durability of effect on participants' relationships with their drinkers

The quality of participants' everyday interactions with their drinkers (when their drinkers were drinking) had steadily improved from mid treatment and was sustained through 6 months post treatment. This improvement was accompanied by incremental, significant reductions in drinkers' consumption of alcohol from mid treatment through 6 months post treatment. Therefore, it was likely that participants were expending less energy on trying to deal with their difficult situations, and not becoming so involved when their drinkers were drinking.

On the other hand, it was not until 6 months post treatment that the quality of everyday interactions between participants and their drinkers when drinkers were *not drinking* had significantly improved. This was consistent with the fact that despite ongoing reductions in mean scores, drinkers' verbal and emotional abuse had not *significantly* reduced until 3 months post treatment and 6 months post treatment respectively. These data seemed to support O'Farrell and Bayog's (1986) finding that partners of excessive drinkers needed time to get over the effects of their drinkers' destructive behaviour, and to develop trust that drinkers would maintain their treatment gains.

The marital state questionnaire (the GRIMS) "tapped" participants' perceptions about the quality of their relationships with their drinkers as a much deeper level. Given

drinkers' persistent abusive behaviour, it was indeed surprising that participants' marital state mean scores had reduced significantly by the end of treatment through 6 months post treatment. However, this *statistically significant* reduction (from "very severe problems" to "severe problems") was obviously not clinically significant. Notwithstanding that the marital state mean scores had indeed moved in the right direction, these data suggested that this deeper aspect of participants' relationships with their drinkers needed long term effort and commitment to repair and rejuvenate.

This research has suggested that participants' psychological functioning was no longer dependent upon their drinkers' behaviour. Despite the continued abuse from their drinkers, it seemed that participants had recognised and accepted that they alone were responsible for creating the kind of life they wanted to live. Moreover, that they were feeling more empowered to take the necessary steps to improve their personal environment – whether their drinkers had decided to change their behaviour or not (as found by Miller, Meyers & Tonigan, 1999). This supposition was confirmed by the qualitative data presented in the following chapter.

The durability of effect on participants' coping strategies

Given Velleman et al.'s finding that partners of excessive drinkers tend to swing from one unsatisfactory coping position to the other, even if participants in the current research *had* decided to place a moratorium on their control and tolerant coping strategies during the waitlist period, it was highly unlikely that they could have sustained this position without the reinforcing, educative, supportive input of the intervention. Without *replacement* strategies to control and channel their reactions to their drinkers' disruptive behaviour, and *counter* their ineffective strategies (Prochaska, et al., 1994), it was unlikely that participants would have been able to sustain their initial action as they did through 6 months post treatment

In fact, prior to entering the intervention program, participants reported that one of the main things they wanted to learn was how to manage their own distressing reactions to the drinking. Had they known what to do to replace their unhelpful coping strategies, *and felt confident about doing it*, surely they would have done it. This seemed to be supported by the fact that participants did *not* significantly increase their use of the assertive coping

strategies during the waitlist period – despite being similarly sensitised to these strategies by the questions on the Drinkers' Partners' Coping Questionnaire (DPCQ). This seemed to support Miller et al.'s (1999) finding that relatives needed extensive tutoring and practise to successfully apply these strategies

10.4.2 The nurturing of relationships and creation of a more personally helpful environment, and rewarding personal efforts to maintain change

During the Holyoake intervention program, participants were actively involved in the group therapy segment of the intervention program. Here, they were given the opportunity to share their feelings, hopes, fears, setbacks, and successes with others within a safe, accepting environment. Given the significant improvement by 6 months post treatment in the quality of everyday interactions between participants and their drinkers (regardless of whether drinkers were drinking or not), the data have suggested that participants may have been becoming more open and honest about their feelings, needs and concerns with their drinkers. Moreover, that participants were likely to have taken a firmer stand with their drinkers and were no longer prepared to accept their unacceptable behaviour. Thus, participants were likely to have created a more helpful personal environment for themselves, and built opportunities which resulted in both intrinsic and extrinsic rewards.

The qualitative interviews (see Chapter 11) have supported these suppositions. For instance, participants were indeed communicating their feelings, needs and concerns to their drinkers, rekindling previous friendships and interests (which they had neglected due to their preoccupation with their drinkers' behaviour), and were undertaking new activities to enrich their lives.

10.4.3 Continuing to re-evaluate personal situation

Once participants had experienced the personal empowerment involved in increasing responsibility for ensuring their own well being in many areas of life (something over which they *did* have control), it was reasonable to assume that they would have never

wanted to return to their previous way of dealing with the problem of excessive drinking in their family. With increased awareness and understanding of their situations, improved skill in monitoring and challenging their feelings and thoughts, increased awareness of the need to communicate these and to maintain effective personal boundaries, it was likely that participants *continued* to use, refine, and adapt the tools they had learned in the Holyoake intervention program.

Thus, more mindful of personal goals, and the need to re-evaluate their personal situations to maintain and sustain progress, participants possessed an effective armoury of tools to sustain their well-being. Given significant improvement in their mental health, coping, and relationship status through 6 months post treatment, it was reasonable to assume that participants were utilising their "new program" action plan strategically and effectively.

The durability of the "spin off" impact of participants' intervention program on their drinkers' consumption patterns

Given the major criterion for participants to take part in the research was that their drinkers were *resistant* to change, it seemed reasonable to assume that improvements in drinkers' behaviour during participants' intervention program were likely to have been facilitated by changes in participants' behaviour and how they were relating to their drinkers – and indeed to themselves.

Although drinkers' verbal abuse also had significantly reduced by mid treatment, this was not sustained through end treatment. It was not until 3 months post treatment that a significant reduction had occurred. This seemed to illustrate the fragility of drinkers' decisions to change their behaviour, and perhaps demonstrated their recycling through the stages of changes en route back to an ultimately sustained reduction in verbal abuse.

By the end of treatment, the strengthening of participants' mental health and coping gains had occurred *in tandem with* strengthened reductions in their drinkers' alcohol consumption, and beginning improvements in participants' marital state (still within the very severe problems range). Similarly, 3 months after the end of treatment, drinkers' verbal abuse had significantly reduced in tandem with significant improvements in the quality of everyday interactions with participants when they (drinkers) *were not drinking,*

Finally, 6 months after the completion of participants' intervention program, a significant reduction in drinkers' emotional abuse had occurred.

Thus, *initial* improvements in participants' coping, mental health, and relationship status seemed to occur independently of reductions in drinkers' consumption or abusive behaviour. It also seemed that *despite* no significant reductions in their drinkers' abusive behaviour, participants persisted with their action plan.

The initial slowness of drinkers to respond positively to participants' changed behaviour may have reflected drinkers' attempts to restore the status quo by provoking participants in some way to resume their more familiar "old program" coping patterns. Before their intervention program, participants would have most likely interpreted these "push back" reactions to their changed behaviour as evidence of strategy failure, rather than merely drinkers' attempts to restore the more comfortable (for them) status quo. However, the Holyoake intervention program had encouraged participants to carry on with their action plan *for their own benefit,* rather than allowing themselves to swing from one coping position to another *in reaction* to their drinkers' reactive behaviour.

Eventually, it seemed that drinkers may have realised that participants "meant business" and were not going to resume their "old program" coping patterns which had inadvertently given drinkers permission to continue with their excessive consumption. Due to the Holyoake intervention and experiences of others in the group therapy sessions, participants were likely to be much more aware of the typical manipulative strategies their drinkers tended to use to protect themselves and their addiction. Because these strategies no longer had the desired effect on participants, it was likely that drinkers would have reduced their use of these strategies. Some participants' comments presented in the next chapter have confirmed this supposition; e.g**.**

- "I'm not taking his emotional junk on board any more. He hasn't been dishing it out any more because he's realised I won't accept it."

This has supported the concept of the stress/coping/transactional model (Orford, 1994) where the changed coping behaviour of one person in an intimate relationship facilitates changed behaviour from the other (for better or for worse). Therefore, this suggested that not only did participants reduce their use of control and tolerant coping strategies, *they substituted other more effective coping strategies.* Moreover, that the

behaviour of both participants and their drinkers had a powerful reciprocal influence on each other. As one participants' comment revealed, some drinkers hotly denied that they were changing in any way at all; e.g.

- "I get clear in my position and he responds to that. He can't fail to respond even if he doesn't want to. So it doesn't matter that he's constantly saying, *'I'm not changing and no bugger is going to make me.'* In fact, he *does* respond to changes which are going on in me and that changes the relationship [for the better]."

Given the impact of participants' intervention program on their drinkers' consumption patterns was sustained through 6 months post treament, it was reasonable to assume that the processes of change found by Prochaska, Norcross and DiClemente (1994) to be important in moving treatment resistant drinkers from precontemplation to the action stage of change (e.g. raised awareness, helpful environment, emotional arousal, and self evaluation), were *inadvertently* created by participants' significantly improved coping, mental health, and relationships with their drinkers.

The aim of the Holyoake intervention program was to:

- Minimise the harm experienced by relatives of excessive drinkers;
- Improve participants' well being and coping; and
- Assist participants to recognise behaviours which might unwittingly enable their drinkers' excessive use to continue.

Before commencing the intervention program, participants were likely to have been in the preparation stage of change characterised by the decision making and thorough preparation which precedes the successful modification of behaviour during the action stage of change. According to participants' qualitative interviews (see Chapter 11), most were aware that their usual coping strategies (particularly their emotionally charged reactions) were counterproductive and often cued further drinking. However, participants did not know what to do instead. That was why they enrolled in the intervention program.

During the waitlist period, it was reasonable to assume that participants merely reduced their use of control and tolerant coping strategies (rather than substituting more effective strategies) because there was no corresponding improvement in participants' mental health and relationship status with their drinkers, nor reductions in drinkers' verbal abuse or alcohol consumption. This suggested that participants were indeed preparing for

the intervention program (where they knew they would receive expert help and support) by placing a moratorium on their ineffective coping strategies. Moreover, it was reasonable to assume that participants had become sensitised to their unhelpful coping strategies by the pre intervention qualitative interview and the various questionnaires they were asked to complete (see Figure 10.1).

The emphasis of the intervention program was on educating participants about their role in inadvertently enabling the excessive drinking to continue, and teaching them more effective, self affirming coping strategies intended to decrease stress and increase their sense of well being. By mid treatment (5 sessions) an *additional*, significant reduction in participants' control coping strategies (with their emotional aspect) had occurred accompanied by significant improvement in some aspects of participants' mental health and relationship status. Therefore, it was reasonable to assume that participants were already beginning to substitute the more effective coping strategies they were learning from the Holyoake intervention program.

The data which have emerged from this research suggest that participants' successful use of these effective coping strategies may have actually "driven" the subsequent mid treatment reduction in their levels of depression (as measured by the DPDS) and marital discord, and improved interactions with their drinkers *when drinkers were drinking*. Moreover, it was likely that this more positive family milieu may have *influenced* the beginning reductions in drinkers' alcohol consumption and verbal abuse (although reductions in verbal abuse were not sustained). Thus, the coping patterns between participants and their drinkers were being powerfully and reciprocally re-choreographed, as the changed behaviour of both participants and their drinkers circularly affected each other (see Figure 10.1).

By end treatment through 6 months post treatment, participants' mental health, coping, and relationship status with their drinkers had consolidated and strengthened *in tandem with* drinkers' reduced abusive behaviour and sustained reduced consumption. This suggested that participants were becoming more self confident and adept with the application of their "new program" strategies and action plans. Thus, it seemed that participants did indeed do much more than just reduce their ineffective coping strategies during the intervention. According to Prochaska, Norcross and DiClemente (1994), the

durability of changed behaviour *depends* upon the *substitution* of healthier behaviours for problematic responses.

The qualitative data presented in the following chapter has explored participants' experiences with their drinkers prior to the intervention, how participants applied what they had learned from the intervention, and what impact they believed their changed behaviour on their drinkers. Moreover, whilst the quantitative data did *not* identify an *increase* in the particular assertive coping strategies as measured by the DPDQ, the qualitative data unequivocally demonstrated that participants did indeed self affirmingly, assertively, and successfully counter their "old program" coping strategies.

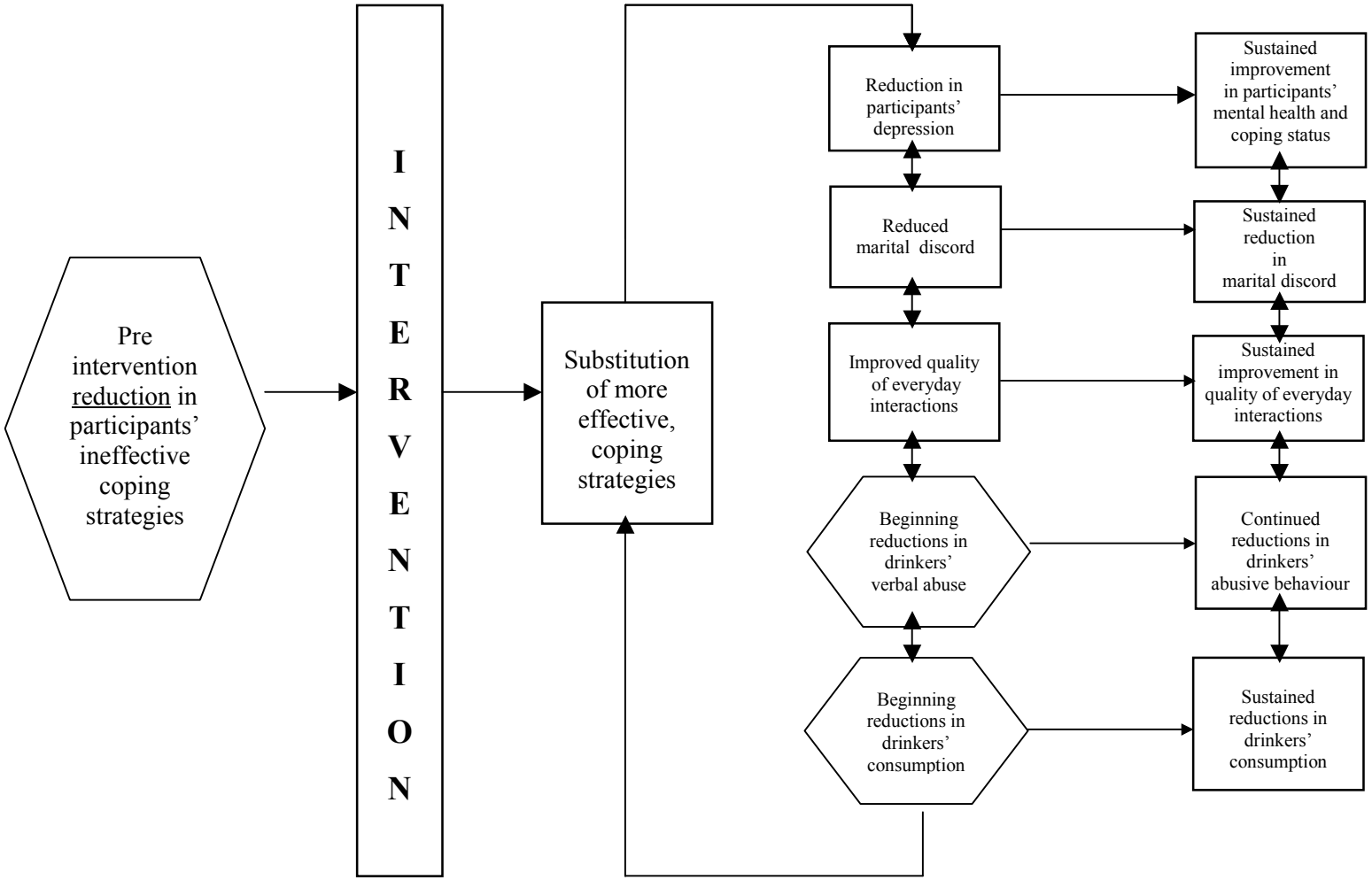

Figure 10.1 Representation of the effects of the intervention on participants' mental health, coping and relationship status, and the "spin off" of this on their drinkers' behaviour

CHAPTER 11

Results and Discussion 2:
Participants' qualitative experiences during treatment

Structured qualitative interviews were used to augment and enrich the quantitative data by "tapping" participants' (i) perceptions and evaluative analyses of their situations; (ii) explanations for changes which may have occurred during treatment; and (iii) perceptions of factors which were underpinning or impeding change. The pre treatment interview asked participants:

- What they were finding most difficult to deal with regarding their drinkers' consumption and/or behaviour,
- How they usually handled[1] that difficulty; and
- What was the outcome when they handled it in that way.

Subsequent qualitative interviews at mid treatment and end treatment asked participants whether any changes had occurred regarding:

- What participants were finding most difficult to deal with in relation to their drinkers' behaviour;
- How they usually handled that difficulty;
- What was the outcome when they handled it in that way;
- How participants handled their situations with their drinkers *in general*;
- The quality of their relationships with their drinkers; and
- Participants' observations of their drinkers' consumption and/or behaviour.

[1] Participants were asked how they *handled* their major difficulty rather than how they coped with it. Preliminary trials revealed people usually responded to a "How do you usually cope" question with, "I don't cope with it at all!"

If participants had identified a change in the drinking or relationship (either positive or negative), they were asked what they thought had prompted that change. Finally, participants were asked to identify (if anything) what was the most *important* element from the Holyoake intervention which had helped them deal more effectively with their situations.

Because of the richness and diversity of the data, each section of the qualitative results has been accompanied by summaries and discussion to reduce the complexity.

11.1 What participants found most difficult to deal with in relation to their drinkers' behaviour prior to the intervention, how they usually handled that and the outcome

11.1.1 What participants found most difficult to handle regarding their drinkers' behaviour prior to the intervention

Participants were asked to respond to the question, "Regarding your partner's drinking and/or behaviour, what have you found most difficult to deal with over the last 2-3 months?" Although participants were likely to be experiencing a wide range of difficulties, this question forced them to choose the one aspect of their situations which they found most difficult. Thematic analysis of participants' responses to this question identified 4 categories which participants found most difficult to handle; viz.

1. Isolation within the relationship;
2. Drinkers' abusive behaviour;
3. Drinkers' consumption behaviour; and
4. Participants' personal issues in reaction to their drinkers' behaviour.

Table 11.1 presents categories of participants' major difficulties, themes within each category, and examples of participants' responses within each theme.

Table 11.1
Thematic analysis of participants' pre treatment responses to the question; "Over the past 2-3 months, what have you found most difficult to deal with in relation to your partner's drinking and/or behaviour?" (n=43)

Categories	Themes	Some participants' responses
Isolation within the relationship (n=14, 33%)	Communication problems (n=8)	• He repeats himself over and over and talks garbage. • It's like talking to a brick wall. • Not being able to say what I need to say because he's angry. • Can't approach her on the situation because it's like she's someone else.
	Loss of a companion (n=6)	• He has no motivation to do anything other than work and watch TV. • I don't want to go out with him because he's always drunk and I feel embarrassed. • No intimacy or emotional sharing. I feel like a nothing.
Abusive behaviour (n=12, 28%)	Blaming (n=5)	• Blaming me for *his* anger (and everything else that goes wrong!). • He asks me to help and when I do he blames me and says it's all my fault.
	Aggressive mood swings (n=4)	• The rage, temper and mood changes. Only look at him wrong [sic] and he changes from happy to aggressive. It's like living on a knife edge. • The mood change from a lovely person to a kind of total ogre. It polarises your emotions and the bad becomes really bad and anything not drinking seems extra good. You lose perspective on reality.
	Anger and aggression (n=3)	• The pent up aggression is so intense. He doesn't threaten me personally but I cringe when he thumps the table.
Drinkers' consumption behaviour (n=11, 25%)	Intoxicated behaviour (n=6)	• He wets the bed. I can't sleep in the bed. It's disgusting. I wake up freezing cold. • She's neglectful of courtesies when she's drunk. • He's influencing our son to drink with him and break the law.
	Excessive intake (n=5)	• Consistency of drinking every night until she can't remember. • He disintegrates and falls apart
Participants' personal issues[2] (n=6, 14%)	Affective (n=4)	• I've got less and less tolerant and angrier.
	Management (n=2)	• It's the constant management of it all - what should I do and how should I do it? (male)
Total n=43, 100%		

11.1.2 How participants usually handled their major difficulty prior to the intervention

After participants had identified what they had found most difficult to deal with concerning their drinkers' behaviour, they were asked, "How do you usually handle that?" If participants described more than one way of dealing with their major difficulty, they were asked to identify which was their *usual* strategy. As Table 11.2 has illustrated, the majority of participants (84%, n=36) predominantly used withdrawal, emotional, inactive, or tolerant coping strategies. However, 7 participants (16%) predominantly used assertive strategies when grappling with their major difficulty; e.g . "I submerge my feelings and try to talk to him in the morning when he's sober...and I've come here for help!" Participants' responses within this category were classified as assertive because they illustrated some attempt to:
Handle their major difficulty strategically and not "over the top" emotionally

- Encourage drinkers to join in family activities; or
- Illustrated that participants were looking after their own needs and concerns.

11.1.3 Pre treatment outcomes associated with participants' predominant coping strategies

After participants had identified their pre treatment major difficulty and how they *usually* handled that, they were then asked, "What happens between you and your partner (or other family member) when you handle it in that way?" Analysis of participants' responses (see Table 11.3) to this question revealed that emotional, inactive, and tolerant coping strategies seemed to be associated with increased discord, resentment, and guilt. Although participants' withdrawal strategies usually calmed their drinkers down, the drinking continued, and the relationship between participants and their drinkers seemed to deteriorated. On the other hand, assertive coping strategies seemed to be associated with drinkers becoming temporarily more approachable or cooperative.

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[2] Two males and 2 parents were in this group

Table 11.2
Thematic analysis of participants' pre treatment responses to the question; "How do you usually handle that?" (i.e. most difficult situation in relation to drinkers' drinking and/or behaviour) (n=43)

Usual coping categories	Some participants' responses to the question
Withdrawal (n=17, 40%)	• I physically remove myself into another room. He can still come but I'm less available. • I try not to be there when he's using. • I avoid inviting him anywhere. • I ignore her. Won't make conversation. Sometimes resort to abuse. Not very polite. • I feel my face harden. The worry sets in. I just go like stone to him and I cut off all feeling.
Emotional (n=11, 26%)	• I lock him out of the house, withdraw sex, affection, and food. • I get angry back at him. Abuse him and get "aggro". • I usually end up snapping back. When I talk quietly and say how it really happened he'll sort of accept what I say - that works best. • I get angry. Said some awful things to him. When he's "sweet", I tell him what he's done wrong because he might listen then.
Assertive (n=7, 16%)	• He hadn't ODd before. I talked to him next day. He was angry and I cried. Told him I would give him no more money. • I talk to him when he's sober and he agrees that I'm right but next time it's the same. • I talk to him. He realises he has a problem. • I keep trying to organise him into family activities. • I talk to other family about it.
Inactive (n=5, 11%)	• I just freeze over like I'm in a glass box. Don't react one way or the other. (male) • I usually I bottle it up. When he's sober I get upset and let it rip!
Tolerant (n=3, 7%)	• I'm accommodating on the nuptial couch to keep the peace. • Just accept it. Wake him if he's asleep on the couch and make him go to bed.
Total n=43, 100%	

Emotional, inactive, and tolerant coping strategies (n=19, 44%)

Most participants who predominantly utilized emotional coping strategies (n=11, 26%) to handle their most difficult situations reported negative outcomes; e.g. "I plunge in without thinking half the time. It causes friction. I say what I feel like saying."

Table 11.3

Predominant coping strategies and outcomes for each category of major difficulty from collation of participants' pre treatment responses to the questions, "What have you found most difficult to deal with in relation to your partner's drinking or behaviour over the past 2-3 months?"; "How do you usually handle that?"; and "What happens between you when you handle it that way?" (n=43)

Categories of participants' major difficulties at pre treatment	**Usual coping strategies**	**Some participants' responses regarding outcome within each coping category**
Isolation within the relationship (n=14, 33%)	Withdrawal (n=8)	• We've grown further apart. I don't like bringing it up because it causes further problems.
	Assertive (n=4)	• He doesn't "charge up" so easily if I'm in a good mood.
	Emotional (n=1)	• Doesn't make any difference. I feel guilty because I'm breaking my value system.
	Inactive (n=1)	• Nothing changes.
Drinkers' abusive behaviour (n=12, 28%)	Withdrawal (n=7)	• We've grown further apart. He can drink peacefully and there are no arguments.
	Emotional (n=3)	• There's a big 'blue" and we go to our rooms.
	Inactive (n=2)	• He loses his block and rants and raves. He says I've got nothing to worry about because he pays the bills.
	Tolerant (n=1)	• The abuse continues...I wish he was dead.
Drinkers' consumption behaviour (n=11, 25%)	Emotional (n=5)	• She comes after me and we keep things going until one of us breaks into tears. We resolve not to do it again but the same pattern is repeated.
	Tolerant (n=2)	• Initially embarrassed and now rebellious anger (bed wetting).
	Withdrawal (n=2)	• She'll continue to drink.
	Assertive (n=1)	• He hasn't asked me for money again.
	Inactive (n=1)	• I just bottle it up and let it build up and then let it rip!
Participants' personal issues (n=6, 14%)	Assertive (n=2)	• He realises he's got a problem.
	Emotional (n=2)	• We both get angry and end up having a screaming row.
	Inactive (n=1)	• If I don't take any notice of her there's a lot of anger.
Total n=43, 100%		

However, some participants reported their emotional coping strategies at least gained their drinkers' attention, and resulted in drinkers moderating their behaviour *in the short term*; e.g.

- "He puts off using for a little while"
- "He doesn't like seeing me that upset. He tries to moderate but it doesn't last"
- "She comes after me and we keep things going until one of us breaks into tears. We resolve not to do it again, but the same pattern is repeated."

It was interesting to note that the one participant who predominantly utilised inaction coping when faced with her drinkers' abusive behaviour reported *increased* discord and abuse as her drinker *tried to provoke and re-engage her*. Moreover, participants' utilisation of tolerant strategies (n=3) seemed to increase their own deep resentment and anger (see Table 11.3).

Withdrawal coping strategies (n=17, 40%)

Although withdrawal coping strategies usually resulted in drinkers eventually calming down, participants reported feeling helpless and confused due to:

- The "wall" that drinkers put up to stop people saying anything about the drinking; e.g. "...I can't get through to him anyhow."
- Drinkers' reactions to participants' use of withdrawal strategies; e.g. "She avoids me for a few days and then phones as though nothing has happened."
- Drinkers' reactions when participants withdraw and finally lashed out with an emotional response; e.g. "As soon as I lose the plot, he thinks he's fine."
- Damage to the relationship; e.g. "We've grown further apart. He can drink peacefully and there are no arguments."

(iii) Assertive coping strategies (n=7, 16%)

Although drinkers were generally more approachable and cooperative when assertive strategies were utilised, only short term benefits seemed to be achieved; e.g.

- "It doesn't make any difference. He just carries on as normal."

- "When he's sober, I talk to him and he agrees [about financially disastrous business deals], but next time it's just the same!"

However, three participants who usually reacted emotionally reported that an assertive response was much more effective; e.g. "When I talk quietly and say how it really happened he'll sort of accept what I say. That works best."

11.1.3 Summary and discussion regarding how participants dealt with their pre intervention major difficulty in relation to their drinkers' behaviour and the outcome

The majority of participants (61%, n=26) identified isolation within their relationships and their drinkers' abusive behaviour as the major difficulties they had faced during the 2-3 months prior to the intervention. Within the isolation category, participants highlighted communication problems and the loss of their companion due to the excessive drinking as their major difficulty. Within the drinkers' abusive behaviour category, participants highlighted drinkers' blaming behaviours and aggressive mood swings. The remaining 39% (n=17) of participants identified their drinkers' consumption behaviour and their own personal issues in reaction to the drinking as their major difficulty. Within the consumption behaviour category, participants found drinkers' intoxicated behaviour or excessive intake most difficult to handle. Within the personal issues category, participants found their own affective reactions or the constant management issues most difficult to handle. In response to these pressures, the majority of participants (84%, n=36) utilised withdrawal, emotional, inactive, or tolerant coping strategies. Only 7 participants predominantly utilized assertive coping strategies to handle their major difficulty.

According to participants, withdrawal, emotional, inactive and tolerant coping strategies were *usually* counterproductive for themselves and their drinkers, because they either enabled the drinking to continue unchecked, or actually cued further drinking. However, although withdrawal or assertive strategies may have enabled drinkers to calm down, or made them more approachable (respectively), participants remained angry, resentful, guilty and frustrated. Moreover, the quality of their

relationships with their drinkers deteriorated, and drinkers remained resistant to change. Therefore, despite participants' efforts, the status quo was maintained.

One participant's answer in response to the "What have you found most difficult to deal with?" question (see Table 11.1), was particularly interesting; viz. "The mood changes change him from a lovely person to a total ogre." When asked to elaborate, she added, "It polarises your emotions and the bad becomes really bad and anything not drinking seems extra good. You lose perspective on reality."

This may help to explain the "denial" some alcohol and other drug therapists remark upon (and frequently become frustrated about) when working with relatives of excessive drinkers. Moreover, it may help to explain why many relatives appear to be prepared to accept unacceptable behaviour - as long as their drinkers are not drinking. Given the chronic stresses and strains to which relatives of excessive drinkers are exposed, it is likely that they gradually become desensitised to "lower level" unacceptable behaviour. For instance, one of the participants in this study did not interpret her husband's grabbing her by the neck and pushing her repeatedly up against the wall as violent - because he didn't actually hit her. This seems to be an example of someone "losing [their] perspective on reality."

Other participants' answers to the "What have you found most difficult?" question illustrate the stresses and strains to which many participants were exposed; viz. "It's like living on a knife edge" (because of the drinkers' rage, temper and mood changes), even when they were not personally threatened ("The pent up aggression is so intense I cringe when he thumps the table.").

The extreme distress, loss of control, guilt, and immobilization that many participants were experiencing was illustrated by their responses to the "How do you usually deal with that?" question (see Table 10.2); e.g.

- "I feel my face harden. The worry sets in. I just go like stone and cut off all feeling";
- "I usually end up snapping back";
- "I abuse him and get 'aggro'";
- "I get angry …and say awful things to him";
- "I freeze over like I'm in a glass box. I don't react one way or the other"; or

- "I'm too weary to handle it any more."

Moreover, many participants' sense of self sacrifice and powerlessness to change their situations was also evident. For instance, one participant had resigned herself to changing the sheets when her husband wet the bed, whilst another was "accommodating on the nuptial couch to keep the peace." Other participants spoke of the desperation involved in trying to "get through" to their drinkers by trying to find the right moment to approach them; e.g.

- "When he's "sweet" [to me], I tell him what he's done wrong because he might listen to me then"; or
- "I try to approach him when *I'm* in a good mood."

Some participants seemed to be acutely aware that their emotional responses were exacerbating their situations and enabling the drinking to continue. It seemed that once these participants "blew up" emotionally, that their drinkers may have felt sufficiently punished. It was almost as if these drinkers <u>needed</u> to provoke an "over the top" emotional reaction from participants to give themselves permission to continue their unacceptable behaviour. Moreover, the data have suggested that emotional reactions were functional for these participants, and may have been the primary method that they were able to communicate their feelings to their drinkers; e.g. "I just bottle it up, let it build up, and then I let it rip!"

This study has provided the first Australian *qualitative* data which has described some of the most difficult situations partners of treatment resistant drinkers face in relation to their drinkers' behaviour, how they usually deal with these situations, and the subsequent outcome. The qualitative data has corroborated, elaborated, and enriched the quantitative data presented in Chapter 9 which found participants' mental health, coping and relationship status was indeed compromised. This Australian description is consistent with Orford et al.'s (1992, 1998a, & 1998b) and Holmila's (1997) cross cultural explorations of the stresses and strains of partners of excessive drinkers. In particular, it supports Orford et al. who found that the most universal stressor faced was finding their drinkers unpleasant to live with. Moreover, in reaction to these stresses and strains, it seems that Australian partners of excessive drinkers use similar patterns of coping to their English, Mexican, and Finnish counterparts.

11.2 Changes during treatment in participants' major difficulty in relation to their drinkers' behaviour, how they handled that difficulty and the outcome (see Appendix 6a)

11.2.1 Changes during treatment in participants' major difficulty

Thematic analysis of participants' mid treatment and end treatment responses to the question, "What have you found most difficult to deal with in regard to your partners' drinking and/or behaviour since your last interview (i.e. 5 weeks) revealed a dramatic increase from mid treatment to the end of treatment (n=1 to n=7)[3] in those participants who claimed to be no longer grappling with any major difficulties in relation to their drinkers' behaviour

However, as the remaining participants (n=36) progressed through mid treatment and end treatment, categorical changes in the major difficulties they were facing were revealed (see Figure 11.1 & Appendix 6a). For instance, whilst the number of participants who identified isolation or their drinkers' abusive behaviour as their major concern had consistently reduced throughout treatment, their major concern with their drinkers' consumption behaviour had correspondingly increased. This was due to thematic changes within the "drinkers' consumption behaviour" category which have been outlined below.

[3] At pre treatment, these participants' most difficult situations were consumption and related behaviour (n=3), isolation (n=3) and abusive behaviour (n=1). They had usually used inactive (n=3), assertive (n=3), or withdrawal strategies (n=1) respectively to deal with these situations

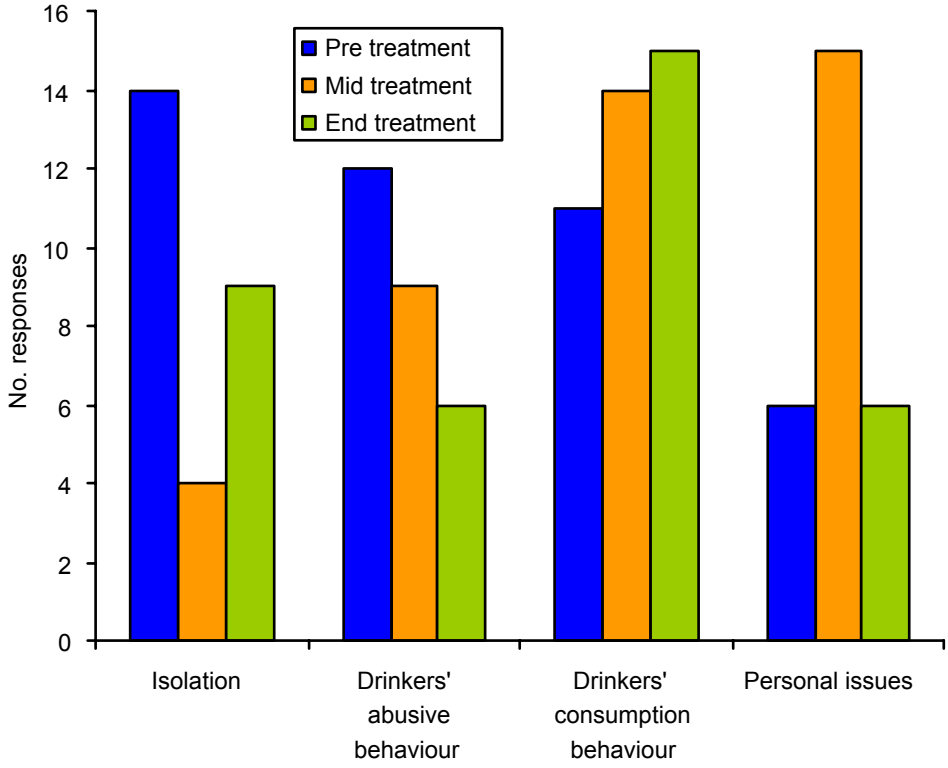

Figure 11.1 Thematic analyses of changes in participants' responses to the question, "What have you found most difficult to deal with in relation to your partners' drinking and/or behaviour?" from pre treatment through end treatment (n=43, n=42, n=36)[4]

It was also interesting to note the mid treatment surge in participants' major focus on their own personal issues (e.g. "I get overwhelming feelings of sadness") rather than their pre treatment *reactions* to their drinkers' behaviour (e.g. "I've got less tolerant and angrier"). As well as changes in categories of participants' primary difficulty with their drinkers' behaviour during treatment, considerable changes in the themes embedded within each category were also evident; viz.

Changes during treatment in the isolation category

As Figure 11.1 has revealed, the number of participants experiencing major difficulty with isolation within their relationships at pre treatment had dramatically reduced by mid treatment and had increased again by the end of treatment (to below pre

[4] At mid treatment 1 participant reported no major difficulty therefore n=42. At end treatment, 7 participants reported no major difficulties therefore n=36

treatment levels); i.e. n=14 to n=4 to n=9. Analysis of participants' responses to the "What have you found most difficult to deal with…?" question identified 2 themes within the isolation category (the number of participants' responses at pre treatment, mid treatment and end treatment within each theme are in parentheses); viz.

1. Communication problems (n=8 to n=0 to n=3); and
2. Loss of a companion (n=6 to n=4 to n=6).

Thematic analysis of participants' responses revealed interesting changes had occurred between pre treatment, mid treatment and end treatment regarding the salience of the 2 themes within this category. For instance, the mid treatment reduction in the number of responses within the isolation category was mainly due to the *elimination* of participants' responses classified as "communication problems" and the reduction in responses classified as "loss of a companion."

By the end of treatment, the number of participant's responses within the isolation category had more than doubled from mid treatment levels. This was primarily due to the *re-emergence* of participants' responses classified as "communication problems", and the return to pre treatment levels of the number of participants reporting the "loss of a companion" as their major difficulty.

Changes during treatment in the drinkers' abusive behaviour category

As Figure 11.1 has illustrated, the number of participants experiencing major difficulty with their drinkers' abusive behaviour had halved by the end of treatment; i.e. n=12 to n=9 to n=6. Analysis of participants' responses during treatment to the "What have you found most difficult to deal with…?" question revealed 3 themes within the drinkers' abusive behaviour category; revealed interesting changes had occurred regarding the salience of the 3 themes within this category between pre treatment, mid treatment, and end treatment (the number of participants' responses at pre treatment, mid treatment and end treatment within each theme are in parentheses); viz.

1. Drinkers' blaming behaviour (n=5 to n=0 to n=0);
2. Drinkers' aggressive mood swings (n=4 to n=2 to n=1)
3. Drinkers' anger and aggression (n=3 to n=7 to n=5); e.g.
    - "He's taunting me about coming to the Holyoake program."
    - "Her constant anger and criticism makes it difficult to show affection."

Changes during treatment in drinkers' consumption behaviour category

As Figure 11.1 has illustrated, the number of participants experiencing major difficulty with their drinkers' consumption behaviour had increased during treatment; i.e. n=11 to n=14 to n=15. Analysis of participants' responses to the "What have you found most difficult…?" question revealed interesting thematic changes within this category. For instance, at pre treatment, 2 themes had emerged (the number of participants' responses at pre treatment, mid treatment and end treatment within each theme are in parentheses); viz.

1. Intoxicated behaviour (n=6 to n=0 to n=0)
2. Excessive intake (n=5 to n=0 to n=5)

Although the number of participants' responses within the drinkers' consumption behaviour had increased by mid treatment, interesting thematic changes within this category had occurred. For instance, the intoxicated behaviour and excessive intake themes had been eliminated as a major difficulty. Instead, participants' were grappling with different challenges within the drinkers' consumption behaviour category (the number of participants' responses at mid treatment and end treatment within each theme are in parentheses); viz.

1. Concern for their drinkers future (n=7 to n=4)[5]; e.g.
   - "I'm thinking about my son's long term future."
2. Drinkers' resistance to change (n=4 to n=2), e.g.
   - "He's become more withdrawn. I don't know if he will change."
3. Drinkers' *maintenance* of their reduced consumption (n=3 to n=0), e.g.
   - "The thought of him relapsing is most difficult: I can't imagine him without it."

As Figure 11.1 has illustrated, by the end of treatment, participants' responses within the drinkers' consumption behaviour category had marginally increased. However, interesting thematic changes within this category had occurred. For instance, whilst the number of participants' responses within the "resistance to change" and "concern for drinkers"[6] themes had halved, drinkers' irresponsibility had become a major concern for some participants (n=4), and drinkers' excessive intake had re-emerged as a major issue for others (n=5).

[5] Four of these were parents
[6] All parents

(iv) Changes during treatment in participants' personal issues category

As Figure 11.1 has illustrated, although participants' major concern with their own personal issues had more than doubled by mid treatment, it had reduced to pre treatment levels by the end of treatment; i.e. n=6 to n=15 to n=6. Analysis of participants' responses to the "What have you found most difficult…?" question revealed interesting thematic changes had occurred. For instance, at pre treatment, 2 themes had emerged . For instance, at pre treatment, 2 themes had emerged ; viz.

1. Affective reactions to their drinkers' behaviour (n=4); e.g.
   - I've got less and less tolerant and angrier."
2. Management issues (n=2); e.g.
   - "It's the constant management. What should I do and how should I do it?"

By mid treatment, thematic analysis of participants' responses within the personal issues category revealed the number of participants' responses within the "affective reactions" theme had doubled and the "management issues" theme had been eliminated. Participants were now grappling with new challenges which had been presented by the Holyoake intervention; viz.

1. Assertive confrontation (n=4); e.g.
   - "I need to find a way to tell him about the drinking";

2. Relinquishing inappropriate responsibilities (n=3); e.g.
   - "Not ringing him up and checking on him"; and
3. Focussing on their own plans for the future (n=2); e.g.
   - "I know I'm going to have to leave sooner or later."

By the end of treatment, participants' responses to the "What have you found most difficult?" question revealed the number of responses within the personal issues category had returned to pre treatment levels. Whilst thematic analysis revealed that participants' "plans for the future" theme had been maintained (e.g. "I'm not quite sure how to end the relationship.") some participants were again grappling with different issues; viz.

1. Maintaining their action plan (n=2); e.g.
   - "It concerns me that I must continue to put the strategies I have learned into practice so I don't fall back into a codependent position"; and
2. Establishing trust (n=2); e.g.

- "I can't trust that she's not going to go off and get drunk and do something silly."

11.2.2 Changes during treatment in how participants handled their major difficulty (see Appendix 6b)

After participants had answered the "What have you found most difficult to handle in relation to your partners' drinking and/or behaviour since your last interview?" question (5 weeks), they were asked (at both mid and end treatment), "How do you usually handle that?" Participants' responses to this question revealed significant changes in their coping strategies as they progressed through the intervention program. As Figure 11.2 has illustrated, whilst participants' predominant use of withdrawal, emotional, inactive, or tolerant coping strategies had markedly *reduced* during treatment, their use of assertive coping strategies had markedly *increased* from pre treatment through mid treatment and end treatment; i.e. n=7, 16%; to n=29, 67%; to n=35, 81%.

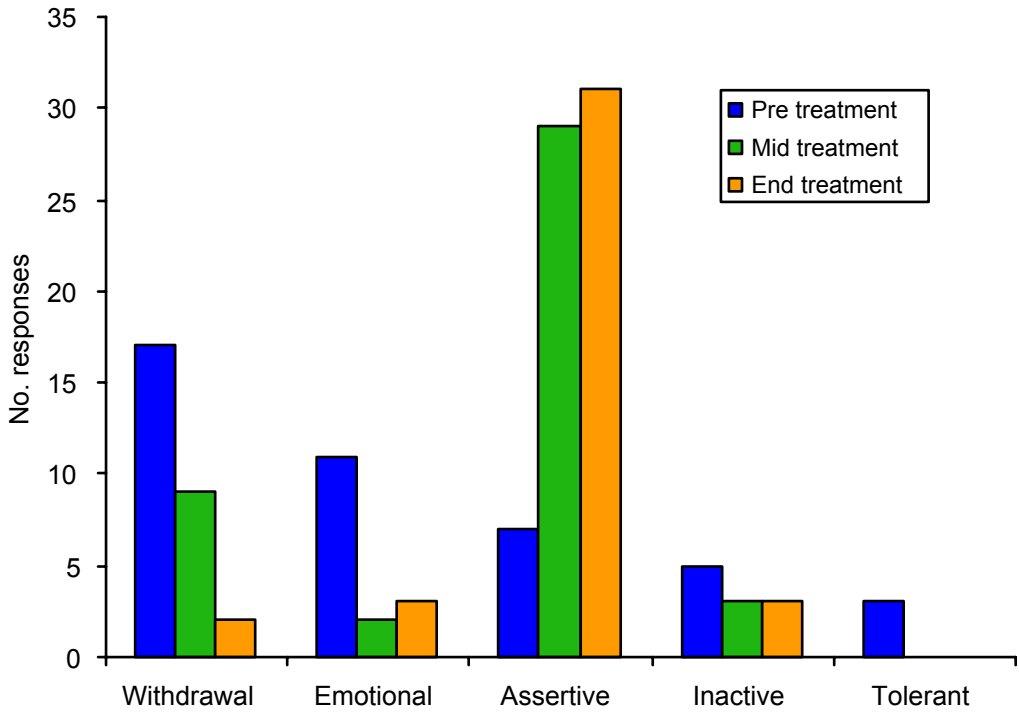

Figure 11.2 Thematic analyses of participants' responses to the question, "How do you handle that?" (i.e. most difficult situation in relation to drinkers' behaviour) from pre treatment through mid treatment and end treatment (n=43)

Participants' use of assertive coping strategies

Thematic analysis of participants' responses identified 4 themes within the assertiveness category. The number of participants' mid treatment and end treatment responses within each theme are in parentheses; viz.

1. Self care and responsibility (n=12 to n=18); e.g.
   - "He has to deal with the drinking now. I leave him with it and concentrate on doing nurturing things for myself."
   - "I'm not so involved and caught up in his problems. I realise I've got more power and choices."
   - "I use self talk. I'm a changed person and I have a strong will to keep using these mechanisms I've learned."
2. Assertive confrontation (n=7 to n=2); e.g.
   - "I work out what I want to say, I tell her and I leave it at that."
   - "I assertively confront him. I gradually let it slip without trying to control."
   - "I say something the following morning. When I do confront her, it's less blaming."
3. Clear messages (n=6 to n=8); e.g.
   - "I give clear messages about my boundaries and stick to what I say and trust my perceptions."
4. Support and encouragement (n=4 to n=7); e.g.
   - "I encourage him to work with me in the garden."

By the end of treatment, participants' predominant use of assertive coping strategies had again increased (n=29 to n=35, 81%). This reflected the thematic increase in participants' self care and responsibility, clear messages, and support and encouragement for their drinkers. However, participants' use of assertive *confrontation* strategies had considerably reduced.

One participant's description of how she handled her drinkers' covert aggression illustrated how she was caring for herself and utilising what she had learned from the Holyoake intervention; viz.

- "When he's talking very vehemently, I listen on the outside but inside I give myself positive messages so I don't get enmeshed in his stuff. That helps me stay separate."

The participants who reported experiencing no major difficulty in relation to their drinkers' behaviour (1 at mid treatment and 7 at end treatment) were asked what coping strategies they had found most effective. All reported predominantly utilising assertive coping strategies; viz. self care and responsibility (n=5), clear messages (n=1), and support and encouragement (n=1).

11.2.3 Changes during treatment in the outcome resulting from how participants were handling their major difficulties (see Appendix 6c)

Thematic analyses of participants' mid treatment and end treatment responses to the question, "What happens between you and your partner when you handle it [i.e. specified major difficulty] in that way?" revealed positive outcomes were generally associated with participants' assertive coping strategies or the combination of assertive and withdrawal coping strategies; e.g.

- "I don't stick around when she's drunk. I move away and don't listen. I use rational self talk and a clear message like, 'This is your stuff mate!'"

Participants reported no positive outcomes from the use of inactive or emotional coping strategies.

(i) The outcome associated with the use of assertive coping strategies

Self care and responsibility

Participants' self care and responsibility coping strategies were more often associated with positive than negative outcomes for drinkers and the relationships between participants and their drinkers; e.g.

- "He's talking more openly about the drinking and what he can do to help himself."
- "Her drinking's out in the open now and our relationship is better."

Whilst this strategy sometimes provoked drinkers' withdrawal, anger, and accusations that participants no longer cared about them, by the end of treatment, the

majority of participants who predominantly used this strategy reported positive outcomes for themselves; e.g.

- "It's very empowering to know that I can handle it and move on."
- "When the conversation's ended I'm not so ravaged. I still hate it and feel overwhelmed but I don't feel responsible for it and I don't think I've got to fix it or take away his pain."
- "My life is much more tolerable and I'm now feeling more confident to make changes."

Clear messages

By mid treatment, participants who used this strategy (n=6) generally reported negative reactions from their drinkers; e.g.

- "He increases the pressure to make me conform to his wishes"; and
- "He actively resists before submitting."

However, by the end of treatment, there was an increase in participants' use of clear messages (n=8), and the outcomes were more positive; e.g.

- "He listens when I stick to 'I' statements."
- "He's starting to voice his opinions too."

Assertive confrontation

By mid treatment, participants who used assertive confrontation strategies (n=7) reported equally positive; (e.g. "He started paying attention") and negative outcomes (e.g. "He gets furious"). One participant illustrated this mixed result; viz.

- "She gets really upset and defensive and tries to shift the focus back onto me. I feel better for telling her though."

By the end of treatment, only 2 participants had reported the use of assertive confrontation strategies, with mostly positive outcomes; viz.

- "It's a bit more settled now and I get some sort of an apology. But it means nothing. I'm going to expect more from her. As long as I keep focussing back on how *I* feel, I'll probably get somewhere."
- "She continues ranting and raving but I say what I need to and walk out. When I return she's calm."

Support and encouragement

Participants' who used support and encouragement as their predominant coping strategy during treatment (i.e. n=4 at mid treatment to n=7 at end treatment) generally achieved good results; e.g. a mother reported helping her son (a heroin user) by buying small things for his house and baby. Her son offered payment in kind by cleaning her house, which seemed to give him a sense of pride. However, others reported that their drinkers were reluctant to take part in simple family activities, especially where some degree of communication was expected.

(ii) The outcome associated with the use of withdrawal coping strategies

Participants who used withdrawal as their *predominant* coping strategy generally reported negative results for their drinkers, their relationships, and themselves; e.g.

- "He repeats himself and talks to me more. If I don't answer him there's a row."
- "I'm living my own life."
- "I'm lonely and I don't get to talk about my issues."

However, 2 participants who used withdrawal strategies reported being better understood and accepted by their drinkers and felt more positive about their situations; e.g. "Sometimes we talk about it."

Thus, it seemed that withdrawal strategies may have given participants and their drinkers time and space to calm down and think about how to handle their situation, particularly if accompanied by assertive communication.

(iii) The outcome associated with participants' use of emotional or inactive coping strategies

No positive outcomes for participants, drinkers or their relationship with participants were associated with inactive or emotional strategies. Inactive strategies provoked drinkers to increase their manipulative pressure, and emotional coping resulted in increased discord. It was interesting to note one participant's description of the usual train of events following her emotional coping strategies; viz.

- "He's remorseful about me getting upset but not about the drinking. He's angry that I'm causing the fights and says I'm imagining it. It ends up with a fight and we sleep in separate rooms. Next morning, he'll bring me a cup of tea as if nothing's happened."

11.2.4 Summary and discussion regarding changes during treatment in participants' primary difficulty with their drinkers' behaviour, how they dealt with this, and the outcome

(i) Changes in participants' primary difficulty with their drinkers' behaviour

By the end of treatment, 16% of participants (n=7) claimed to be no longer grappling with any major difficulty in relation to their drinkers' behaviour. This was likely to have been related to reductions in their drinkers' alcohol consumption. However, the quantitative data (see Table 9.22) identified 21 participants who had reported *substantial* changes in their drinkers' consumption by the end of treatment. These data suggest the need for therapeutic intervention with excessive drinkers (and their relatives) *after* they have reduced their excessive consumption to repair, preserve, and enrich their relationships.

Participants' primary difficulty with isolation within their relationships

According to the data received from the remaining 36 participants, both quantitative and qualitative changes had occurred during treatment in what participants were finding most difficult to handle in relation to their drinkers' behaviour (see Appendix 6a). For instance, the number of participants' responses within the "isolation within the relationship" category had reduced from a pre treatment level of n=14 (33%) to n=9 (21%) at end treatment. However, thematic changes within this category revealed that despite the improvement in communication which had occurred between

participants and their drinkers, some were still experiencing major challenges with the loss of their drinkers *as companions* (n=6).

This was consistent with the quantitative data presented in Chapter 9 which found that despite significant improvements in the *quality* of everyday interactions between participants and their drinkers (only when drinkers were drinking as opposed to not drinking),[7] there was no corresponding improvement in participants' marital state (e.g. shared interests, communication, warmth and love, and trust and respect).

Participants' primary difficulty with drinkers' abusive behaviour

Similarly, the number of participants' responses within the drinkers' "abusive behaviour" category had reduced from n=12 (28%) at pre treatment to n=6 (14%) at end treatment. However, the *nature* of participants' difficulty in dealing with their drinkers' abusive behaviour at pre treatment had undergone substantial change by the end of treatment. For instance, by mid treatment through end treatment, drinkers' blaming behaviour and aggressive mood swings were no longer of serious concern for participants. However, this improvement was accompanied by an increase in the number of participants who were now grappling with their drinkers' anger and aggression.

This was consistent with the quantitative data which found that drinkers' verbal and emotional abuse did not significantly reduce until 3 months and 6 months post treatment. However, marital discord (e.g. participants' irritability and anger due to their drinkers' behaviour, and drinkers' abuse) had significantly *decreased* by mid treatment and was sustained through 6 months post treatment. This suggests that participants had become more aware of their drinkers' manipulative behaviour patterns and had reduced their reactive behaviour accordingly. Thus, it seemed that participants were no longer seriously concerned about their drinkers' attempts to blame and provoke. Rather, they were likely to be putting their intervention program into action. As one participant said:

- "I've stopped reacting…I'm learning to walk away from it...I let it go."

Moreover, as participants reduced their *contribution* to the level of family tension by reducing their reactivity to their drinkers' unacceptable behaviour, drinkers'

were likely to have reciprocally benefited. However, more basically, given these blaming behaviours and aggressive mood swings no longer facilitated drinkers' relief of tension feelings *so successfully* (i.e. participants were not so ready to co-operate by reacting), drinkers may have decided to stop using them.

This reduction in drinkers' options to relieve their negative feelings may help to explain the corresponding increase in drinkers' anger and aggression which had occurred by mid treatment. Moreover, this may have also been indicative of the period of instability which may have occurred as participants disengaged from the interdependent stress, coping and transactional patterns which had enabled drinkers' unacceptable behaviour to continue. It is likely that drinkers increased their pressure on participants to provoke them back into the more familiar patterns of behaviour where drinkers were more in control of the choreography and therefore much more comfortable. One participant's comment illustrates this supposition; viz. "He increases pressure to make me conform to his wishes."

This was consistent with the quantitative data presented in Chapter 9 which found that the quality of everyday interactions between participants and their drinkers did not significantly improve until 3 months post treatment. Similarly, given drinkers' verbal abuse had not significantly decreased until 3 months post treatment, participants were likely to be experiencing considerable struggle to maintain their action plans in the face of their drinkers' reactions to the changes they (participants) were making.

Participants' primary difficulty with their drinkers' consumption behaviour

The number of participants who identified their drinkers' consumption behaviour as their primary difficulty had *increased* between pre treatment and end treatment (from n=11, 25% to n=15, 35%). This increase *seemed* inconsistent with the significant *decrease* in drinkers' consumption reported in Chapter 9. However, an exploration of the themes within the "consumption behaviour" category illustrated that changes in the *nature* of participants' difficulty with their drinkers' consumption behaviour had occurred during treatment.

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[7] The quality of interactions between participants and drinkers when drinkers were not drinking did not improve significantly until 3 months post treatment

For instance, by mid treatment, participants were no longer seriously concerned with their drinkers' intoxicated behaviour (n=6) or excessive intake (n=5). Rather they were now more concerned about their drinkers' welfare (n=7), their drinkers' resistance to change (n=4) or drinkers' maintenance of reduced consumption (n=3). This suggests that the Holyoake intervention had been successful in raising participants' awareness about the process of dependency and its impact upon their drinkers. Moreover, that participants were likely to be responding to the beginning reduction in their drinkers' consumption as reported in Chapter 9).

By end treatment, participants' were no longer grappling with whether their drinkers would maintain their reduced consumption, nor were they as seriously concerned about their drinkers' welfare or resistance to change. Given the significant reduction in drinkers' consumption found by the quantitative data, participants were perhaps more relaxed about the changes their drinkers were making. Moreover, as participants were becoming more confident about the changes that they themselves were making, it is likely that they were leaving the excessive drinking and associated problems where they belonged – with their drinkers.

However, by the end of treatment, drinkers' irresponsible behaviour had emerged as a serious issue for some participants (n=4) and drinkers' excessive consumption had re-emerged as a primary difficulty for others (n=5, 12%). This was consistent with the quantitative data presented in Chapter 9 which found 37% of participants (n=16) reported that their drinkers had made no change in their drinking or had actually increased their consumption by the end of participants' treatment program.

Participants' primary difficulty with their own personal issues

Whilst the number of participants' responses within the "personal issues" category of primary difficulty had more than doubled between pre treatment and mid treatment (from n=6, 14% to n=15, 35%), the number of participants' responses had returned to pre treatment levels by the end of treatment (n=6, 14%). The mid treatment surge in the number of participants' responses within this category demonstrated how these participants were now grappling with issues raised by the intervention program; e.g. the need to take more responsibility for their own emotions (n=8), the need to effectively communicate their concerns to their drinkers (n=4), to decrease their inappropriate responsibilities (n=3) and make plans for their future (n=2).

By the end of treatment, whilst some participants' responses revealed an ongoing difficulty with planning for the future (i.e. whether to separate from their drinkers), others were now grappling with the challenge of maintaining their action plan (n=2) and re-establishing trust with their drinkers (n=2).

(ii) Changes in participants' coping strategies during treatment

Participants' responses to the question, "How do you usually handle that?[8] revealed a huge, progressive decrease in their predominant coping strategies between pre

treatment through mid treatment and end treatment (see Appendix 6b); viz.

- Withdrawal (from n=17, 40%; to n=9, 21%; to n=2, 5%);
- Emotional (from n=11, 26%; to n=2, 5%; to n=3, 7%);
- Inactive (from n=5, 11%; to n=3, 7%; to n=3, 7%); and
- Tolerant (from n=3, 7%; to n=0; to n=0).

Moreover, analysis of participants' responses to the "How do you usually handle that?" question revealed participants had progressively substituted more assertive coping strategies from pre treatment levels through mid treatment and end treatment (i.e. n=7, 16%; to n=29, 67%; to n=35, 81%). More specifically, participants had increased their use of particular strategies between mid treatment and end treatment; viz.

- Self care and responsibility (n=12, 28%; to n=18, 42%);
- Clear messages (n=6, 14%; to n=8, 19%); and
- Support and encouragement for their drinkers (n=4, 9%; to n=7, 16%).

However, although participants' use of self care and responsibility, clear messages and support and encouragement had substantially *increased* during treatment, their use of assertive *confrontation* strategies had *decreased* from n=7, 16% at mid treatment to n=2, 5% at end treatment. This may have been because 63% (n=27) of participants had reported a decrease in their drinkers' consumption by the end of

[8] i.e. What participants had identified as their primary area of difficulty since their last interview (5 weeks)

treatment (see Chapter 9). Thus, assertive confrontation may have no longer been necessary or appropriate.

Similarly, participants' use of the assertive confrontation strategies as measured quantitatively by the Drinkers' Partners' Coping Questionnaire (DPCQ)[9] had not increased by the end of treatment. The assertive subscale from the DPCQ asked questions about assertive confrontation, supporting drinkers' reduced consumption, or reducing dependence upon drinkers. Participants' responses indicated their use of these strategies had remained within the "sometimes" range throughout treatment. The assertive confrontation questions were as follows:

- Made it quite clear to your partner (when h/she was sober) that their drinking or other drug use was causing you upset and that you wanted them to do something about it;
- Made it quite clear to your partner (when he/she was sober) that you wouldn't accept their reasons for drinking or drugging, or cover up for them;
- Calmly and firmly communicated to your partner that something they had done (or planned to do) was unacceptable;
- Sat down with your partner and talked frankly about what could be done about the drinking or other drug use; and
- Clearly told your partner (when s/he was sober) what you expected them to contribute to the family.

Most people find assertive confrontation difficult. This difficulty is especially exacerbated where there is an addiction problem with associated anger and aggression (e.g. Barber & Crisp, 1995). In fact, Miller, Meyers, and Tonigan (1999) spent considerable time *tutoring* partners of excessive drinkers on *how* to communicate their feelings, needs and concerns effectively. This was because Miller et al. were training partners to be intervention agents. According to Miller et al., several role-play sessions were required before partners thoroughly learned the principles of assertive confrontation and were able to use them effectively in difficult situations.

However, the Holyoake intervention aimed to improve the mental health and coping status of participants *without training them as intervention agents.* Participants were presented with only one formal communication session which aimed to (i) raise

[9] Developed by the current author

their awareness of passive, aggressive and assertive communication styles, and (ii) increase their ability to actively listen and communicate feelings without blaming. Therefore, it was not surprising to find that participants use of assertive confrontation as measured by the DPCQ did not significantly increase during treatment.

Not only were participants not sufficiently trained in assertive confrontation in particular, their drinkers' reactions to their attempts to use this approach were likely to have made it even more difficult; e.g.

- "He gets furious. It's still difficult."
- "He makes an angry retort."
- "He accuses me of not listening, not loving him and not being a friend."
- "She gets really defensive and tries to shift the focus back onto me. I feel better for telling her though."

Despite drinkers' active resistance and increased anger and aggression which had occurred by mid treatment (replacing blaming and aggressive mood swings), participants had continued to increase their use of assertive coping strategies by end treatment
(n=35, 81%). In particular, they seemed to be putting the Holyoake program into practice by increasing self care and responsibility, the use of clear messages, and support and encouragement for their drinkers. Thus, participants were demonstrating persistence, courage, and determination to maintain their action plan. Moreover, given the consistency between participants' attributions for their improved coping were completely consistent with the aims and objectives of the Holyoake intervention, it was reasonable to assume that the increase in participants' assertive coping strategies were indeed related to the intervention.

By end treatment, previously resistant drinkers may have realised that their attempts to restore the status quo by provoking participants to return to the more familiar, interdependent coping patterns had failed. Thus, participants' persistence, courage and determination was finally rewarded; e.g.

- "He works through his anger on his own. He's better."
- "He's starting to voice his opinions too."
- He's talking more openly about the impact of the drinking and what he can do to help himself."

- "Because I've made a change, he's made a change. Therefore, it's changed things for both of us."

Changes in outcome as a result of participants' changed coping strategies

Analysis of participants' responses to the question, "What happens between you when you handle it that way?" revealed very few positive outcomes for participants, or their relationships were associated with the use of withdrawal, emotional, inactive, or tolerant coping strategies. Moreover, these particular coping strategies usually provided drinkers with the opportunity to continue (or even increase) their unacceptable consumption and behaviour.

Whilst participants' withdrawal strategies at best temporarily calmed drinkers down, participants were left feeling helpless, confused and distressed. Emotional coping strategies always resulted in increased marital discord and usually left participants feeling guilty. Inactive strategies seemed to encourage drinkers to provoke and re-engage participants, and tolerant strategies left participants feeling deeply resentful and angry;

On the other hand, participants' responses to the "What happens between you…" question revealed mixed outcomes associated with the use of assertive coping strategies. Whilst the positive outcomes for participants, their drinkers and their relationships had generally outweighed the negative *by the end of treatment* participants' mid treatment responses revealed the considerable resistance many of their drinkers had mounted in reaction to participants' changed behaviour; e.g.

- "He withdraws and gets angry."
- "He's less involved in the family."
- "The relationship is distant."
- "He shrugs it off. I don't think he cares."
- "He gets defensive."
- "He increases the pressure to make me conform to his wishes."
- "He actively resists before submitting."

Thus, the qualitative data has indeed supported, elaborated, and enriched the quantitative data presented in Chapter 9. It has explored how participants used what they were learning in the Holyoake intervention to deal more effectively with the most

salient issues in relation to their drinkers' behaviour. By the end of treatment, participants seemed to be no longer feeling helpless, confused, guilty, resentful and angry. Rather their self control, confidence, and self esteem seemed to have returned which helped them to do what was necessary to improve their situations. Moreover, the qualitative data has highlighted the courage and determination of participants in this study to continue to take responsibility for their own well being – regardless of the cost. According to one participant; "I'm prepared to do something even if it does threaten our relationship."

11.3 Changes during treatment in how participants handled their <u>overall</u> situations with their drinkers (see Appendix 7)

In addition to the more specific question regarding how participants handled their primary difficulties with their drinkers, participants were also asked to respond to the more global question (if they had reported a change had occurred), "What's different about how you're handling your *overall* situation with your partner (or other family member)?" Analysis of participants' mid treatment and end treatment responses to this question revealed 4 categories of change had occurred. The number of participants' mid treatment and end treatment responses within each category are in parentheses. It was interesting to note the considerable increase in the number of responses within the personal responsibility category between mid treatment and end treatment; viz.

- <u>Improved emotional health</u> (n=16, 37%; to n=16, 37%)
- <u>Improved personal responsibility</u> (n=13, 30%; to n=19, 44%)
- <u>Improved communication</u> (n=10, 23%; to n=8, 19%)
- <u>No change</u> (n=4 to n=0)

Moreover, participants' mid treatment responses to this question revealed an overwhelming majority (n=39, 91%) had experienced a significant change, and this had increased to 100% by the end of treatment (see Figure 11.3). Appendix 7 has presented examples of participants' responses within the themes emerging from each category**.**

a) Increased self efficacy

Within the improved emotional health category, 3 themes had emerged by mid treatment which were largely sustained through end treatment; viz.

1. Self containment (n=7 to n=5); e.g.
   - "Trying not to let the drinking worry me so much instead of fretting and getting myself tied up in knots."
2. Emotional control (n=7 to n=8); e.g.
   - "I don't scream and hit him any more."
3. Confidence (n=2 to n=3); e.g.
   - "I feel more confident about the way I handle things."

b) Increased personal responsibility

Within the "increased personal responsibility" category, 2 themes had emerged by mid treatment. the number of participants' responses within each theme had increased by the end of treatment ; viz.

1. Improved boundaries (n=7 to n=9); e.g.
   - "I'm more aware of the need to have boundaries and stick by what I say."
   - "I'm not taking his emotional junk on board any more. He hasn't been dishing it out any more because he's realised I won't accept it."
2. Self care (n=6 to n=10) e.g.
   - "I care more about myself now."
   - "When I make a decision I stick to it. It's not made in haste or anger now."

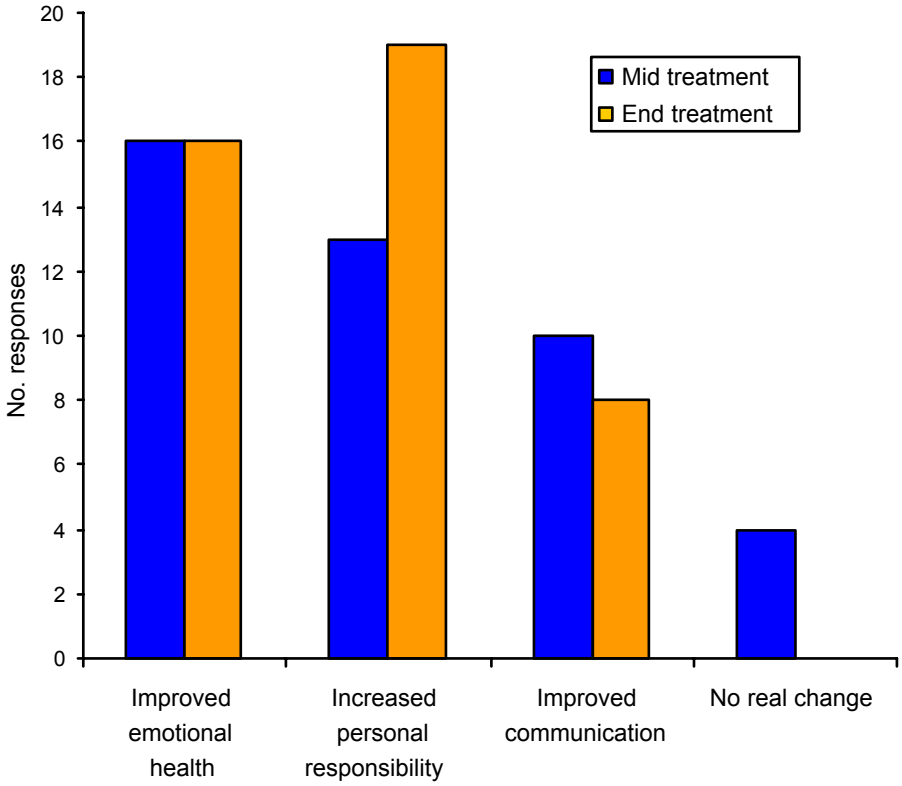

Figure 11.3 Categorisation of participants' mid treatment and end treatment responses to the question, "What's different about how you're handling your overall situation with your partner?"

b) Improved communication

Within the improved communication category 3 themes had emerged by mid treatment; viz.

1. Clear messages (n=6); e.g.
   - "I say what I've got to say and walk away."
2. Improved sharing (n=2); e.g.
   - "We have gone out of the reactive relationship and are actually able to sit down and communicate."

3. Understanding the situation (n=2); e.g.
   - "I now have a clearer understanding of the tough love approach. I'm backing off and controlling less."

However, by the end of treatment, only 2 themes had remained within the improved communication category; viz.

1. Clear messages (n=6 to n=5); e.g.
   - "I have more courage to share my feelings with my partner. If I'm angry he collects it and wears it."
2. Planned confrontation (n=3); e.g.
   - "I don't bottle it up now. I wait until the morning to say what I need to say."

d) No change (n=4 to n=0)

By the end of treatment, the number of responses in the "no change" category had reduced to zero.

11.3.1 Summary and discussion regarding changes during treatment in how participants were handling their *overall* situations with their drinkers

If participants reported they had changed how they were handling their overall situations with their drinkers, they were then asked, "What's different about how you're handling your overall situation?" If participants' supplied more than one difference in how they were handling their situations, they were asked to choose the *most* important one. Participants' responses to this more global question were not only entirely consistent with their previous responses to, "How do you usually handle [your most difficult situation with your drinker]", they provided additional information regarding participants' experiences during treatment and how they were applying what they had learned from the Holyoake intervention.

For instance, participants' responses identified 3 categories of change which described how they were handling their overall situations; viz. improved emotional health (n=16, 37%), increased personal responsibility (n=12, 30%), and improved communication (n=10, 23%). Whilst participants had previously identified personal responsibility and communication as important in their improved ability to handle their most difficult situations, improved emotional health had not previously emerged as an important qualitative category of change. However, participants' responses had already

previously demonstrated the close relationship between personal responsibility, communication and emotional health; e.g.

- "I give clear messages about my boundaries and stick to what I say and trust my perceptions."
- "I'm not so caught up in his problems. I realise I've got more power and choices."

Thematic analysis of participants' responses within each category has revealed additional information regarding participants' experiences during treatment and how they were applying the principles of the intervention program.

For instance, within the improved emotional health category, participants spoke of their improved ability to contain and control their emotions, and to control their reactive (sometimes even violent) behaviour, *despite being abused by their drinkers*.

It was not surprising that this substantial improvement in participants' ability to handle their situations (and indeed themselves!) was accompanied by renewed self confidence. This qualitative improvement in emotional health was consistent with the quantitative reductions in participants' emotionality as reflected by significantly reduced somatic anxiety, free floating anxiety, obsessionality and depression. Participants had calmed down enough to think, were applying what they had learned, and were largely maintaining their emotional equilibrium. Thus, by the end of treatment, rather than "plunging in without thinking", participants were behaving in ways which had gradually strengthened their emotional resilience.

Although participants were managing their situations much more effectively, it was important to recognise and validate their ongoing effort, persistence, determination, and courage as they learned to successfully apply the principles of the intervention program to their lives.

The second categorical change which participants identified as important in improving their ability to handle their overall situations with their drinkers was increased personal responsibility. The Holyoake intervention gave great emphasis to this (as did Miller et al. 1999). Whilst personal responsibility and one of its embedded themes of self care has recurred throughout the research, participants' responses revealed another important aspect of self responsibility which participants were applying; i.e. improved boundaries.

The need for participants to improve and strengthen their personal boundaries and reduce their emotional "fusion" with their drinkers was also highlighted by one of the male participants in his pre treatment response to the "How do you hope the Holyoake program will help you?" question; viz.

- "I just want to be able to wake up in the morning and not have to look at her to see what kind of a day I am going to have."

The third category of change which participants identified as important in how they were handling their overall situations was communication with embedded themes of clear messages, improved sharing, and understanding. Whilst the importance of giving clear messages has previously been identified, one participant's response within the "improved sharing" theme highlighted the need for participants to maintain their action plan until their drinkers are "ready" to abandon their campaign of active resistance and become "willing" to learn the steps of the new choreography.

Moreover, given participants' improved emotional health, renewed confidence, and commitment to taking responsibility for their own feelings, needs and concerns, they were breaking through the once debilitating fear barrier ("He'll only get upset and drink if I tell him how I feel").

The importance of the educational component of the intervention program in helping participants understand the dynamics of the process of dependency, its impact upon drinkers and their families, and how participants could improve their situations was also highlighted by participant's responses; e.g. "I give him heaps of information, support, and understanding."

11.4 Participants' identification of what most helped to more effectively handle their situations (see Appendix 8)

Participants (n=43) were asked at mid treatment and end treatment, "What is the most important thing which has helped you deal more effectively with your situation?" If participants identified more than one element, they were asked to choose which one had been most helpful. Thematic analysis of participants' mid treatment and end treatment responses revealed 4 categories of most important help (the number of

participants' responses at mid treatment and end treatment within each category are in parentheses); viz.

1. Personal empowerment (n=18, 42% to n=29, 67%)
2. Raised awareness (n=15, 35% to n=6, 14%)
3. Group therapy (n=7, 16% to n=3, 7%)
4. New skills and strategies (n=3, 7% to n=5, 12%)

As Figure 11.4 has illustrated, the number of participants' responses within the personal empowerment category increased considerably during treatment. Similarly, there was an increase in the number of responses within the "new skills and strategies" category. However, the number of responses classified within the "raised awareness" category had more than halved between mid treatment and end treatment, and the number of responses within the group therapy theme had similarly reduced.

1. Personal empowerment

Within the personal empowerment category, 2 themes had emerged from participants' responses; viz.

(i) Responsibility for self (n=13 to n=19) , e.g.

- "My future is up to me. I tended to live in the past in a regurgitating manner. Now I live in the now - the only moment I *can* control."
- "I get back and really look at what I want in life instead of running ragged trying to please everyone else."

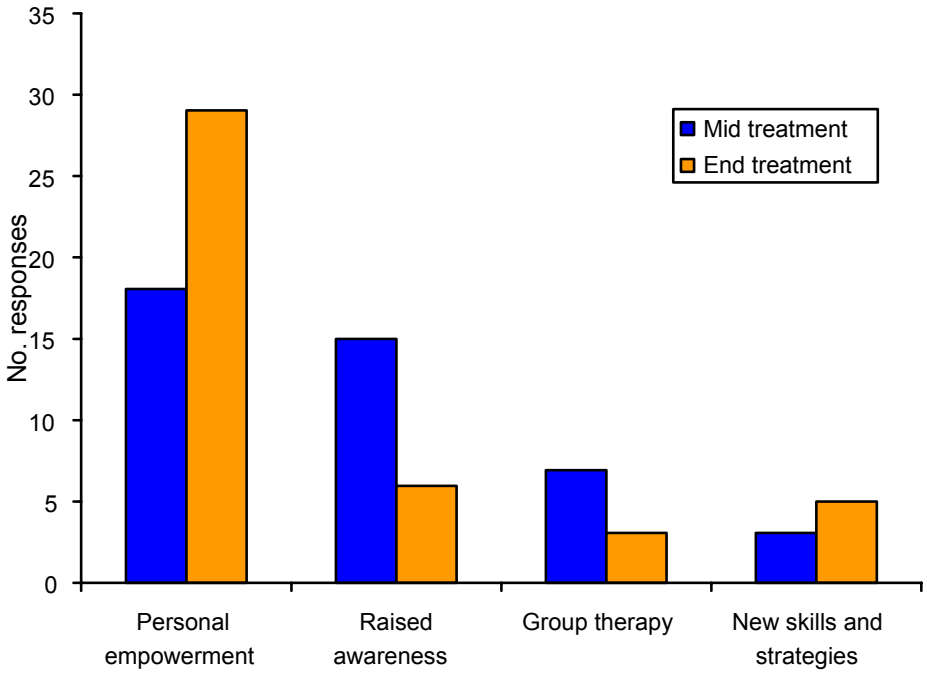

Figure 11.4 Thematic analyses of participants' mid treatment and end treatment responses to the question, "What's the most important thing which has helped you deal more effectively with your situation? (n=43)

- "I learned that it's *my* life and I'm the only one who can make it better - or worse!"

(ii) Self efficacy (n=5 to n=10); e.g.

- "It's helped me to strengthen up and feel more free to actually be myself."
- "The single best thing internally about coming to Holyoake is that it sort of gives you courage somehow."

2. Raised awareness (n=15, 35% to n=6, 14%)

Within the raised awareness category, 2 themes had emerged from participants' responses; viz.

(i) Understanding personal situation (n=11 to n=5); e.g.

- "It's made me aware of just what the problem is at home and that I have a responsibility to myself and my children."
- "The systematic way of looking at relationships, how we think, believe, and behave and what influences us and how you view it was very helpful."

(ii) Not alone (n=4 to n=1); e.g.

- "Knowing I'm not alone. They help you talk. You can explain yourself better without being threatened and without putting them on guard."

3. **Group therapy** (n=7, 16% to n=3, 7%)

- "Being able to talk about things and saying how you feel about things you've had bottled up for years and never had the chance to talk about."
- "You get a bond and trust with people who have suffered and have the strength to talk about it and come up with positive ways of dealing with it."

4. New skills and strategies (n=3, 7% to n=5, 12%)

- "It's teaching me how to handle the situation in a different way. I say and do things differently. I speak to him calmly."
- "Now I don't accept behaviour I was prepared to in the past because I was trying to provide a nurturing environment - no matter what he did!"

11.4.1 Summary and discussion regarding participants' identification of what helped them most to deal more effectively with their situations

By mid treatment, 42% of participants had identified personal empowerment as most helpful in assisting them to handle their situations more effectively. The remaining 58% identified raised awareness (35%), group therapy (16%), and new skills and strategies (7%) as most helpful. However, by the end of treatment, the majority of participants (67%) identified personal empowerment as being most helpful in assisting them to deal more effectively with their situations. This reflected the considerable increase in the 2 embedded themes; viz. "responsibility for self" and "self efficacy". Moreover, by the end of treatment, the number of participants who had identified skills and strategies as most helpful had also increased.

On the other hand, by the end of treatment, there had been a reduction in the number of participants who had identified raised awareness and group therapy as most helpful in assisting them to deal more effectively with their situations.

The sharp reduction in the helpfulness of the raised awareness and group therapy categories between mid treatment and end treatment supports Prochaska, Norcross, and DiClemente's (1994) claim that these processes are most helpful in earlier rather than later stages of change. Thus, it seemed that most participants' need for information, support, encouragement and validation were satisfied during the first 5 sessions of the program. As participants' self responsibility and self efficacy grew, and they had become more confident and adept in the application of what they were learning from the intervention program, it was likely that they began to rely more and more on their own resources.

Not only are these data consistent with participants' previous reports of how they improved their ability to cope with their situations, they are also consistent with the quantitative data presented in Chapter 9 which found early improvement in participants' emotional resilience had consolidated and strengthened by the end of treatment due to reductions in anxiety and depression (as measured by the DPDS).

It was interesting to note the small number of participants who had identified new skills and strategies (12%, n=5 at end treatment) as most helpful in assisting them to deal more effectively with their situations. However, this is understandable, given the psycho-educational nature of the Holyoake intervention. Information from the educational components of the program were processed in group and participants were encouraged to share their experiences. No formal teaching of skills and strategies were undertaken. Thus, participants were given the opportunity to learn from the educational presentations, from the program manual, and from each other's experiences in group.

11.5 Changes in the quality of relationships between participants and drinkers throughout treatment

Participants were asked at mid treatment and end treatment whether a change had occurred in the quality of their relationships with their drinkers. If a change was so identified, participants were then asked;

(i) "What's different about the quality of your relationship with your partner (or other family member) and how you interact together?" and

(ii) "What do you think has prompted that change?"

By the end of treatment, 23 participants (53%) reported that their relationships had improved. Although a further 6 participants (14%) had reported an improvement by mid treatment, this was not sustained through end treatment. Fourteen participants (33%) reported no improvement in the quality of their relationships throughout treatment. When responses from participants (n=19, 44%) who had reported *sustained* improvement in their relationships throughout treatment were thematically analysed, 3 categories had emerged; viz.

1. Open and honest communication; e.g.
   - "He's much better to me. A lot nicer, more open and seems more honest."
   - "It's a bit more even and less defensive. Our interactions are a bit more equal."
2. Warmth and enjoyment; e.g.
   - "We're talking and laughing and enjoying being in each other's company."
   - "There's more warmth and humour. We're more at ease with each other. We even joke about things."
3. Reduced discord; e.g.
   - "It's good. He's usually not drinking so we don't fight."
   - "It's better because *I'm* not arguing all the time."

When participants who reported *sustained* improvements in their relationships were asked what they thought had prompted these positive outcomes, they all attributed them to their drinkers' responses to changes *in their own behaviour*.

It was interesting to note that all participants who reported a *sustained* improvement in (i) open and honest communication and (ii) warmth and enjoyment in their relationships had also reported a reduction in their drinkers' consumption.

11.5.1 Summary and discussion regarding changes in relationships between participants and their drinkers

By the end of treatment, 53% (n=23) of participants had reported that their relationships with their drinkers had improved. This was consistent with the quantitative data (see Chapter 9) which found significant reductions in marital discord and drinkers' verbal abuse, accompanied by significant improvement in the quality of interactions between participants and their drinkers (when drinkers were drinking as opposed to not drinking). Whilst this may have been merely due to the absence of conflict, these data are consistent with the qualitative evidence from 53% (n=23) of participants that their relationships with their drinkers had improved.

Participants' responses to the "What do you think prompted that change?" question revealed their willingness to assume more responsibility for their own needs. Moreover, their responses highlighted the impact participants' increased self care and responsibility, increased self efficacy and improved communication ability was having on their drinkers.

This seemed to support the supposition made previously that once drinkers' unacceptable behaviour no longer worked, they were likely to stop using it. Just as participants were able to recognise the interdependent stress, coping and transactional patterns that had developed between themselves and their drinkers, and take remedial action, they similarly recognised the positive, ongoing impact of their changed behaviour patterns on their drinkers. Thus, the status quo was in the process of being dismantled.

Participants were increasingly demonstrating their self efficacy; ability to set and maintain personal boundaries; increased ability to take responsibility for their own feelings, needs and concerns; and ability to relinquish inappropriate responsibilities. Thus, by "getting back and really looking at what [they] wanted in life instead of running ragged trying to please everyone else", participants were offering the same opportunity to their drinkers.

Many drinkers responded to participants' modeling and changed behaviour (which was far more attractive than before) by putting some of the same choreography into action into their own lives. This has given additional support to Orford's (1994) stress/coping and transactional model where each successful coping episode between two people results in increased learning about themselves and each other. Moreover, the

reciprocal impact as a result of how each person handles the situation provides a guide for how they approach difficult situations in the future.

It was interesting to note that whilst 67% (n=29) of participants had reported improved relationships with their drinkers by mid treatment, only 53% (n=23) reported that this improvement had been sustained through end treatment. One of the reasons for this may have been that drinkers were initially responding to their perceptions of the reasons for participants' changed behaviour; e.g. "…He thinks I'm having an affair." Many participants reported that they thought their drinkers' improved behaviour (which helped to facilitate the improved relationship) was merely manipulative to "encourage" them to "come to their senses" and restore the status quo. When these drinkers realised that participants were serious about the changes they had made, and were determined to maintain them, they seemed no longer willing to cooperate.

However, whatever reasons may be mused upon, the non sustainability of changes in drinkers' behaviour definitely illustrated the fragility of change.

By the end of treatment, some participants (n=17, 40%) had identified their drinkers' excessive consumption (n=5), anger and aggression (n=5), irresponsibility (n=4), resistance to change (n=2), and aggressive mood swings (n=1) as most difficult to handle. Therefore, it was not surprising that 33% (n=14) had reported no improvement in their relationships.

These data were consistent with the quantitative evidence presented in Chapter 9. For instance, despite the significant improvement in the quality of everyday interactions between participants and their drinkers *when drinkers were drinking,* the corresponding improvement in the quality of their interactions when drinkers were *not* drinking did not occur until 3 months post treatment. This suggests that participants and their drinkers were not enjoying non drinking time together. Similarly, although a statistically significant improvement in marital state had occurred 6 months post treatment, the improvement from "very severe problems" to "severe problems" was obviously not clinically significant. Moreover, these data were consistent with the number of participants who reported that their drinkers had made no change in their consumption or had even increased it.

11.6 Changes in drinkers' consumption during participants' intervention program

Participants were asked at their mid treatment and end treatment interviews whether they had observed any changes in their drinkers' consumption and/or behaviour. If a change was reported, participants were asked what they thought had prompted these changes. By mid treatment, 31 participants (72%) had reported various degrees of change; viz. 20 (47%) of their drinkers had reduced their consumption, and 7 (16%) had sought help. On the other hand, eight participants reported an improvement in their drinkers' behaviour *despite no reductions in consumption*. However, four participants reported an *increase* in their drinkers' consumption which was accompanied by deteriorated behaviour.

Drinkers' reduced consumption (n=20)

Some participants (n=3) reported their drinkers had made initial, albeit temporary reductions; e.g. "At first he stopped and did a few sessions at Holyoake's treatment program for dependents, but now he's back drinking again. It gives him a speech impediment and I know." Participants' attributions for these changes were;

- "It's me coming to Holyoake and being different. Not trying to control him and interfering in things which are not my business."

Another participant reported her husband's see-saw reactions to her changed confidence and assertiveness (she hadn't told him she was attending Holyoake); "In the first 3 weeks of the program, he increased his drinking and verbal abuse. It's now much better and he's coming home earlier because he thinks I'm having an affair!"

However, by the end of treatment, this drinkers' consumption had again escalated ("It's out of character") because by now he was *sure* she must have been having an affair, whereas she was merely, "Off with my new life."

By the end of treatment, 20 (47%) of participants reported their drinkers had reduced to varying degrees. Sixteen of these had maintained the reductions they had made by mid treatment. When participants' attributions for change were analysed, the predominant reason (n=13) given for the reductions in drinkers' behaviour was *in reaction to changes in participants' behaviour*; e.g.

- "It's a ripple effect from me coming to Holyoake. He knows I have a problem with his drinking and it's a diffuse response to that."
- "It's me changing. I've got out of that nagging reactive role. I never put any pressure on him. He could see the benefits it was having on me."
- "I think it's basically me telling her how I feel about the drinking."
- "It must be me. I'm the only one that's done anything about the drinking. There's something in me that he didn't see before. He knows he can't fight me. It doesn't work. Usually he'd yell and scream and I'd buckle under. It's good finding the strength."
- "Because I have made a change he has made a change. He's definitely cut down on his drinking. Therefore, it's changed things for both of us."

Other reasons given by participants for their drinkers' reduced consumption were lack of money and employment concerns (n=4), participants setting clear limits (n=2), and increased involvement with the family (n=1); e.g.

- "I know he really wants to drink but he finds it difficult because I've got a much firmer approach to it. He knows I would remove myself from the situation if he ever drank again."
- "He now enjoys being with the kids."

Drinkers' help seeking behaviour (n=7)

By mid treatment, 7 participants reported their drinkers had sought help; viz. 2 at Holyoake, 2 at another alcohol/other drug agency; 1 at Alcoholics Anonymous; 1 with a psychologist, and 1 with a medical practitioner. Five of these had reduced their consumption as well as seeking help, and sustained their reductions through end treatment. Analysis of participants' attributions for the changed behaviour revealed that drinkers were under considerable pressure; e.g.

- "Although his environment at home is generally supportive, there are strong elements of rejection regarding some elements of his behaviour."
- "I insisted because he'd been violent towards me."
- "He's scared he'll wake up one morning and I'll be gone."
- "I think it was because I'd come for help at Holyoake."

- "Maybe it was me talking to her about it."

No change in drinking but improvements in drinkers' behaviour (n=7)

Analysis of participants' responses to the question, "What do you think has prompted this change?" revealed most participants attributed the improved behaviour as being in response to changes in their own attitude and demeanor; e.g.

- "It's probably because I'm a bit more pleasant. I tackle things differently and am taking an interest in his garden."
- "There's more change in me than him. Things are blowing out less. I'm not feeding into them so they are not snowballing so much."
- "I've stopped the chain reaction. I don't react now. She's becoming more aware of her own behaviour."
- "I'm communicating better. Not so many mixed messages and I'm using boundaries without blame."
- "I'm sticking to my plan of refusing to accept his responsibilities and I'm acting as if he's going to do the right thing."

Drinkers' increased consumption (n=7)

Four of the seven participants who reported an increase in consumption also attributed this change to their drinkers' *reactions* to their (i.e. participants' changed behaviour); e.g.

- "It's mostly because of the changes in me. I'm reacting to him differently and his way of coping with this is to panic."
- "I'm getting more in control of myself now. When he drinks I don't throw any of the rubbish at him that I used to. He says, 'You don't nag me any more.' I get a sense that he's a bit mixed up and whenever there's a problem in his life he goes to the drink."

11.6.1 Summary and discussion regarding changes in drinkers' consumption during participants' treatment program

The qualitative data regarding changes in drinkers' consumption is entirely consistent with the qualitative data presented in Chapter 9. Given the improvements in the way participants were handling their situations with their drinkers, their increased self efficacy, self care and responsibility, clearer boundaries, and improved communication, it is understandable that many (53%, n=23) had reported improved relationships with their drinkers by the end of treatment.

For instance, the quantitative data identified that significant decreases in marital discord,[10] improved quality of interactions between participants and drinkers and reduced drinkers' verbal abuse had occurred between mid treatment and end treatment. Moreover, even though the improvement in participants' marital state had not clinically improved, the *statistically* significant improvement suggested that some degree of positive movement was occurring.[11]

Prior to the Holyoake intervention, participants' drinkers were drinking in a dependent fashion. Fifty six percent were in the precontemplation stage of change, and, according to participants, 44% had been in the contemplation stage of change for many years. Given the compulsive nature of dependent drinking, drinkers would have experienced considerable conflict between their powerful incentive to use and the considerable restraints against using (Orford, 1985; 1988b).

One of the most powerful incentives for dependent drinkers to keep using is to medicate their tension and emotional pain. Prior to the intervention, participants' levels of anxiety and depression were elevated. Moreover, they usually used control and tolerant coping strategies which were associated with increased discord within the family. Given this was accompanied by elevated levels (rated by participants as moderate) of emotional and verbal abuse from drinkers, poor quality of everyday interactions, and a marital state with very severe problems, it is reasonable to assume that drinkers were also under substantial stress. Therefore, their incentive to drink to relieve this stress must have been very powerful. Some participants described their family milieu as "living in a war zone!"

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[10] i.e. Participants' irritability and anger due to their drinkers' behaviour, money shortages, and drinkers' abusive behaviour

[11] The quantitative investigation of the durability of treatment revealed strengthening treatment effect on most variables by 6 months post treatment. Thus, had the 3 months and 6 months post treatment qualitative data also been reported in this thesis, ongoing improvements would have been confirmed

However, when participants began to remove their *contribution* to their drinkers' stress levels, and replaced their ineffective ways of coping with more effective ways, it was likely that drinkers' incentive to use may have indeed been moderated. Moreover, given the improved relationship between participants and drinkers, and drinkers' increased involvement in their families, the restraints against using were likely to have increased.

Most participants were acutely aware of the positive influence they had had on their drinkers' behaviour and reduced consumption; e.g.

- "I've stopped some of the destructive interactions we were having and step back from it and say, 'Hang on, I'm not jumping on the bandwagon. I'm not playing these games."

The see-saw changes in drinkers' behaviour and the initial unsustained reductions in consumption as reported by participants have illustrated the struggle between drinkers' incentives to use and restraints against using. This early stage of action is very fragile as drinkers weigh up the benefits of making substantial changes in their behaviour However, as the processes of change (Prochaska, Norcross, & DiClemente, 1994) began to operate (facilitated by participants' changed behaviour) a fertile milieu for change was created.

Thus, drinkers' hope and belief that they could indeed successfully change their behaviour and enjoy the benefits that participants' changed behaviour were demonstrating was likely to have been enhanced. Similarly, the drinkers who decided to seek help would have been "encouraged" to make this decision by the growing restraints against using which were overpowering their incentives to drink; e.g. "I insisted because he'd been violent towards me."

Thus, the improvements in participants' mental health, coping and relationship status seemed to create an environment which provided drinkers with a valuable opportunity to confront the reality and severity of their situations, and assisted them to increase the salience of their incentives to change. Moreover, as drinkers noticed participants' ability to change their own behaviours, a belief (and indeed a hope) may have germinated that they too may have been able to successfully tackle their own

difficulties. According to one participant, her drinker reacted to her changed behaviour with: "If *you* could change *anyone* could!! [So perhaps there's hope for me after all]."

The final chapter has summarised this research by presenting the significance and limitations of its major findings, and has identified areas where further research would be appropriate.

CHAPTER 12

Summary and Conclusions

This final chapter has summarised the research undertaken in this thesis by presenting the significance and limitations of its major findings, and identifying the need for further research.

12.1 Rationale for this research

Although alcohol treatment outcome studies have been published for more than half a century, little evaluation research has been devoted to the problem of helping relatives who are concerned about their drinkers' excessive consumption (Liepman, Nirenberg & Begin, 1989; Miller et al., 1999). Despite the considerable level of chronic stress and associated health problems suffered particularly by partners of excessive drinkers (and consequently their children), the main focus of the literature has generally been how to successfully rehabilitate drinkers. However, rehabilitation and treatment services have largely failed to motivate those drinkers into treatment early enough to minimise the harm to themselves and their families.

Given Paolino and McCrady's (1977) assertion that for every excessive drinker there are likely to be at least 5 others who also suffer deleterious effects, it is of great concern that family distress has largely been overlooked in the race to get these drinkers into treatment. According to Mattick et al. (1993), it is not only *ethically* important to treat relatives *in their own right,* it also makes good economic sense from a harm minimisation perspective.

A review of the empirical literature has revealed that relatives (particularly partners) of excessive drinkers are indeed a high risk group who experience considerable stress/anxiety, depression, low self esteem and guilt, marital discord and disturbance, and ineffective coping patterns (see Chapter 6.1). Moreover, many children of excessive drinkers experience anxiety, depression and other psychiatric disorders (Lynskey, Fergusson, & Horwood, 1994; Rolf, Johnson, & Israel, 1988; Sher, 1997),

personality disorders (Fitzgerald, 1995), cognitive difficulties (Pihl & Bruce, 1995); decreased self esteem (Clair & Genest, 1987; Howells, 1989), a wide range of health problems (Moos & Billings, 1982), and a propensity for guilt, self blame, and impulsive or disruptive behaviour (Sher 1997b). Furthermore, children raised in problem drinking families have demonstrated an increased vulnerability to developing future alcohol dependence (Brown, Creamer, & Stetson, 1987; Duncan, Jacob, Windle, Seilhamer, & Bost, 1999; Duncan, Tildesley, Duncan & Hops, 1995; Schuckit & Smith, 1995; Sher, 1997b; Windle, 1996), particularly when their families are chaotic, discordant, and unsupported (Cooper, Peirce & Tidwell, 1995; Phil & Bruce, 1995; Orford & Velleman, 1991). According to Kaufman (1980), the critical variable in the deteriorating family milieu is not the drinking per se but the personal functioning and degree of life stress of the non alcoholic partner (particularly if they exhibit high anxiety, depression and physical symptoms).

Given relatives' motivation to improve their circumstances and do something positive about their drinkers' unacceptable consumption, they have variously been co-opted into their drinkers' treatment process. However, whilst there is a large literature on family therapy involving partners as *adjuncts* to their drinkers' treatment (e.g. Bowers & Al-Redha, 1990; McKay, Longbraugh, Beattie, Maisto & Noes, 1993; Moos, Finney & Chronkite, 1990; O'Farrell, 1993; O'Farrell & Bayog, 1986; O'Farrell & Cowles, 1989; Orford et al. 1975; Smith, 1969; Wright & Scott, 1978), very few researchers reported (or even considered) the well-being of the partners involved in their studies (e.g. McCrady, Stout, Noel, Abrams & Nelson, 1991).

Furthermore, there is much less evaluative research on intervention with treatment resistant drinkers through training their relatives as early intervention agents (e.g. Barber & Crisp, 1995; Barber, Gilberston & Crisp, 1997; Garrett, Landau, et al. 1998; Garrett, Stanton, et al. 1999; Landau & Brinkman-Sull, 1997; Liepman, 1993; Miller et al. 1999; Sisson & Azrin, 1986; Thomas & Agar, 1993). Similarly, scant attention has been paid to the impact of these interventions on relatives' psychological functioning. For instance, whilst Barber and Crisp (1995) and Barber et al. (1997) did not *specifically* aim to improve relatives' wellbeing, they at least measured the impact of the intervention training on relatives (with mixed results). However, 60% of these relatives reported that their drinkers had reduced their consumption or presented for help. Whilst these studies indeed confirmed the value of relatives in influencing

beginning change in their drinkers' behaviour, they did not investigate the durability of drinkers' reduced consumption or the outcome of their help seeking behaviour.

On the other hand, although Miller et al. (1999) *primarily* aimed to train relatives as intervention agents, they also aimed to improve relatives' psychological functioning. Miller et al. found *sustained* improvements in relatives' mental health, coping, and relationship status, *as well as* the engagement of 64% of their treatment resistant drinkers (into assessment and 1 treatment session). However, the outcome of this engagement on drinkers' consumption patterns was not investigated. Miller et al. also highlighted the need for qualitative data to investigate *how* relatives had *applied* the skills they had learned from the intervention. Others have also identified the neglect of qualitative data in the literature (e.g. Araya, 1995; Bodgen & Bilken, 1992; Heath, 1995; Miller et al. 1999; Ogborne, 1995; Orford et al. 1998a).

Evaluative research which has *primarily* focussed upon improving the mental health and coping status of relatives of treatment resistant drinkers *in their own right* is even more sparse (e.g. Binns et al. 1989; Dittrich, 1993). However, whilst both Binns et al. and Dittrich had a positive impact on relatives' mental health, only Binns et al. provided empirical evidence of the *sustainability* of these effects. Moreover, only Dittrich reported on coping status; i.e. partners reduced their "enabling behaviours". Whilst Dittrich (1993) *primarily* aimed to improve partners' mental health and coping status, she also trained them in intervention strategies. This resulted in the "engagement" of 47% of treatment resistant drinkers. However, Dittrich did not investigate the outcome of this on drinkers' consumption patterns.

Thus, the literature was not fully developed in this field. Moreover, interventions have typically lacked a theoretical base (Meyers et al. 1999). For instance, whilst Binns et al. (p.87) claimed their intervention "exhibits similarities to many therapeutic approaches that are based on systems theory … and makes much use of Rational Emotive Therapy", Dittrich (1993) based her intervention on Alanon principles.

Whilst the evidence is clear that relatives are capable of exerting great *influence* over their drinkers' behaviour, several unanswered questions have arisen from the research of Binns et al. (1989), Dittrich (1993), Meyers et al. (1999) and Miller et al. (1999); e.g.

- What was the nature of relatives' experiences with their treatment resistant drinkers?
- What was the nature of relatives' intervention experiences?

- *How* did relatives apply what they had learned from the intervention?
- How did relatives explain their improved psychological functioning?
- Would a clinically derived intervention which appeared to be consistent with the range of therapeutic elements suggested by the empirical literature and *specifically* aimed to improve relatives' mental health and coping status (*without training them as intervention agents),* have a positive "spin off" effect of motivating their drinkers to seek help or reduce their consumption?

12.2 Purpose of this research

Despite the importance of relatives (particularly partners) in the successful rehabilitation of their drinkers, their separate needs have largely been ignored by the empirical literature. Given empowering relatives through improving their psychological functioning (without involving their drinkers in any way) may indeed be a valuable approach to the secondary prevention of addiction (Orford, 1993), this thesis has attempted to redress the gaps in the literature by testing an intervention which aimed to:

- Minimise the harm experienced by relatives of excessive drinkers;
- Improve relatives' emotional well-being and coping; and
- Assist relatives to recognise behaviours that might unwittingly enable their drinkers' excessive consumption to continue.

Although this intervention had been *clinically* developed by the Australian Institute on Alcohol and Addictions in Perth, Western Australia (Holyoake), it was necessary to move beyond clinical judgment and best guesses towards the development of a clearly articulated framework of intervention derived from empirical and conceptual foundations. Therefore, this thesis has evaluated the Holyoake intervention in terms of its consistency with the conceptual underpinnings of an "ideal" intervention derived from an understanding of the empirical literature regarding the successful treatment of relatives of excessive drinkers (see Chapter 6.2, 6.3 & 6.4).

Many of the clinical derived elements of the Holyoake intervention were indeed supported by the literature. However, some elements were not supported, others seemed to be superfluous, or needed revision. Thus, with some limitations, the Holyoake intervention seemed to be *generally* consistent with the conceptual framework

underpinning the successful treatment of the anxiety, depression, marital discord and disturbance, and ineffective coping experienced by relatives of excessive drinkers.

The initial focus of this thesis has been to examine and evaluate the Holyoake intervention on a number of levels; viz.

- The *impact* the intervention appeared to have on participants' mental health, coping and relationship status;
- The specific *outcomes* associated with the intervention in terms of possible improvements in participants' mental health, coping and relationship status; and
- The process by which the intervention appeared to operate. This has drawn largely on the qualitative nature of the data, in terms of participants' statements and perceptions about the processes of change they were experiencing, and how they were applying the various ideas and strategies they had learned from the intervention program.

However, whilst the Holyoake intervention was *essentially* concerned with relatives' issues, the focus of this thesis has extended beyond this into exploring whether improvements in relatives' mental health, coping and relationship status would facilitate a positive, "spin off" effect of motivating their drinkers to seek help or reduce their consumption. Thus, the Holyoake intervention was also examined and evaluated in terms of its *unintended* impact on treatment resistant drinkers.

Having developed the conceptual framework of an "ideal" intervention (see Chapter 6.2, 6.3 & 6.4), the Holyoake intervention, and the model which seemed to be underpinning it were tested. This supported the principal intervention hypotheses which have been summarised as follows:

It was expected that the Holyoake intervention would result in:

1. Significant, durable improvements in participants' mental health,[1] coping, and relationship status; and as a "spin off" from these improvements in participants' psychological functioning;
2. Significant, durable reductions in their drinkers' alcohol consumption, accompanied by increased help seeking behaviour.

[1] i.e. Significantly reduced anxiety and depression

12.3 The qualitative experiences of participants during the Holyoake intervention

The qualitative nature of the research was most important because it supported the aims and objectives of the intervention, and presented an opportunity to confirm, elaborate, and enrich the quantitative data. For instance, based on the hypotheses that the intervention would improve participants' mental health, coping and relationship status and thereby facilitate (i) a reduction in their drinkers' consumption, and (ii) increased help seeking behaviour, it was of vital clinical importance to understand the "hows and whys" of such an outcome. For instance, it was important to understand *how* the interdependent stress, coping and transactional patterns which had helped to maintain participants' distress and their drinkers' excessive consumption had been dismantled. Moreover, it was also important to understand how participants had applied what they had learned from the intervention and the "hows and whys" underpinning their improved relationships with their drinkers, as well as their drinkers' decisions to reduce their alcohol consumption and/or seek help.

12.4 Strengths and weaknesses of the research design

Strengths

The design of this study had several strengths; viz.

1. This study was much more than a simple before and after design since the Composite Treatment group (n=43) was assessed on no fewer than 5 occasions including follow up at 6 months post treatment. This was unusual and enabled changes in participants' mental health, coping and relationship status to be plotted over time, as well as the "spin off" of this on their drinkers' behaviour.
2. Although the length of the waitlist period was not ideal, it enabled the identification of significant change which had occurred in 3 key variables (viz. control coping, tolerant coping, and marital discord) before the intervention commenced. These findings have added to what was known about how relatives' coping strategies in particular can change very rapidly with very little input.
3. Wherever possible, data in this study were analysed according to the intention to treat principle. Thus, the characteristics of those participants who did not

commence treatment have been reported, as well as data which described the effect of partial treatment (i.e. 5 sessions) vis-a-vis full treatment (i.e. 10 sessions). This was unusual in the psychological literature because other researchers whose work has been cited in this thesis did not appear to have analysed their data in this way (e.g. Barber & Crisp, 1985; Dittrich, 1993;. Miller et al. 1999).

4. The personnel who delivered the Holyoake intervention were highly trained and supervised. Therefore, even though participants were assigned to various small groups which were led by different facilitators, every attempt was made to standardise the group facilitation process. Another strength of this study was the independence between those delivering the intervention from those scoring the questionnaires, conducting the qualitative interviews, and analysing the data.

Weaknesses

The predominant weaknesses of this study were due to incomplete randomisation, the less than ideal length of the waitlist period, and the small sample size which made it impossible to match subjects. Thus, the design was quasi-experimental and therefore accompanied by all the attendant threats to internal validity. For instance, whilst the Holyoake intervention *appeared* to produce a number of significant changes, it was not possible to fully attribute these changes to the intervention, especially as significant change had occurred during the waitlist period. Therefore, the results from this study need to be viewed with caution.

12.5 Major findings from the research

Many elements from the Holyoake intervention seemed to be supported by the literature; viz. the process of dependency, letting go, boundaries, self responsibility, effective communication, and challenging beliefs. However, whilst some of the concepts within the codependency element also seemed to be supported, others were not and appeared to have been drawn from "pop" psychology. Moreover, the term "codependency" has no valid definition and has a tendency to label and blame relatives. Thus, the codependency element needed revision. In addition, the Holyoake intervention contained no element regarding problem solving, particularly in terms of dealing with an alcohol related crisis. As this had been identified by the literature as important in the

treatment of relatives of excessive drinkers, it was a serious omission. Whilst the grief, self esteem, family dynamics, denial, and intimacy and sexuality elements were indeed related issues for relatives of excessive drinkers, they seemed superfluous and incidental to an "ideal" intervention supported by the literature.

Thus, one of the major findings from this research seemed to support the *general* consistency of the Holyoake intervention (with some limitations) with the conceptual framework underpinning the "ideal" treatment of relatives of excessive drinkers. Moreover, notwithstanding the threats to internal validity, both principal hypotheses seemed to have been supported; viz.

(i) The effectiveness of the Holyoake intervention and the durability of its effects

Findings from the quantitative data from pre treatment through 6 months post treatment for the Full Treatment group (n=43)

- The Holyoake intervention appeared to result in significant, sustained reduction in participants' pre treatment levels of anxiety and depression. Thus, the intervention seemed to produce significant improvement in participants' mental health status which was sustained through 6 months post treatment.
- Despite the significant decrease in participants' control and tolerant coping strategies during the waitlist period, the results tended to suggest that the Holyoake intervention may have *influenced* the additional, significant reduction in control coping strategies which had occurred by mid treatment, and the maintenance of reductions in both control and tolerant coping strategies through 6 months post treatment. This supposition was supported by the qualitative data.
- Despite the significant reduction in marital discord[2] during the waitlist period, the results have tended to suggest that the Holyoake intervention may have influenced the *additional,* significant reduction in marital discord which occurred during treatment and sustained through 6 months post treatment. This supposition was also supported by the qualitative data
- In addition to the significant reduction in marital discord, the Holyoake intervention seemed to produce significant, sustained improvements in relationships between

[2] i.e. Participants' irritability and anger due to their drinkers' behaviour, money shortages, and verbal and physical abuse from their drinkers

participants and their drinkers; i.e. improved quality of everyday interactions, and reduced verbal and emotional abuse from drinkers by 3 and 6 months post treatment respectively.

- According to participants' reports (n=43), the Holyoake intervention seemed to have facilitated a significant "spin off" reduction in the number of drinks their drinkers consumed on any given drinking day and this was sustained through 6 months post treatment. Moreover, participants' raw data revealed that whilst 63% (n=27) of their drinkers had sought help (n=7) or reduced their consumption *to some degree* by the end of treatment, 47% (n=20) had made *substantial* change in their consumption behaviour.

(ii) Findings from the qualitative data from pre treatment through end treatment

- There was a high degree of consistency between the qualitative and quantitative data in the pre treatment assessment of participants' mental health status. For instance, participants' responses to the question, "What have you found <u>most</u> difficult to deal with in relation to your drinkers' behaviour over the past 2-3 months" were consistent with their responses to the Drinkers' Partners' Distress Scale (DPDS). Moreover, the degree of distress participants experienced in relation to this major difficulty was consistent with their responses to the Crown Crisp Experiential Index (CCEI).
- There was a high degree of consistency between the qualitative and quantitative data in the pre treatment assessment of participants' coping status. For instance, participants' pre treatment coping strategies identified by their responses to the question, "How do you usually handle that? [i.e. major difficulty] were consistent with the control and tolerant coping subscales within the Drinkers' Partners' Coping Questionnaire (DPCQ). There was also a high degree of consistency between the quantitative and qualitative data concerning the relationships between participants and their drinkers, as well as drinkers' consumption and help seeking behaviour. Therefore, the qualitative data has confirmed, elaborated, and enriched the quantitative data.
- Prior to the intervention, the majority of participants (61%, n=26) identified isolation within their relationships (i.e. communication problems and loss of a companion) and drinkers' abusive behaviour as most difficult to deal with. Eighty

four percent of participants (n=36) predominantly used withdrawal, emotional, tolerant or inactive coping strategies to handle these difficulties. Only 16% (n=7) predominantly utilised assertive strategies (which seemed consistent with the mean rating of "sometimes" on the DPCQ assertive subscale). Whilst withdrawal and assertive strategies seemed effective in the short term, drinkers' excessive consumption and abuse continued, participants remained angry and resentful, and their relationships deteriorated.

- By the end of treatment, 81% of participants (n=35) reported the predominant use of assertive behaviours to handle major difficulties with their drinkers; i.e. self care and responsibility, assertive confrontation, clear messages and support and encouragement. When asked what was different (if a change had occurred) in how they handled their *overall* situations with their drinkers, participants identified improved emotional health (i.e. self containment, emotional control and confidence), increased personal responsibility (improved boundaries, self care, and communication). By the end of treatment, 67% of participants (n=29) identified personal empowerment (i.e. self responsibility and self efficacy) as the *most important thing* which helped them deal more effectively with their situations.
- By the end of treatment, 53% of participants (n=23) reported that their relationships with their drinkers had improved. Open and honest communication, warmth and enjoyment, and reduced discord were associated with sustained improvement.
- The predominant reason given by participants for their drinkers' increased help seeking behaviour and reduced consumption were changes in their *own* behaviour; e.g.

> "Because I have made a change he has made a change. He's definitely cut down on his drinking. Therefore, it's changed things for both of us."
> "I've taken responsibility for myself and let him take responsibility for himself. So I've given him back that self respect I suppose. Therefore, he really does need to look after himself rather than have me caretaking for him."

(iii) Findings from the quantitative data after 5 treatment sessions for the Late Dropout group who were available for follow up 5 weeks post treatment (n=13)

- Despite the small sample size of the Late Dropout group available for follow up, the Holyoake intervention seemed to produce a similar pattern of significantly improved mental health status, coping status, and marital discord to the Full Treatment group. These improvements were sustained through 5 weeks post treatment.
- According to the Late Dropout group's reports, reductions in mean scores for their drinkers' verbal and emotional abuse had reached significance by 5 weeks post treatment. This was in contrast to the Full Treatment group where drinkers' verbal and emotional abuse which did not significantly reduce until 3 and 6 months post treatment respectively.
- According to Late Dropout group's reports, the intervention appeared to have a more pervasive "spin off" effect upon their drinkers' consumption patterns than that reported by the Full Treatment group. For instance, despite the small sample size, significant reductions in mean scores for drinkers' frequency of use, effect of use, and the number of drinking days in the past month occurred after 5 treatment sessions, and were sustained through 5 weeks post treatment. By 5 weeks post treatment, reductions in mean scores for the number of drinking days in the past week and the number of drinks consumed on any given drinking day had reached significance. However, only the "effect of use" retained its statistical significance after the Bonferroni correction was applied. Given a larger sample size, the reductions in mean scores for the other consumption variables may have become more statistically significant.
- The Late Dropout group's raw data revealed a similar pattern of help seeking and reduced consumption to the Full Treatment group. After 5 treatment sessions, 45% (n=9) had either sought help (n=5) or *substantially* reduced their consumption. However, by 5 weeks post treatment (comparable to the end treatment point for the Full Treatment group), the number of drinkers who had made *substantial* change in their consumption patterns had increased to 65% (n=13).
- These data tended to suggest that the Late Dropout group may have decided to terminate treatment because their mental health, coping and relationship status had improved, their drinkers' help seeking behaviour had increased, and their drinkers' consumption patterns had reduced. Thus, these data also suggest that 5 treatment sessions are likely to be sufficient for some participants. Given optimum change

appeared to have occurred after 10 sessions for the Full Treatment group, it is likely that somewhere in between 5 and 10 sessions would be appropriate. Thus, this has supported the length of the "ideal" 8 session intervention as described in Table 6.4.

12.5 Significance of the findings from this research

Notwithstanding the threats to internal validity, the Holyoake intervention appeared to be successful. Not only did it seem to result in significant, sustained outcomes for participants' mental health, coping, and relationship status, participants' improved psychological functioning seemed to facilitate their drinkers' help seeking behaviour and significant, sustained reductions in consumption. Moreover, the qualitative data made an important contribution to the research because it supported the aims and objectives of the intervention by identifying the important processes of change which the intervention seemed to produced. Thus, the qualitative data augmented the impact of the intervention program because it enabled participants to articulate what they had found valuable, how they had applied what they had learned, and how this had helped them to deal more effectively with their situations. So many intervention programs are only evaluated by the question, "*Did* participants change?" without also asking the vital question, "*How* did participants change, and *why* did they think those changes had occurred?"

12.5.1 Significance to the research literature

Original contribution to the research literature

- Whilst this thesis was concerned with the evaluation of an intervention which aimed to improve the mental health and coping status of relatives of excessive drinkers, it provided the first Australian data concerning the possible "spin off" impact of this intervention on the help seeking behaviour and consumption patterns of treatment resistant drinkers.
- Through assessing participants at the beginning and end of the waitlist period, this research identified significant change which had occurred in 3 key variables (viz. control coping, tolerant coping, and marital discord) before the intervention commenced. These data have added to what was known about how relatives' coping strategies in particular can change very rapidly with very little input.

- This research seemed to have identified an alternative method of early intervention with treatment resistant drinkers, through improving their relatives' mental health, coping, and relationship status. Whilst this method improved on Dittrich's (1993) intervention "hit rate", it achieved comparable results to Barber and Crisp (1995), Barber et al. (1997) and Miller et al (1999) *who trained relatives as intervention agents.* However, it is important to recognise that this in no way suggests that relatives are ever *responsible* for their drinkers' behaviour. It merely acknowledges (i) the *contribution* relatives have made to the maintenance of their own distress and their drinkers' excessive consumption, and (ii) the *influence* one person has on another within the family system.
- This research has provided the first qualitative data describing the *process* by which the Holyoake intervention appeared to operate. This was achieved by drawing on participants' statements and perceptions about the processes of change they were experiencing, and how they were applying the various ideas and strategies they had learned from the intervention.
- This research has identified the key behaviours which participants in this study identified as being most useful in improving their ability to deal more effectively with their situations; viz. personal empowerment (i.e. increased self responsibility and self efficacy), improved emotional health (i.e. self containment, emotional control, and confidence), and improved personal boundaries and communication. Thus, the current research has extended the work of Dittrich (1993) and Miller et al. (1999) by identifying the various coping strategies that 81% of participants (n=35) had substituted for their "enabling behaviours".
- The current research has suggested that the improvement in participants' psychological functioning may have been "driven" by the significant reduction in their control and tolerant coping behaviours, complemented by the increasing substitution of the above key behaviours. Therefore, this research seemed to have supported the powerful influence of changed *behavioural* responses upon feelings and thoughts, as they interacted and circularly affected each other (Ellis, 1988).
- This research seemed to have explained why Velleman et al.'s (1993) relatives (particularly partners) of excessive drinkers may have tended to swing from one unsuccessful coping position to another. For example, in the current research, participants' responses to "What happens between you and your drinker when you

handle your major difficulty in that way", revealed the considerable resistance many of their drinkers had mounted *in reaction to* participants' changed coping strategies. Therefore, participants seemed to be under considerable pressure to abandon their changed behaviour and restore the status quo. Although positive outcomes had generally outweighed negative outcomes by the end of treatment (i.e. 10 sessions), some participants' mid treatment responses revealed their struggle; e.g. "He increases the pressure to make me conform to his wishes."

- This research seemed to have provided general support for Prochaska, Norcross and DiClemente's (1994) theory regarding the processes of change (see Tables 5.1 & 5.2) for a *different* group of clients; i.e. relatives of excessive drinkers. For instance, as participants in the current study progressed through the intervention, their statements revealed that the *salience* of earlier processes of change (e.g. raised awareness, helpful relationships emotional arousal, self re-evaluation) had reduced in favour of the processes associated with the maintenance of changed behaviour; e.g. countering unhelpful behaviours, commitment, environment control, and social liberation (see Tables 5.1 & 5.2). Moreover, as participants' personal empowerment consolidated and improved, their statements indicated that they were indeed applying the strategies identified by Prochaska, Norcross and DiClemente as being crucial to the *maintenance* of change (see Table 5.3). For instance, participants had not only substituted more effective, self affirming behaviours for their ineffective coping strategies, they had also created a more personally helpful environment by assuming more responsibility for their own quality of life; e.g.
    - "I've learned that it's *my* life and I'm the only one who can make it better - or worse!"

Support for others' research findings

- This research supported the work of Binns et al. (1989), Dittrich (1993), and Miller et al (1999) who improved the mental health of relatives of excessive drinkers, and reduced their "enabling behaviours" (i.e. Dittrich, and Miller et al.), by using similar intervention elements; viz. education about addiction and partner stress and coping patterns; increased self responsibility; setting appropriate boundaries; the relationship between feelings, thoughts and behaviour; and effective communication.

- This research seemed to have supported the value of working with relatives of treatment resistant drinkers to motivate their drinkers to reduce their consumption and/or seek help.
- This research supported the validity and usefulness of the stress/coping and transactional model (Orford, 1994) where the changed coping behaviour of one person in an intimate relationship results in changed behaviour from the other (for better or for worse). Moreover, that the changed behaviour of both participants and their drinkers seemed to produce a powerful reciprocal influence; e.g.

  > "There's more change in me than him. Things are blowing out less. I'm not feeding into them so they are not snowballing so much."
  > "I've stopped the chain reaction. I don't react now. [Therefore], she's becoming more aware of her own behaviour."

- This research supported Barber and Crisp (1995), Liepman (1993), and Miller et al. (1999) who found relatives of excessive drinkers were reluctant to assertively confront their drinkers. For instance, by mid treatment only 16% (n=7) of participants in the current study predominantly used assertive *confrontation* to handle difficult situations with their drinkers. By the end of treatment, this had reduced to 5% (n=2). Whilst this may have reflected the decrease in major alcohol related problems participants were dealing with by the end of treatment (or that participants were already using assertive confrontation to its optimal degree), it seemed they had extended their use of assertive behaviour through increased self care and responsibility, clear messages, and support and encouragement for their drinkers.

Whilst the clinically derived Holyoake intervention contained several superfluous elements and needed some degree of revision, it embodied many features which were supported by the empirical literature. Moreover, when the conceptual framework which appeared to be embedded within the Holyoake intervention was compared to what one would hope would be best empirical practice at this stage, there was a considerable degree of overlap. Thus, this research has identified the conceptual underpinnings of the Holyoake intervention and seemed to have demonstrated its effectiveness.

12.5.2 Significance for family and community harm minimisation

At least 1% of the Australian population have a family member with an alcohol problem serious enough to come to the attention of health or welfare agencies (Mattick, 1993). Unfortunately, the vast majority of dependent drinkers remain uninvolved in either treatment or self help groups (Garrett, et al. 1999). Given the deleterious impact of dependent drinking on families, the longer it takes to get these drinkers into treatment, the greater the damage will accrue to themselves, their relatives, and their children.

The Holyoake intervention not only appeared to reduce the level of harm to relatives of treatment resistant drinkers (and most likely their children), it also seemed to facilitate significant, sustained reductions in the amount of alcohol drinkers consumed on any given drinking day, and perhaps a more pervasive effect on the Late Dropout group's drinkers).

Moreover, raw data from *all participants who had commenced treatment* (n=68, including dropouts) revealed that whilst 69% (n=47) of drinkers had either sought help (n=13) or made some degree of positive change in their consumption, 50% (n=34) had made *substantial* change in their behaviour. Under the intention to treat principle, these numbers have also been expressed in terms of *all* participants who were allocated to treatment (n=83); viz. whilst 57% of drinkers had made *some degree* of positive change in their help seeking or consumption behaviour, 41% had made substantial change.

12.6 Limitations and ethical and professional issues involved in this research

Limitations involved in this research

- The Holyoake intervention program was well known to the Western Australian community. So was its policy of immediate entry to program after the assessment process. Whilst every attempt was made to randomly assign participants to either the Immediate Entry treatment group or the Waitlist group, some participants were unable to wait at least 2 weeks before commencing their program for a variety of reasons (e.g. pre arranged holidays). On the other hand, some participants were so distressed by their circumstances at home that they wanted to begin their program as soon as possible, and therefore could not ethically be asked to wait any longer.
- During the course of the intervention 8 participants from the Waitlist group were lost to the research (many because their situations at home had improved). Therefore new participants were often allocated to the Waitlist group merely to

restore the numbers required for successful statistical analysis. It was therefore virtually impossible to randomly allocate participants to the Waitlist Group.

- Thirty seven percent (n=25) of participants did not complete the entire treatment program. Five terminated after less than 4 sessions and 20 terminated after 5 sessions. This degree of attrition was quite acceptable, especially as many reported their situations at home had improved and they did not want to pay for further sessions. However, it compounded the problems presented by the scarce supply of prospective research participants who were still in ongoing contact with their treatment resistant drinkers. Therefore, it took 2 years to achieve a total of 43 participants who had completed the *entire* treatment program.[3] Data collection was terminated at this point because it was no longer possible for Holyoake to continue the allocation of their scarce resources to the research program.[4]

Delimitations involved in this research

Given the focus of the research was to evaluate the effectiveness of an intervention for relatives of treatment resistant drinkers without involving their drinkers in any way, it was necessary to obtain data from participants regarding drinkers' levels of consumption at each of the 5 data points (i.e. pre, mid, and end treatment; and 3 and 6 months post treatment) Although collaterals' estimates of their drinkers' consumption patterns have been found to correlate well with drinkers' own estimates (Jarmas & Kazak, 1992; McAuley, Longbraugh, & Gross, 1978; Meyers, Miller, Hill & Tonigan, 1999), it was important to recognise that conclusions regarding drinkers' consumption needed to be interpreted with some degree of caution. Although participants' reports of their drinkers' help seeking behaviour were undoubtedly accurate, they may not have been able to count their drinkers' drinks accurately (even though they chose from a range of possibilities; e.g. 5-8 drinks or 9-12 drinks). Despite this difficulty, it was decided to obtain drinkers' consumption data from the only source possible – their close relatives. Moreover, there was precedent for this decision: this was how Barber and Crisp (1995) and Barber, Gilberston and Crisp (1997) obtained similar data. However, in the current research, the qualitative data supported and elaborated the quantitative data regarding drinkers' consumption patterns.

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[3] Every participant who had completed the entire program presented for their 3 months and 6 months post treatment assessment

[4] Also the research team was exhausted!

Ethical issues involved in this research

- Four participants who had been allocated to the Waitlist group did not present for treatment. Therefore, there was an ethical concern that these people may have decided not to begin their program *because* they were required to wait for a minimum of 2 weeks. Although when contacted by the research team, these prospective participants gave good reasons why they were not able to commence the intervention, the ethical question remained; i.e. If these people had been given the choice to commence the intervention immediately, would they have decided not to attend?
- One person from the Waitlist group decided not to continue with the research program (although she did commence the intervention program) because she found the questionnaire packages "too burdensome" given her home situation. This raised an ethical concern about expecting participants to complete 5 questionnaire packages, despite their considerable levels of anxiety and depression. Thus, to compensate participants for their time and effort, the researcher gave each participant written feedback regarding their questionnaire scores at each of the 5 data collection points. Moreover, each participant who completed the research program received a one page summary of the results of the research (which raised a professional issue of increasing the time commitments of the research staff).
- Although participants had voluntarily chosen to enrol in the Holyoake intervention program, and subsequently the research program, there were ethical issues concerned with asking them to report on their drinkers' consumption and behaviour at 5 measurement points particularly where violence may have been an issue for some participants. However, whilst participants rated the level of verbal and emotional abuse within the "moderate" range, physical abuse was rated within the "mild" range. Where participants were concerned about their drinkers' reactions to their involvement in the research program, they chose to complete the questionnaire packages on site.

Professional and clinical issues which have emerged from this research

- Given Holyoake has been providing treatment programs for families of alcohol and other drug dependent people for over 25 years, their staff is well trained in dealing with the particular issues which beset relatives of treatment resistant drinkers.

However, many treatment agencies do not have counsellors who are well trained in dealing with these issues. Therefore, to effectively minimise the harm for relatives, their children and their drinkers, it is necessary for staff to acquaint relatives who present for help with the evidence about how to most effectively empower themselves and intervene with their drinkers. Therefore, it is essential that staff are expertly trained in this early intervention process, so they can inspire a belief in their relatives that they (relatives) can indeed make a difference to their situations.

- One of the clinical issues arising from this research is the need to acquaint relatives with the fact that once they start changing their behaviour and handling their situations differently, that their drinkers are likely to mount a similar resistance campaign to the drinkers in the current study. Relatives need validation, encouragement, and strategies to maintain their action plan even in the face of considerable resistance from their drinkers. Of course, in the event that participants are facing a violent situation at home, there is need for extreme caution, support, and encouragement.
- Given the time lag found in this research between drinkers' reduced consumption and the significant reduction in their verbal and emotional abuse (3 months and 6 months post treatment respectively), it is important for clinicians to alert their clients to the possibility that drinkers may experience grief related anger due to the loss of alcohol in their lives. Therefore, relatives will need reassurance that their drinkers' anger is *likely* to abate, and support in the continued use of their effective communication and self affirming strategies.
- Although the Holyoake intervention seemed to produce significant, sustained improvement in the quality of *everyday* interactions between participants and their drinkers, the quality of deeper aspects of their relationships had only *begun* to improve 6 months post intervention. Therefore, this has indicated that relationship counselling for drinkers (who have sustained their reduced consumption) and their relatives would be valuable.

12.7 The need for further research identified by this thesis

- This thesis has explored the stresses and strains of *relatives* of treatment resistant drinkers, and the impact the Holyoake intervention appeared to have on their psychological functioning. Given this research seemed to demonstrate that the

personal empowerment of participants facilitated previously treatment resistant drinkers to significantly reduce their consumption or seek help, the intervention seems to be a valuable approach to secondary prevention of addiction. Therefore, it is likely that it may be similarly effective with *parents* of young people who are either using alcohol or other drugs inappropriately, or who are in serious trouble due to their alcohol/other drug use. Further research needs to focus upon interventions with parents as a way of positively influencing their children's consumption, and if necessary, effectively encouraging them into treatment.

- The evidence is clear that many children who are raised in problem drinking families develop psychosocial problems and are at elevated risk of future alcohol or other drug dependency. According to Kaufman (1980), the *severity* of damage experienced by these children is mitigated by the personal functioning and degree of life stress of the *non alcoholic parent.* Therefore, as a means of secondary prevention, further research needs to focus upon the impact of the empowerment of relatives (particularly partners) of excessive drinkers on their children.
- The majority of participants in this research were female partners of treatment resistant drinkers. There is a paucity of empirical research which has explored the stresses and strains of *male* partners of excessive drinkers (or other drug users), the effect of intervention on their psychological functioning, and the impact of this on their drinkers' consumption behaviour. Therefore, more research is needed in this area.
- Given the Holyoake intervention seemed to be successful with relatives of treatment resistant *drinkers,* further research may support its use with families of people experiencing other addictive problems; e.g. gambling.
- Although the Drinkers' Partners' Coping Questionnaire (DPCQ)[5] identified participants' pre and post treatment control and tolerant coping strategies, it did not satisfactorily identify the full range of participants' post intervention assertive coping strategies. Therefore, more work may need to be done on the DPCQ.

12.8 General conclusions

[5] Developed by the present author

1. This research has confirmed that Australian relatives of excessive drinkers (or other drug users) are indeed a high risk group who experience elevated anxiety, depression, marital discord and disturbance, and ineffective coping patterns. Moreover, this research has identified the importance of the family in two ways. Firstly, the key role they seem to play in helping to maintain the interdependent stress and coping patterns which develop in problem drinking families (which seems to support the status quo). Secondly, that when the separate needs of the family are addressed, it is possible that they can act as agents of change in their drinkers' early intervention.
2. However, despite the cost to the community of the chronic stress and associated health problems suffered by relatives of excessive drinkers, their needs have largely been overlooked. Instead, governmental attention has remained on the largely *unsuccessful* enterprise of how to motivate drinkers into treatment early enough to minimise the harm to themselves, their families, and the community. This research has highlighted the possibility that the best interests of the community are likely to be served by reducing the chronic distress suffered by the family of excessive drinkers by empowering them to improve their *own* situations - especially as this may have a positive "spin off" effect on their drinkers' behaviour.
3. Moreover, if the stress and strains that relatives of treatment resistant drinkers experience are reduced and their psychological functioning is improved, their children may be less likely to develop addiction problems in the future.
4. This thesis has developed a conceptual framework for a model of intervention which looked not only at program elements and intervention outcome, but also at the processes and issues involved in working with families of excessive drinkers.
5. This research seemed to have demonstrated the significant impact of the Holyoake intervention, and more importantly it also demonstated that the conceptual framework which seemed to underpin the Holyoake intervention had a positive effect on mental health, coping, and relationship status of the family of excessive drinkers. According to many participants, the Holyoake intervention had changed their lives.
6. Through addressing the separate needs of relatives, the Holyoake intervention seemed to facilitate a significant reduction in the amount of alcohol relatives' drinkers consumed on any given drinking day which was *sustained* through 6 months post treatment. Therefore, this research has helped to debunk the widely held belief that dependent drinkers cannot be helped until they admit their problem or seek help.

7. This research has revealed, for the first time, the *qualitative* impact of an intervention on the coping status of relatives of excessive drinkers. This research not only demonstrated that participants significantly reduced their ineffective coping strategies, it also revealed *how* they applied what they had learned from the intervention, *what* more effective coping strategies they had substituted, and *what* had helped them to deal more effectively with their situations.

8. Overall, this research has added considerably to the literature. The Holyoake intervention seemed to empower relatives of treatment resistant drinkers, facilitate their drinkers' help seeking behaviour and reduced consumption, as well as improving the quality of their relationships. Therefore, as a result of the Holyoake intervention, many families seemed to have been helped; e.g.

- "I'm getting bolder and I speak out. Now I know I can without being jumped on. He knows he can't brow-beat me and he's not so aggressive. I'm finding it easier to talk to him. I've just realised I'm sleeping in the middle of the bed instead of on the edge with one foot hanging over the edge. Something's changed."

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APPENDIX 1

Psychometric instruments

Drinkers' Partners' Distress Scale (DPDS)

Drinkers' Partners' Coping Questionnaire (DPCQ)

Crown-Crisp Experiential Index (CCEI)

Golombok Rust Inventory of Marital Satisfaction (GRIMS)

Questionnaire Results Form

DRINKERS' PARTNERS' DISTRESS SCALE

Section A Current problems

We all know that when people drink too much (or use too much of any mood altering drug) they run the risk of developing various problems. Unfortunately, an individual's drug or alcohol use often causes problems for other people as well - especially the person's family and close friends.

During the last month have YOU experienced ANY OF THE FOLLOWING PROBLEMS as a result of another person's alcohol use? (*Please circle one number for each item*)

		Never	Sometimes	Often	Frequently	Always	N/A
1.	Irritability (feeling edgy, or cross)	1	2	3	4	5	6
2.	Loneliness	1	2	3	4	5	6
3.	Anger (feeling enraged, having angry outbursts)	1	2	3	4	5	6
4.	Insecurity (about your relationship with the drinker)	1	2	3	4	5	6
5.	Neglect (feeling neglected by the drinker)	1	2	3	4	5	6
6.	Worry about leaving the drinker in charge of household responsibilities	1	2	3	4	5	6
7	Physical abuse from the drinker	1	2	3	4	5	6
8.	Embarrassment as a result of the drinker's behaviour	1	2	3	4	5	6
9.	Money shortages	1	2	3	4	5	6
10.	Lack of stimulating adult company	1	2	3	4	5	6
11.	Verbal abuse from the drinker	1	2	3	4	5	6
12.	An unsatisfactory sex life	1	2	3	4	5	6

DRINKERS' PARTNERS' COPING QUESTIONNAIRE (DPCQ)

Name..... Date.....

Listed below are a number of ways people deal with the problem of heavy drinking or other drug use in their family. Please indicate the extent to which you have used each one during the past 2-3 months by TICKING ONE BOX FOR EACH ITEM.

	Never	**Sometimes**	**Often**	**Frequently**	**Always**	**N/A**	*Office use only*
1. Put yourself out for your partner; e.g. getting him/her to bed, or cleaning up his/her mess after a drinking or drugging episode.	0	1	2	3	4		T
2. Quarrelled with your partner about his/her drinking or other drug use.	0	1	2	3	4		C
3. Kept out of the way, or left the room when he/she had been drinking or using.	0	1	2	3	4		T
4. Made it quite clear to your partner (when he/she was sober) that his/her drinking or other drug use was causing you upset and that you wanted him/her to do something about it.	4	3	2	1	0		A
5. Didn't wait for your partner to join in family activities, or didn't wait for him/her to give permission for you to go out.	4	3	2	1	0		A
6. Took responsibility to pay financial debts which were created by your partner's excessive expenditure on alcohol or other drugs.	0	1	2	3	4		T
7. Reacted to your partner with an emotional outburst (sometimes when you really didn't intend to).	0	1	2	3	4		C

	Never	Sometimes	Often	Frequently	Always	N/A	*Office use only*
8. Accepted your situation as part of life that you couldn't do anything about.	0	1	2	3	4		T
9. Waited for your partner to fall asleep before going to bed.	0	1	2	3	4		T
10. Made it quite clear to your partner (when he/she was sober) that you wouldn't accept his/her reasons for drinking or drugging, or cover up for him/her.	4	3	2	1	0		A
11. Tried to involve your partner in family activities/outings or tried to make him/her feel important in the family.	4	3	2	1	0		A
12. Assumed the majority of your partner's household responsibilities.	0	1	2	3	4		C
13. Attempted to control your partner's drinking or other drug use by telling him/her that you were going to leave or get a divorce.	0	1	2	3	4		C
14. Drove with your partner when he/she was under the influence of alcohol or other drugs.	0	1	2	3	4		T
15. Avoided interactions with your partner by becoming excessively busy inside/outside the home.	0	1	2	3	4		T
16. Communicated your pleasure to your partner about his reduced/nil alcohol or other drug consumption.	4	3	2	1	0		A

	Never	Sometimes	Often	Frequently	Always	N/A	*Office use only*
17. Covered up, lied, or made excuses for your partner's drinking/drugging behaviour to family, friends, or business associates.	0	1	2	3	4		C
18. Hid or threw away your partner's alcohol or other drugs.	0	1	2	3	4		C
19. Helped your partner through a crisis created by his/her drinking or drugging.	0	1	2	3	4		T
20. Had sexual relations with your partner when you really didn't want to because he/she had been drinking or using.	0	1	2	3	4		T
21. Became so angry with your partner that you wanted to (or did) hurt him/her.	0	1	2	3	4		C
22. Felt too hopeless to want to go on.	0	1	2	3	4		T
23. Pretended to be asleep when your partner came to bed.	0	1	2	3	4		T
24. Calmly and firmly communicated to your partner that something he/she had done (or planned to do) was unacceptable.	4	3	2	1	0		A
25. Put the interests of others members of your family before those of your partner	4	3	2	1	0		A

26. Asked your partner to make a promise regarding his/her drinking or other drug use.	0	1	2	3	4		C
27. Accused you partner of not loving you or letting you down because of the drinking or other drug use.	**Never** 0	**Sometimes** 1	**Often** 2	**Frequently** 3	**Always** 4		*Office use only* C
28. Felt too frightened to do anything about the drinking or other drug use.	0	1	2	3	4		T
29. Sat down with your partner and talked frankly about what could be done about the drinking or other drug use.	4	3	2	1	0		A
30. Made threats you later did not carry out (or did not mean to carry out).	0	1	2	3	4		C
31. Didn't say the things you really wanted to say about your partner's drinking or other drug use.	0	1	2	3	4		T
32. Begged or pleaded with your partner to moderate/stop drinking or drugging.	0	1	2	3	4		C
33. Tried to keep things looking normal, pretended all was well, or concealed the extent of your partner's drinking or other drug use.	0	1	2	3	4		C
34. Clearly told your partner (when he/she was sober) what you expected him/her to contribute to the family.	4	3	2	1	0		A
35. Kept track of your partner's drinking or other drug use at home or at social gatherings.	0	1	2	3	4		C

36. Tried to limit your partner's drinking or drugging by making rules about drinking/drug use in the house; e.g. bringing drinking/drugging friends home, or in some other way.	0	1	2	3	4		C

Appendix 1 The Crown-Crisp Experiential Index (Crown & Crisp, 1979)

1. Do you often feel upset for no obvious reason? *Ye No*
2. Do you have an unreasonable fear of being in enclosed spaces such as shops, lifts, etc? *Often Sometimes Never*
3. Do people ever say you are too conscientious? *No Yes*
4. Are you ever troubled by dizzyness or shortness of breath? *Never OftenSometimes*
5. Can you think as quickly as you used to? *Yes No*
6. Are your opinions easily inf luenced? *Yes No*
7. Have you ever felt as though you might faint? *Frequently Occasionally Never*
8. Do you find yourself worrying about getting some incurable illness? *Never Sometimes Often*
9. Do you think that 'cleanliness is next to godliness'? *No Yes*
10. Do you often feel sick or have indigestion? *Yes No*
11. Do you feel that life is too much effort? *At times Often Never*
12. Have you, at any time in your life, enjoyed acting? *Yes No*
13. Do you feel uneasy and restless? *Frequently Sometimes Never*
14. Do you feel more relaxed indoors? *Definitely Sometimes Not particularly*
15. Do you find that silly or unreasonable thoughts keep recurring in your mind? *Frequently Sometimes Never*
16. Do you sometimes feel tingling or pricking sensations in your body, arms or legs? *Rarely Frequently Never*
17. Do you regret much of your past behaviour? *Yes No*
18. Are you normally an excessively emotional person? *Yes No*
19. Do you sometimes feel really panicky? *No Yes*
20. Do you feel uneasy travelling on buses or the Underground even if they are not crowded? *Very A little Not at all*
21. Are you happiest when you are working? *Yes No*
22. Has your appetite got less recently? *No Yes*
23. Do you wake unusually early in the morning? Yes *No*
24. Do you enjoy being the centre of attention? *No Yes*
25. Would you say you were a worrying person? *Very Fairly Not at all*
26. Do you dislike going out alone? *Yes No*
27. Are you a perfectionist? *No Yes*
28. Do you feel unduly tired and exhausted? *Often Sometimes Never*
29. Do you experience long periods of sadness? *Never Often Sometimes*
30. Do you find that you take advantage of circumstances for your own
31. Do you often feel 'strung-up' inside? *Yes No*
32. Do you worry unduly when relatives are late coming home? *No Yes*
33. Do you have to check things you do to an unnecessary extent? *Yes No*
34. Can you get off to sleep alright at the moment? *N Yes*
35. Do you have to make a special effort to face up to a crisis or difficulty? *Very much so Sometimes Not more than anyone e/se*
36. Do you often spend a lot of money on clothes? *Yes No*
37. Have you ever had the feeling you were 'going to pieces'? *Yes No*
38. Are you scared of heights? *Very Fairly Not at all*
39. *Does* it irritate you if your normal routine is disturbed? *Greatly A little Not at all*
40. Do you often suffer from excessive sweating or fluttering of the heart? *No Yes*
41. Do you find yourself needing to cry? *Frequently Sometimes Never*
42. Do you enjoy dramatic situations? *Yes No*
43. Do you have bad dreams which upset you when you wake up? *Never Sometimes Frequently*
44. Do you feel panicky in crowds? *A/ways Sometimes Never*
45. Do you find yourself worrying unreasonably about things that do not really matter? *Never Frequently Sometimes*
46. Has your sexual interest altered? *Less The same or greater*
47. Have you lost your ability to feel sympathy for other people? *No Yes*
48. Do you sometimes find yourself posing or pretending? *Yes No*

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Appendix 1 The Golombok Rust Inventory of Marital State (GRIMS)

1. My partner is usually sensitive to and aware of my needs	SD D A SA
2. I really appreciate my partner's sense of humour	SD D A SA
3. My partner doesn't seem to listen to me any more	SD D A SA
4. My partner has never been disloyal to me	SD D A SA
5. I would be willing to give up my friends if it meant savmg our relationship	SD D A SA
6. I am dissatisfied with our relationship	SD D A SA
7. I wish my partner was not so lazy and didn't keep putting things off	SD D A SA
8. I sometimes feel lonely even when I am with my partner	SD D A SA
9. If my partner left me life would not be worth living	SD D A SA
10. We can 'agree to disagree' with each other	SD D A SA
11. It is useless carrying on with a marriage beyond a certain point	SD D A SA
12. We both seem to like the same things	SD D A SA
13. I find it difficult to show my partner that I am feeling affectionate	SD D A SA
14. I never have second thoughts about our relationship	SD D A SA
15. I enjoy just sitting and talking with my partner	SD D A SA
16. I find the idea of spending the rest of my life with my partner rather boring	SD D A SA
17. There is always plenty of 'give and take' in our relationship	SD D A SA
18. We become competitive when we have to make decisions	SD D A SA
19. I no longer feel I can really trust my partner	SD D A SA
20. Our relationship is still full of joy and excitement	SD D A SA
21. One of us is continually talking and the other is usually silent	SD D A SA
22. Our relationship is continually evolving	SD D A SA
23. Marriage is really more about secunty and money than about love	SD D A SA
24. I wish there was more warmth and affection between us	SD D A SA
25. I am totally committed to my relationship with my partner	SD D A SA
26. Our relationship is sometimes strained because my partner is always correcting me	SD D A SA
27. I suspect we may be on the brink of separation	SD D A SA
28. We can always make up quickly after an argument	SD D A SA

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PARTNERS OF HEAVY DRINKERS STUDY

Questionnaire Results

Pre treatment End waitlist Mid Program End Program
3 Months 6 Months

_____ _____
Your confidential code Date

Date commencement _____ No. of sessions completed _____

Your perception of your partner

Alcohol dependency _____

Readiness to change _____

Your own results

General psychological health _____

_____

_____

Marital state _____

_____

_____

Recommendations _____

_____

Northfields Avenue, Wollongong, 2522
Phone: (042) 213445 Fax: (042) 214767

APPENDIX 2

Non psychometric instruments

General Questionnaire 1 (pre treatment)

General Questionnaire 2 (mid & end treatment, 3 & 6 months post treatment)

Qualitative interview 1 (pre treatment)

Qualitative interview 2 (mid & end treatment, 3 & 6 months post treatment)

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PARTNERS OF HEAVY DRINKERS STUDY

The following questionnaires are about you, your family of origin, your partner, and your relationship. Please answer all the questions as honestly and completely as you can. Don't worry if you are not quite sure of your answer: it's important that you give your own opinion. THERE ARE NO RIGHT OR WRONG ANSWERS. Please do not spend too much time on any one question.

To ensure confidentiality, please DO NOT WRITE YOUR NAME ANYWHERE on the following questionnaires.

_____ _____

Your confidential code Date

Date of Program commencement _____

Contents

Northfields Avenue, Wollongong, 2522
Phone: (042) 213445 Fax: (042) 214767

INITIAL INTERVIEW

About you

1. Are you male or female? Male Female (*circle one*)

2. What is your age? _____ yrs

3. In which country were you born? _____
   If you were born outside Australia, how many years have you lived in Australia?

4. What is the highest level of education you have completed? (*circle one number*)
   School up to Year 8 equivalent 1
   School up to Year 10 equivalent 2
   School up to Year 12 equivalent 3
   Post secondary such as Certificate or Associate Diploma 4
   Diploma or degree 5
   Postgraduate degree 6

5. Are you currently employed? Yes No (*circle one*)
   If "no" please proceed to question 6.
   If "yes", what is your occupation?
   (*please complete the sentence below*; *e.g. I work as a teacher at a high school*)

   I work as a .....at.....

6. Which category best describes your annual gross family income? (*circle one number*)
   Less than $10, 000 1
   Between $10,000 and $20,000 2
   Between $20,000 and $30,000 3
   Between $30,000 and $40,000 4
   More than $40,000 5
   Don't know 6

7. Are you currently taking prescribed medication? Yes No (*circle one*)
   If "no" please proceed to question 8.
   If "yes", for what condition/s has your medication been prescribed? _____
   _____

8. Are you currently receiving counselling to help you deal with your partner's drinking/drug use?
Yes No (*circle one*)
If "no", please proceed to question 9.
If "yes", from whom are you receiving counselling?

_____

9. Are you currently attending Alanon Family Groups? (self help group for partners of heavy drinkers/drug users) Yes No (*circle one*)
If "no", please proceed to question 10.
If "yes", how long have you been attending Alanon?_____

10. How many times have you previously been married/in a defacto relationship? _____

11. How many (if any) of your previous partners have had problems with alcohol? _

12. What circumstance/s prompted you to seek help NOW?

_____

About your family of origin

13. Please describe your parents' alcohol/other drug use (or the people you regard as your parents) *(circle one number for each parent)*

Mother

Non drinker _____ 1
Social drinker _____ 2
Heavy drinker _____ 3
Problem drinker _____ 4
Ex problem drinker _____ 5

Father

Non drinker _____ 1
Social drinker _____ 2
Heavy drinker _____ 3
Problem drinker _____ 4
Ex problem drinker _____ 5

About your partner

14. What level of education has your partner completed? (*circle one number*)

School up to Year 8 equivalent 1

School up to Year 10 equivalent 2

School up to Year 12 equivalent 3

Post secondary such as Certificate or Associate Diploma 4

Diploma or degree 5

Postgraduate degree 6

15. Is your partner employed? Yes No (*circle one*)

If "no" please proceed to question 17.

If "yes", what is your partner's occupation?

(*please complete the sentence; e.g. My partner works as a teller at a bank*)

My partner works as a .....at a .....

16. When did you first become aware that excessive drinking/other drug use was creating problems for your partner and yourself? (*circle one number*)

During the past month 1

During the past 6 months 2

During the past year 3

1-2 years ago 4

3-4 years ago 5

Longer than 5 years ago 6

About your partner's drinking

17. Over the past 2- 3 months, what has been your partner's drinking/drug use pattern? *(circle one number*)

Daily (drinks/uses every day) 4

Binge (periods of NO DRINKING/DRUG USE followed by periods of excessive drinking/drug use*)* 3

Regular (drinks/uses 4-6 times a week) 2

Occasional (drinks/uses 1-3 times a week) 1

Doesn't use alcohol or other drugs 0

18. Over the past MONTH, on approximately how many days did your partner drink alcohol or use other drugs? (*circle one number)*

None 0
On 1-2 days 1
On 3-5 days 2
On 6-9 days 3
On 10-19 days 4
On 20 or more days 5
Every day 6

19. Over the past WEEK, on how many days did your partner drink alcohol or use other drugs? (*circle one number)*

None 0
On 1-2 days 1
On 3-4 days 2
On 5-6 days 3
Every day 4

20. On a DAY that your partner uses alcohol or other drugs, how many drinks (or other drugs) would s/he usually have? (*circle one number*)

Doesn't drink alcohol 0
A few sips or mouthfuls 1
1 - 2 drinks 2
3 - 4 drinks 3
5 - 8 drinks 4
9 - 12 drinks 5
Over 12 drinks 6

21. On a DAY when your partner usually drinks alcohol or uses other drugs what kind of effects would it normally have? (*circle one number*)

No effects 0
Hardly any effect 1
Slightly drunk/tipsy 2
A fair bit drunk 3
Very drunk 4
Passed out 5

22. Does your partner use any other non prescribed drugs (e.g. marijuana), or prescribed drugs (e.g. valium, serapax, anti-depressant)? Yes No (*circle one*)

If "no" please proceed to question 24.

If "yes" what other drugs does he/she use? _____

About your relationship with your partner

23. Over the past 2-3 months, how would you describe your everyday interactions with your partner?

When he/she is drinking/using (*circle one number in each category below)*

Very Poor	Poor	So-So	Good	Very Good	N/A
1	2	3	4	5	6

When he/she is not drinking/using (*circle one number in each category below)*

Very Poor	Poor	So-So	Good	Very Good	N/A
1	2	3	4	5	6

24. Over the past 2-3 months, have you been abused by your partner? Yes No (*circle one*)

If "yes" to what extent have you been abused ? (*circle one number on each line below*)

	No Abuse	Minimal Abuse	Moderate Abuse	Severe Abuse	Very Severe Abuse
	0	1	2	3	4 Verbal
Physical	0	1	2	3	4
Emotional	0	1	2	3	4
Financial	0	1	2	3	4
Sexual	0	1	2	3	4

25. Were you abused as a child? Yes No (*circle one*)

If "yes", what kind of abuse? (*circle one or more numbers below*)

Verbal 1
Physical 2
Emotional 3
Sexual 4

Thank you very much for providing this valuable information. It will help in the provision of better services for partners of heavy drinkers/users.

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PARTNERS OF HEAVY DRINKERS STUDY

End Waitlist/Mid/End program

3/6 Months Follow up

The following questionnaires are about you, your partner, and your relationship. Please answer all the questions as honestly and completely as you can. Don't worry if you are not quite sure of your answer: it's important that you give your own opinion. THERE ARE NO RIGHT OR WRONG ANSWERS. Please do not spend too much time on any one question.

To ensure confidentiality, please DO NOT WRITE YOUR NAME ANYWHERE on the following questionnaires.

_____ _____

Your confidential code Date

Date of Program commencement _____

Sessions completed _____

Contents

Northfields Avenue, Wollongong, 2522
Phone: (042) 213445 Fax: (042) 214767

University of Wollongong

SUBSEQUENT INTERVIEW

Mid / End/3 months/6 months

About you

1. Are you currently taking prescribed medication? Yes No (*circle one*)
   If "no" please proceed to question 2.
   If "yes", for what condition/s has your medication been prescribed?

   _____

2. Are you currently receiving other counselling to help you deal with your partner's drinking/other drug use? Yes No (*circle one*)
   If "no", please proceed to question 3.
   If "yes", from whom are you receiving counselling?

   _____

3. Are you currently attending Alanon Family Groups? (self help group for partners of heavy drinkers/drug users) Yes No (*circle one*)
   If "no", please proceed to question 4.
   If "yes", how long have you been attending Alanon?_____

About your partner's drinking/other drug use

4. Since your last interview, what has been the pattern of his/her use?
   (circle one number)

   Daily (drinks/uses every day) _____ 4

   Binge (periods of NO DRINKING/DRUG USE followed by periods of excessive use*)* _____ 3

   Regular (drinks/uses 4-6 times a week) _____ 2

   Occasional (drink/usess 1-3 times a week)_____ 1

Northfields Avenue, Wollongong, 2522
Phone: (042) 213445 Fax: (042) 214767

Doesn't drink alcohol or use other drugs 0

5. Over the past MONTH, on approximately how many days did your partner use alcohol/other drugs? (*circle one number)*

None 0
On 1-2 days 1
On 3-5 days 2
On 6-9 days 3
On 10-19 days 4
On 20 or more days 5
Every day 6

6. Over the past WEEK, on how many days did your partner use alcohol or other drugs? (*circle one number)*

None 0
On 1-2 days 1
On 3-4 days 2
On 5-6 days 3
Every day 4

7. On a DAY (since your last interview) that your partner drinks alcohol or uses other drugs, how many drinks or drugs would s/he usually have? (*circle one*)

Doesn't drink alcohol or use other drugs 0
A few sips or mouthfuls 1
1 - 2 drinks 2
3 - 4 drinks 3
5 - 8 drinks 4
9 - 12 drinks 5
Over 12 drinks 6

8. On a DAY (since your last interview) when your partner usually drinks alcohol or uses other drugs, what kind of effects would it normally have? (*circle one)*

No effects 0
Hardly any effect 1
Slightly drunk/tipsy 2
A fair bit drunk 3
Very drunk 4
Passed out 5

9. a) Has there been a change in your partner's consumption of alcohol or other drugs since your last interview? Yes No (*circle one*)
If "no", please proceed to question 10.

If "yes", please describe how your partner's consumption of alcohol/other drugs has changed. (*circle one number*)

Increased a little 1
Increased considerably 2
Increased dramatically 3
Reduced a little 4
Reduced considerably 5
Reduced dramatically 6
Ceased using 7

b) What do you think has prompted your partner to reduce his/her consumption?

10. a) Has your partner requested help for his/her drinking/drugging since your last interview? Yes No (*circle one*)

If "no", please proceed to question 11.

b) From whom did your partner request help for his/her drinking/drug use?

c) What incident/circumstance/s prompted your partner to ask for help?

d) What was the outcome?

11. Does your partner use any other non prescribed drugs (e.g. marijuana), or prescribed drugs (e.g. valium, serapax, anti- depressant)?
Yes No (*circle one*)
If "no" please proceed to question 12.
If "yes" what other drugs does he/she use?

About your relationship with your partner

12. Since you began your program, how would you describe your everyday interactions with your partner? (*circle one number in each category below)*

When he/she is drinking

Very Poor	Poor	So-So	Good	Very Good	N/A	Poor
1	2	3	4	5		6

When he/she is not drinking

Very Poor	Poor	So-So	Good	Very Good	N/A
1	2	3	4	5	6

13. Have you been abused by your partner over the past 2 weeks / 5 weeks / 3 months? Yes No (*circle one*) If "no" please proceed to question 14.

If "yes" to what extent are you being abused ? (*circle one number on each line)*

	No Abuse	Minimal Abuse	Moderate Abuse	Severe Abuse	Very Severe Abuse
Verbal	0	1	2	3	4
Physical	0	1	2	3	4
Emotional	0	1	2	3	4
Financial	0	1	2	3	4
Sexual	0	1	2	3	4

Other (*please give details if you wish*) _____

14. a) Have you separated from your partner? Yes No (*circle one*)

If "yes" when did you separate? (*circle one number below*)

Before I came into the Program 1

During my Program 2

After I completed my Program 3

Thank you very much for providing this valuable information. It will assist in the provision of better services for partners of heavy drinkers.

Qualitative Interview

Pre treatment/Waitlist #1

_____ _____ _____

Client ID Immediate entry/Waitlist Date

The main purpose of this interview is check out how you're handling the situation with your partner (or other), and what you hope to gain from the FOCUS program. We have 10-15 minutes and I'd like you to talk for 1-2 minutes in answer to each question.

1. Just thinking about your partner's (or mother/son etc) drinking (or drug use) and behaviour over the past 2 - 3 months, what are you finding MOST DIFFICULT to deal with?

2. How do you usually deal with .....? (specify what participant finds most difficult)

3. What usually happens when you .....? (specify how participant deals with the identified difficulty)

4. What support do you have from family/friends/others which helps you deal with your partner's drinking and/or behaviour?

5. Have you told your partner that you are coming to Holyoake?
If "yes", what was his/her reaction?

6. What do you hope the Program will help you deal with /change?

Notes for interviewer

- If you would like the client to say more: "Would you expand on that please?"; or "Would you tell me a bit more about that?"
- If you do not fully understand the client's response: "Would you explain what you mean by …… please?" Once participant has clarified, move on to next item. Do not ask any more questions.
- If answer to question 5 is "no", ask again at subsequent interviews.

Qualitative Interview

Mid / End Program

3 / 6 Months Follow Up

Client ID	Date	Date first session

Number of sessions completed _____

You've now done 5/10 sessions here at Holyoake (or it's now 3/6 months since you completed your Holyoake Program). Nothing would have stayed the same over that period. Some things <u>may</u> have improved, other things <u>may</u> have deteriorated. The purpose of this interview is to check out what's happening with you, your partner, and your relationship since our last interview. We've got 15-20 minutes and I'd like you to talk for 1-2 minutes in response to each question. Let's start with you.

1. a) What's different about the way you're handling your situation with your partner since our last interview?
   b) What do you think has prompted this .....? (identify difference)

2. a) What's different about how you're feeling since our last interview?
   b) What do you think has prompted .....? (identify difference)

3. a) In relation to your partner's drinking/behaviour, what are you finding most difficult to deal with since our last interview?
   b) How do you usually handle it when.….(specify identified difficulty)
   c) What happens between you and your partner when you…..(identify how client handles difficulty)

4. a) What's different about your partner's drinking and/or behaviour since our last interview?
   b) What do you think prompted .....? (identify difference)

5. a) What's different about the <u>quality</u> of your relationship and how you interact together since our last interview?
   b) What do you think has prompted .....? (identify difference)

6. What do you think is the most important thing that's helping you (or has helped you) deal more effectively with your situation?

Notes to interviewer

- Check if drinker knows participant is attending/has attended Holyoake and what was his/her reaction (if this information not already available).
- Only other questions allowed: "Please expand…" or "Please explain…"

APPENDIX 3

Selection instruments

Short Michigan Alcoholism Screening Test (SMAST)

Short Michigan Alcoholism Screening Test (SMAST) Family Form

Consent Form

The following questions concern YOUR PARTNER'S DRINKING. Please read each question carefully, and then circle the answer which you believe is most likely.

1.	Do you feel he/she is a normal drinker? (by normal we mean he/she drinks *less than or as much as* most people)	Yes	No
2.	Do you, a parent, or other near relative ever worry or complain about his/her drinking?	Yes	No
3.	Does your partner ever feel guilty about his/her drinking?	Yes	No
4.	Do friends or relatives think he/she is a normal drinker?	Yes	No
5.	Is your partner able to stop drinking when he/she wants to?	Yes	No
6.	Has he/she ever attended a meeting of Alcoholics Anonymous?	Yes	No
7.	Has drinking ever caused problems between your partner and you, a parent, or other near relative?	Yes	No
8.	Has your partner ever been in trouble at work because of his/her drinking?	Yes	No
9.	Has your partner ever neglected his/her obligations, family, or work for two or more days in a row because he/she was drinking?	Yes	No
10.	Has your partner ever gone to anyone for help about his/her drinking?	Yes	No
11.	Has he/she ever been in a hospital because of drinking?	Yes	No
12.	Has he/she ever been arrested for drunk driving, driving whilst intoxicated, or driving under the influence of alcoholic beverages?	Yes	No
13.	Has your partner ever been arrested, even for a few hours, because of other drunken behaviour?	Yes	No

The following questions concern YOUR OWN DRINKING. Please read each of the questions carefully and then circle your answer.

1.	Do you feel you are a normal drinker? (by normal we mean you drink *less than or as much as* most people)	Yes	No
2.	Does your wife/husband, a parent, or other near relative ever worry or complain about your drinking?	Yes	No
3.	Do you ever feel guilty about your drinking?	Yes	No
4.	Do friends or relatives think you are a normal drinker?	Yes	No
5.	Are you able to stop drinking when you want to?	Yes	No
6.	Have you ever attended a meeting of Alcoholics Anonymous?	Yes	No
7.	Has drinking ever caused problems between you and your wife/husband, a parent, or other near relative?	Yes	No
8.	Have you ever been in trouble at work because of your drinking?	Yes	No
9.	Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking?	Yes	No
10.	Have you ever gone to anyone for help about your drinking?	Yes	No
11.	Have you ever been in a hospital because of drinking?	Yes	No
12.	Have you ever been arrested for drunk driving, driving whilst intoxicated, or driving under the influence of alcoholic beverages?	Yes	No
13.	Have you ever been arrested, even for a few hours, because of other drunken behaviour?	Yes	No

University of Wollongong

CONSENT FORM

Research Title

Therapy for partners of heavy drinkers: does this facilitate positive changes in the drinking?

This research in no way suggests that the partner is responsible for the drinker's behaviour. It merely acknowledges the influence one family member may have on another within the family system.

Purpose of the research

The needs of partners of excessive drinkers have largely been ignored in the professional literature. This research will attempt to identify an early intervention strategy which will not only reduce the considerable emotional pain suffered by partners, but will also debunk the widely held belief that heavy drinkers cannot be helped until they admit their problem and actively seek treatment.

More particularly, this research will explore whether therapy results in:

(i) Improvements in partner's mental health and coping style;
(ii) Reduction in marital discord;
(iii) Improvement in marital relationship; and
(iv) Reduction in drinker's alcohol use.

Researcher

Janis A. Fairbairn, BA (Hons) Dip Teach. MAPS, is an experienced psychologist who has been working in the alcohol field for 15 years. Her research is being conducted as part of a PhD (Clinical Psychology) degree supervised by Dr Jessica Grainger at the University of Wollongong, NSW.

What is required of research participants?

- One 15-20 minute AUDIO taped interview before program commencement, mid/end program, and 3/6 months post program.
- Completion of questionnaires (30-40 minutes) pre program, mid/end program, and 3/6 months post program. Participants will receive feedback concerning their questionnaire results. At the completion of the research program, participants will receive a 1 page summary of the results.
- Participants will be free to leave the FOCUS program or the research program at any time and no attempt will be made to persuade them otherwise.

Confidentiality

- The need for confidentiality is of paramount importance. Personal identification is detailed only on this Consent Form, which will be locked away and ONLY available to Ms Fairbairn or her Research Assistant.

University of Wollongong

- No names will be used on any of the questionnaires. Instead participants will identify themselves by their personal code. Only group data will be analysed and no individual will be identifiable at any stage of the research.

- The audiotaped interview will also be coded and listened to ONLY by Ms Fairbairn or her Research Assistant.
- If you have any queries regarding this research, please contact Ms Karen McCrae of the University of Wollongong Human Research Committee on (02 4221 3079).

Participant's consent

- I fully understand the study described above and I voluntarily give consent to participate.
- I understand that I will be contacted by Ms Fairbairn or her Research Assistant 3 & 6 months after I complete the FOCUS program to complete my follow up questionnaires, Information regarding the reason for the call will not be given to any other person who may answer the telephone.
- If I cannot be contacted at the number/address given below, I am willing to supply the name and number of a close family member or friend who will advise Ms Fairbairn, or her Research Assistant, how to contact me.

If you agree to take part in this research, please sign and complete the form below.

....
(signature) (date)

.
..... …… ……(w).....…(h)
(please print your name) (telephone number/s)

.....…
(please print your address)

.....

.....
(please print the name, address, and telephone number of a close family member or friend)

Your identifier

Please identify yourself in two ways. Firstly, by your mothers' maiden name initials, and secondly the date and month (but not the year) of your own birth. For example if your mothers' maiden initials were CMC and you were born on 3rd April, you would identify yourself as CMC0304.

_____ (please print your identifier here)

APPENDIX 4

Standardised procedures

Interview procedures

Questionnaire Report Form procedure

STANDARDISED INTERVIEW PROCEDURES

A. PRE TREATMENT INTERVIEW

1. Selection criteria

a) Dependency

- "We are evaluating the FOCUS program and need people who are in ongoing contact with heavy drinkers/drug users who don't want to change. Is that the situation you're in?"

  If "Yes"

- "OK, let's see how serious your partner's drinking/drug use is."

Administer SMAST Family Form

- Read instructions to client.
- Demonstrate by reading first question and circle client's answer.
- Allow client to complete questionnaire independently

If score is 3 or greater

- "Would you complete one of these for yourself?"

Administer SMAST

If score is lower than 3

b) Resistance to change

- '"Do you reckon your partner is thinking about changing?; is s/he actually doing something about it?; or is s/he not even thinking about changing?"

If client's response indicates drinker is making NO attempt to reduce/stop drinking, inform client s/he has met the selection criteria, and invite him/her to take part in the research.

If client is willing, read Consent Form, and ask client to sign and record his/her confidential ID.

Place Consent Form in a confidential envelope and lock in filing cabinet

2. Tape qualitative interview

a) Note client's ID on tape

- Read preamble to client from pre treatment qualitative interview form
- Only ask given questions. Additional approved questions appropriate when:

  (i) Client's response is very short (1-2 sentences). Ask, "Would you expand on that please?"

(ii) Client uses commonly used term; e.g. "aggressive", ask, "What do you mean by aggressive?"

3. Questionnaire package

- Read instructions to client
- Make sure client answers all questions

General Questionnaire
Drinkers' Partners' Distress Scale (DPDS)
Drinkers' Partners' Coping Questionnaire (DPCQ)
Crown Crisp Experiential Index (CCEI)
Golombok Rust Inventory of Marital Satisfaction (GRIMS)

B. END WAITLIST, MID/END TREATMENT, 3/6 MONTHS POST TREATMENT INTERVIEWS

1. Qualitative interview

2. Questionnaire package

3. Questionnaire Report Form from previous interview

QUESTIONNAIRE REPORT FORM PROCEDURE

1. Drinkers' dependency[1]

Describe according to SMAST - Family Form scores; viz.

3 - 5	Mild
6 - 10	Moderate
11 - 13	Severe

2. Drinkers' readiness to change

Record participant's comment; e.g.

"He's not even thinking about it."

"He's been talking about it for years but never does anything."

3. General psychological health

a) Total score

(i) If within 1 SD either side of the mean for urban women:

"Within average levels of emotional toughness."

(ii) If > 1 SD above mean:

"Higher than average levels of emotional distress."

(iii) If > 2 SD above the mean:

"Much higher than average levels of emotional distress."

- Suggest participant take advantage of the 3 1:1 interviews included in FOCUS program.
- Notify FOCUS co-ordinator to monitor participant's progress.
- If > 2 SD by end of treatment, refer to a clinical psychologist.

(iv) If > 1 SD below mean:

"Higher than average levels of emotional toughness."

b) Identify elevated subscale scores

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[1] N.B. Drinkers' dependency and readiness to change are only reported upon at the Pre Treatment interview.

If approaching 1 SD above mean:

e.g. "Elevated levels of anxiety expressed as physical symptoms."

c) Identify any particular concerns

(i) If > 1 SD above the mean:

e.g. "Concerns re higher than average levels of depressive symptoms."

(ii) If > 2 SD above the mean:

e.g. "Concerns re much higher than average levels of anxiety expressed as physical symptoms."

3. Marital state

a) Marital discord

Describe marital discord subscale score in terms of relationship to the mean as above; e.g. "Average levels of marital discord for problem drinking families."

b) Marital state/satisfaction

Describe score between "Very Severe Problems" and "Above Average" in accordance with GRIMS manual.

4. Recommendations

a) If participant's situation is improving:

"Keep doing what you are doing. It's obviously working!"

b) If participant's situation is not improving:

"Keep doing what's best for <u>you.</u> Focus on your <u>own</u> needs."

c) If participant's general psychological health is > 2 SD above the mean at

(i) Pre treatment interview:

" Take advantage of 1:1 counselling sessions as part of your program";

(ii) End or post treatment interview:

" Please make an appointment to see a clinical psychologist."

APPENDIX 5

Statistical information regarding the Crown Crisp Experiential Index (CCEI)

Comparison between published reliabilities for the Crown Crisp Experiential Index (CCEI) and the present research

Appendix 5 Comparison between subscale reliabilities quoted by Crown & Crisp, 1979 and the present research (n=83)

	Crown & Crisp, 1979				This research		
	Test-retest		Split half		Test-retest**	Split half	Chronbach's alpha
	Normal* n=129	Neurotic# n=74	Normal n=43	Neurotic n=62	Repeat 2 wks		
Free floating anxiety	.77	.50	.64	.82	.76	.66	.79
Phobic anxiety	.68	.76	.37	.73	.83	.55	.74
Obsessionality	.73	.76	.44	.43	.80	.31	.53
Somatic anxiety	.68	.55	.41	.37	.63	.43 -.55	.70
Depression	.72	.58	.35	.65	.61	.33 -.53	.63
Hysteria	.72	.84	.55	.63	.76	.28 -.44	.52
Total Score	n/a	n/a	n/a	n/a	.76	.81	.90

* *Repeat 1 year* # *Repeat 4 weeks* ** *All significant at the .01 level*

APPENDIX 6

Qualitative data 1

6 a) Pre treatment through end treatment categories and themes from participants' responses to the question, "What are you finding most difficult to deal in relation to your partners' drinking and/or behaviour?"

6 b) Mid treatment and end treatment coping categories, themes and examples of participants' responses to the question, "How do you usually handle that? (i.e. major difficulty in relation to drinkers' behaviour)? (n=43)

6 c) Positive and negative outcomes (for drinkers and the relationship) related to particular coping strategies from thematic analysis of participants' mid treatment and end treatment responses to the question, "What happens between you when you handle it in that way?" (i.e. major difficulty)

Appendix 6a Pre treatment through end treatment categories and themes from participants' responses to the question, "What have you found most difficult to deal in relation to your partners' drinking and/or behaviour over the past 2-3 months?" (n=43)

PRE TREATMENT		MID TREATMENT		END TREATMENT	
Categories	**Themes**	**Categories**	**Themes**	**Categories**	**Themes**
Isolation within the relationship (n=14, 33%)	• Communication problems (n=8) • Loss of a companion (n=6)	**Loneliness** (n=4, 9%)	• Loss of a companion (n=4)	**Isolation within the relationship** (n=9, 21%)	• Loss of a companion (n=6) • Communication problems (n=3)
Drinkers' abusive behaviour (n=12, 28%)	• Blaming (n=5) • Aggressive mood swings (n=4) • Anger and aggression (n=3)	**Drinkers' abusive behaviour** (n=9, 21%)	• Aggressive mood swings (n=2) • Anger & aggression (n=7)	**Drinkers' abusive behaviour** (n=6, 14%)	• Anger & aggression (n=5) • Aggressive mood swings (n=1) •
Drinkers' consumption behaviour (n=11, 25%)	• Intoxicated behaviour (n=6) • Excessive intake (n=5)	**Drinkers' consumption behaviour** (n=14, 33%)	• Concern for drinkers (n=7) • Resistance to change (n=4) • Maintaining reductions (n=3)	**Drinkers' consumption behaviour** (n=15, 35%)	• Excessive intake (n=5) • Concern for drinkers (n=4) • Irresponsibility (n=4) • Resistance to change (n=2)
Personal issues (n=6, 14%)	• Affective (n=4) • Management (n=2)	**Personal issues** (n=15, 35%)	• Affective (8) • Assertive confrontation (n=4) • Relinquishing inappropriate responsibilities (n=3) • Plans for the future (n=2)	**Personal issues** (n=6, 16%)	• Maintaining action plan (n=2) • Plans for the future (n=2) • Establishing trust (n=2)
		No major difficulties (n=1, 2%)		**No major difficulties** (n=7, 16%)	
Total n=43, 100%		**Total n=43 100%**		**Total n=43, 100%**	

Appendix 6b Mid treatment and end treatment coping categories, themes and examples from participants' responses to the question, "How do you usually handle that? (primary difficulty in relation to drinkers' behaviour)? (n=43)

MID TREATMENT			END TREATMENT		
Coping categories	**Themes**	**Some participants' comments**	**Coping categories**	**Themes**	**Some participants' comments**
Assertiveness (n=29, 67%)	Self care & responsibility (n=12)	• He has to deal with the drinking now. I leave him with it and focus on doing nurturing things for myself. • I'm not so involved and caught up in his problems. I realise I've got more power and choices. • I'm prepared to do something even if it does threaten our relationship. • I use self talk. I'm a changed person and I have a strong will to keep using these mechanisms I've learned.	**Assertiveness** (n=35, 81%)	Self care & responsibility (n=18)	• Not numb now. Acutely aware that they aren't my problems. Not weighed down like I was. • I try to express my opinions and it's OK if he doesn't agree with me. • I listen on the outside but inside I give myself positive messages so I don't get enmeshed in his stuff. That helps me stay separate.
	Assertive confrontation (n=7)	• I work out what I want to say. Tell her and leave it at that. • I assertively confront him - gradually let it slip without trying to control.		Assertive confrontation (n=2)	• I say something the following morning. When I do confront her it's less blaming.
	Clear messages (n=6)	• Speak briefly with him about what happened. • I give clear messages about my boundaries, what's OK and what's not and stick to what I say and I trust my perceptions. • Say what I've got to say and walk away. Next day try to talk to him about what happened.		Clear messages (n=8)	• Now I step back from it and say, "You're angry right now and I don't want to be around that so I'm going for a walk. I'll see you in a few hours." • Calmly communicated my fear that he's drinking if he's late.

Appendix 6c Positive and negative outcomes (for drinkers and the relationship) related to predominant coping strategies from thematic analysis of participants' mid treatment and end treatment responses to the question, "What happens between you when you handle it that way?" (i.e. major difficulty) (n=43)

	MID TREATMENT		END TREATMENT	
Coping categories and themes	**Positive outcomes**	**Negative outcomes**	**Positive outcomes**	**Negative outcomes**
ASSERTIVE (n=29, 67%, n=35, 81%)*				
Self care and responsibility (n=12; n=18)	• He's not so threatening. • He works through his anger on his own. He's better. • There's less discord. • He's talking more openly about the impact of the drinking and what he can do to help himself. • We talk about it when he's calmer.	• He withdraws and gets angry. • The relationship is distant.	• Because I've made a change he's made a change. He's definitely cut down on his drinking. Therefore, it's changed things for both of us. • He's stopped. putting so much pressure on me. Her drinking's out in the open now and our relationship is better (daughter). • He realises he's got no chance of coming back into the family unless he does something about the drinking.	• He's less involved in the family. • We don't discuss the problems. • He accuses me of not listening, not loving him and not being a friend. • Her drinking affects my love for her. She has noticed I'm not in it as much as she is.
Clear messages (n=6; n=8)	• She understood me. • There was no escalation of the situation.	• He shrugged it off. I don't think he cares. • He increases pressure to make me conform to his wishes. • He actively resists before submitting. • He gets defensive.	• He listens when I stick to "I" statements. • He doesn't ask for money any more. • She takes the point sometimes. • He's starting to voice his opinions too . • He didn't realise how uptight I was. It's a good step forward.	• He just ignores what I've said. • He walks away. Can't really say anything else.
Assertive confrontation (n=7, n=2)	• He started paying attention. • Communication improved. • He seems a lot better.	• Angry retort. • Gets furious. Still a difficult issue. • She gets really upset and defensive. and tries to shift the focus back onto me. I feel better for telling her though	• It's a bit more settled and I get some sort of an apology. But it means nothing. I'm going to expect more from her. As long as I keep focussing back on how I feel, I'll probably get somewhere. • She continues ranting and raving but I say what I need to and walk out. When I return she's calm.	

cont...

* The first n size = number of mid treatment responses, and the second = number of end treatment responses

Appendix 6 (c) cont...

	MID TREATMENT		END TREATMENT	
Coping categories and themes	**Positive outcomes**	**Negative outcomes**	**Positive outcomes**	**Negative outcomes**
Support and encouragement (n=4, n=7)	• He's more willing to cooperate. • Realises what I say is true and asks my opinion. • Offered payment in kind by cleaning the house. • We're still good friends.		• I like him. He's my best friend . • Our day to day life is much better. He has decided to be more civil. • It seemed to give him a sense of pride and he's less helpless.	• Gets defensive. Simple things are boring. It always has to be big and expensive. He stays home because he doesn't want to communicate. • He won't participate. Becomes quite bitter and angry. I give up.
WITHDRAWAL (n=10, n=2)	• Sometimes we talk about it when he's calmer. • He accepts I'm doing my stuff.	• S/he tries to engage me in arguments. • He repeats himself and talks to me more. There's a row if I don't answer him.	• He forgets the trouble easily. • When I come back 5 minutes later he'll be completely calm and normal.	• He's less involved in the family. • If it's something he doesn't want to do he'll fight harder and it always comes back to me.
INACTIVE (n=3, n=3)		• The relationship is strained • I leave it up to him (and he's not doing anything). • I'm not very happy and not much fun to be with.		• He's manipulative and tries to pressure me into reacting. • The relationship's finished.
EMOTIONAL (n=2, n=4)		• Increased discord • Don't discuss anything.		• He gets so angry. I haven't learned not to control him. • Nothing changes.

APPENDIX 7

Qualitative data 2

Categories and themes from thematic analysis of participants' mid treatment and end treatment responses to the question:

"What's different in how you're handling your *overall* situation with your partner?" (if participants had reported a change).

Appendix 7 Categories, themes, and example responses from thematic analysis of participants' mid treatment and end treatment responses to the question, "What's different about how you're handling your *overall* situation with your partner?" (n=43)

MID TREATMENT			END TREATMENT		
Categories	**Themes**	**Example responses**	**Categories**	**Themes**	**Example responses**
Improved emotional health (n=16, 37%)	• Self containment (n=7) • Emotional control (n=7) • Confidence (n=2)	• Trying not to let the drinking worry me so much instead of fretting and getting myself tied up in knots. • Ability to handle the verbal assault has improved - don't get knotted stomach and paralysis (male). • I don't scream and hit him any more. • I feel more confident about the way I handle things.	**Improved emotional health** (n=16, 37%)	• Self containment (n=5) • Emotional control (n=8) • Confidence (n=3)	• Don't let the drinking bother me as much. If he wants to drink, that's his problem. • I feel more calm about the situation. • Don't overreact as much - I don't go on about it. • Don't hit things or scream and yell any more. • Have more confidence in how I'm handling myself.
Increased personal responsibility (n=13, 30%)	• Improved boundaries (n=7) • Self care (n=6)	• More aware of the need to have boundaries and stick by what I say. • I don't take on the responsibility of his drinking like I used to. • Realise I've got more power and choices. • I care about myself more now.	**Increased personal responsibility** (n=19, 44%)	• Improved boundaries (n=9) • Self care (n=10)	• Not taking his emotional junk on board any more. He hasn't been dishing it out. because he's realised I won't accept it. • When I make a decision I stick to it. It's not made in haste or anger. • I don't think about the drinking - I'm focussing on myself.

Appendix 7 cont....

MID TREATMENT			END TREATMENT		
Categories	**Themes**	**Example responses**	**Categories**	**Themes**	**Example responses**
Improved communication (n=10, 23%)	• Clear messages (n=6) • Improved sharing (n=2) • Understanding the situation (n=2)	• Say what I've got to say and walk away. • We have gone out of the reactive relationship and are able to sit down and actually communicate. • I now have a better understanding of the tough love approach. I'm backing off and controlling less.	**Improved communication** (n=8, 19%)	• Clear messages (n=5) • Planned confrontation (n=3)	• I have more courage to share my feelings with my partner. If I'm angry, he collects it and wears it. • I don't bottle it up. I wait until the morning to say something. • I give him heaps of information, support, and understanding.
No real change (n=4, 9%)	• Haven't changed much (n=2) • Separation issues (n=2)	• I don't think I've changed very much at all. • I'm going to have to leave the family environment and home.			

APPENDIX 8

Qualitative data 3

Thematic analysis and examples of participants' mid treatment and end treatment responses to the question;

"What's the most important thing that's helped you deal more effectively with your situation?"

Appendix 8 Thematic analysis and examples of participants' mid treatment and end treatment responses to the question, "What's the most important thing that's helped you deal more effectively with your situation?" (n=43)

MID TREATMENT			END TREATMENT		
Most important elements of treatment	**Themes**	**Some participants' comments**	**Most important elements of treatment**	**Themes**	**Some participants' comments**
Personal empowerment (n=18, 42%)	Responsibility for self (n=13)	• Handing back his responsibility, and realising I was being controlled • Not responsible for another's anger especially when it's unreasonable or outrageous. • Doing something constructive for me and the children. • My future is up to me. I tended to live in the past in a regurgitating manner. Now I live in the now - the moment I can control. • Learning to concentrate on me and my feelings. Looking for reasons within me rather than him. • Taking responsibility for how I feel and act and not be affected by other persons' actions. • Get back and look at life instead of running ragged trying to please everyone else. • I leave the kids with my partner twice a week and it gives him more insight into what I had to put up with 7 days a week.	**Empowerment** (n=29, 67%)	Responsibility for self (n=19)	• No matter how much I scream and accuse I can't change him. I have to try to change my own future. • I can't change him but I can change my attitude to the situation. If I can do this I will not be so tense and uptight. • Both intellectually and emotionally accepting that I'm not responsible for him. • I learned that it is my life and I'm the only one who can make it better - or worse. • Learning to concentrate on me and my feelings. Looking for reasons within me rather than him. • I found it empowering to focus on the things I want to do. • I've done a complete turnaround about doing virtually a lot for myself and nothing for anybody else for a change.

Appendix 8 cont...

MID TREATMENT			END TREATMENT		
Most important elements of treatment	**Themes**	**Some participants' comments**	**Most important elements of treatment**	**Themes**	**Some participants' comments**
Personal empowerment cont...	Self efficacy (n=5)	• Given me a sense of assurance that I've done the right things, that I'm coping OK, and don't have to blame myself for what's happened. I get lots of strength and understanding. It's good to be listened to. You can say things and people don't say you're a fool. • It's given me confidence to deal with the problems. • I feel more confident. I'm now acting rather than reacting. • I'm picking up on the good things now instead of the bad. • I have confidence that I'm doing the right thing. Before I used to worry if I was aggravating things or making things worse.	**Personal empowerment cont...**	Self efficacy (n=10)	• Helping me to strengthen up and feeling more free to actually be myself. • I've really learned how to stop screaming and yelling. It's taught me to stop, think about it, and then deal with it. • I really thought I could change him and that everything was going to be wonderful. Now I realise I can't change him and everything *is* going to be wonderful but not between him and me. • Don't feel guilty when I make a decision that's best for me. • Single best thing internally about coming to Holyoake is that it sort of gives you courage somehow. • I've really learned to stop screaming and yelling. Now I stop, think about it, and deal with it. • It's taught me to stop some of the destructive interactions we were. having and step back from it and say, "Hang on, I'm not jumping on the bandwagon. I'm not playing these games."

Appendix 8 cont..

MID TREATMENT			END TREATMENT		
Most important elements of treatment	**Themes**	**Some participants' comments**	**Most important elements of treatment**	**Themes**	**Some participants' comments**
Raised awareness (n=15, 35%)	Understanding personal situation (n=11)	• Understanding the problem, where it comes from and the triggers. • The information from the presentations was helpful especially boundaries • Just the manual and the presentations. The systematic way of looking at relationships and how we think, believe, and behave and what influences us and how you view it. • Being realistic about the situation. Not putting my head in the sand. I've crossed the denial barrier. • Realising my son has a problem but he's got to deal with it himself. • Made me aware of what the problem is at home and that I have a responsibility to myself and my children • Made me aware of what my own feelings are, what I really want, and how to make up my own mind. • Realising or admitting that my son has a problem and he's got to deal with it	**Raised awareness** (n=6, 14%)	Understanding personal situation (n=5)	• A realisation that I feel more comfortable dealing with him honestly. • I understand how I've approached things in the past. He has an alternative reality and that's OK. He has issues underneath the alcohol. I'm learning tolerance. • I'm learning to be more aware and more conscious

Appendix 8 cont...

MID TREATMENT			END TREATMENT		
Most important elements of treatment	**Themes**	**Some participants' comments**	**Most important elements of treatment**	**Themes**	**Some participants' comments**
Raised awareness cont...	Not alone (n=4)	• I'm not alone in my feelings. It's nice to hear others saying the same things and that it's not just in my head. It's also happening right in front of me when I hear other people talking about it • Knowing I'm not alone. They help you talk. You can explain yourself better without being threatened and without putting them on their guard.	**Raised awareness** cont...	Not alone (n=1)	• It's opened my eyes to other people's problems and sufferings - you're not the only one who's going through all this.
Group therapy (n=7, 16%)		• Talking things through and saying how you feel about things you've bottled up for years and never had a chance to talk about. • They help you talk. You can explain yourself better without being threatened and without putting them on their guard. • I don't feel so isolated and that's good • Most definitely the group. Just talking to other women who are experiencing the same thing and learning so much information	**Group therapy** (n=3, 7%)		• Group sessions definitely. Interesting to see you're not the only one because you think your problems are so huge. Have others' output on your problem. • Hearing others' experiences in group is very helpful • There's lots of support. They ring you up and ask how you're going.

cont...

Appendix 8 cont...

MID TREATMENT			END TREATMENT		
Most important elements of treatment	**Themes**	**Some participants' comments**	**Most important elements of treatment**	**Themes**	**Some participants' comments**
New skills & strategies (n=3, 7%)		• It's teaching me how to handle the situation in a different way. I say and do things differently. I speak to him calmly; e.g. "I don't know if you're an alcoholic but your drinking has really affected me and hurt me. *Dead silence*! He didn't know what to say." • Learning new skills; e.g. not getting caught up in his stuff - not taking it on. If he's attacking me, I think, "This is your stuff mate!"	**New skills & strategies** (n=5, 12%)		• Now I don't accept behaviour I was prepared to in the past because I was trying to provide a nurturing environment no matter what he did. (male) • Setting limits which are best for me • No pot smoking in the house. He can go to the shed away from the house and the kids and the normal running of things. Also I decide how much I want to let myself be abused by him.
Total n=43, 100%			**Total n= 43, 100%**		