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AUTHOR O'Farrell, Timothy J.; Cutter, Henry S. G.
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ABSTRACT

After describing a social learning formulation of the male alcoholic's marriage, this paper reviews the few studies of behavioral marital therapy (BMT) for alcoholics and their wives. Although none of these studies are as rigorous as one might wish and many of them are merely case studies, a review of the literature shows that behavioral marital therapy in combination with social and vocational behavioral alcoholism treatment produces better results with State Hospital alcoholics than does a less intensive traditional alcoholism treatment. When intensity of treatment is held constant, behavioral marital therapy for outpatient alcoholics is not only superior to three alternative behavioral treatments but clearly exceeds the outcome statistics in the nonbehavioral literature. With the exception of a study treating only the wife, behavioral marital therapy has had positive results in 29 of 31 cases treated. A series of issues and questions future studies should address are listed. In addition, a study to compare behavioral and non-behavioral couples groups is proposed. (Author)

BEHAVIORAL MARITAL THERAPY (BMT) FOR ALCOHOLICS AND WIVES: REVIEW OF LITERATURE AND A PROPOSED RESEARCH PROGRAM

Timothy J. O'Farrell and Henry S. G. Cutter

Veterans Administration Hospital

Brockton, Massachusetts 02401 USA

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Today I would like to present a review of the literature and a preview of a proposed research program dealing with behavioral marital therapy (BMT) for alcoholics and their wives. I had planned to present the first results of this new research project but unforeseen delays make this impossible. That is why I changed my title and why I am a bit embarrassed. Nonetheless, let me start with a brief review of the literature which covers the most important features of past studies and the needs they reveal for future research; time limitations prevent a detailed methodological critique of each study.

Behavioral marital therapy (BMT) for the alcoholic's marriage is based on a social-learning formulation. According to this model, the marriages of male alcoholics and their wives are generally conflicted; the couple fight repeatedly about drinking and positively reinforce each other at a low rate. Marital interaction, under these conditions, is hardly a viable alternative to drinking.

In this behavioral view, certain antecedent and consequent events are assumed to maintain abusive drinking. An important antecedent to drinking by married alcoholics may be their lack of assertiveness in interaction with their wives. Wives who attend primarily to alcoholic behaviors but virtually ignore positive nondrinking behaviors provide consequences likely to increase drinking. Wives, furthermore, often provide financial, emotional and sexual support when alcoholic husbands are actively drinking. A detailed consideration, however, of the evidence for and issues involved in this behavioral formulation of the alcoholic marriage is beyond the scope of my paper today.

I want to tell you briefly about the few available reports of BMT for married male alcoholics. Table 1 of your handout summarizes these studies.

Cheek, Franks, Laucius and Burtle (1971) tried to teach 24 wives and relatives of treated alcoholics to apply operant principles to family

interactions likely to threaten sobriety.' Their rather meager findings indicated that wives were unable consistently to apply this new learning at home.. The authors speculated that the wives were so sensitized to their alcoholic husbands' behavior that the tension and anger they felt when dealing with their husbands inhibited the wives from changing their emitted reinforcers. It may also be significant that only the wives were treated in this study. Recent reviews of the marital therapy literature suggest that the joint treatment of husbands and wives is more likely to succeed than individual treatment.

The effects of assertive training have been reported in a case study by Eisler, Miller, Hersen and Alford (1974). The results showed that the husband was more assertive in post treatment videotaped interactions with his wife and, apparently as a consequence, weekly breath alcohol levels (taken on a random basis for 6 weeks before and after therapy) decreased. This imaginative case study is noteworthy because it applied specific behavioral procedures and demonstrated changes on objective measures of marital and drinking behavior.

Miller (1972), in another case study, found that the husband's drinking dropped to and remained at agreed-on limits following the establishment of a contingency contract between spouses. At six months follow-up the couple also reported an improved marital relationship. This study is the first in the literature to apply contracting to the relationship between an alcoholic and his wife.

Wilson and Rosen (1976) in a case study also employed a contract (specifying the amount and stimulus conditions for controlled drinking) as part of a multifaceted behavioral treatment program that also included BAC discrimination training, thought stopping, and assertive training. The wife

observed treatment and provided feedback to the husband and to the therapists during therapy sessions. The couple, initially teetering on the brink of divorce, reunited with both reporting greater happiness. The husband was controlling his drinking at 6 months follow-up.

Miller and Hersen (1975), in an as yet unpublished case report provide a model example of treatment-relevant assessment and the effective use of a more comprehensive marital treatment package. Assessment consisted of direct observation of the couple during interviews together, videotaped conversations in which the couple discussed various problem and non-problem areas of their life, and audiotape recordings of mealtime interaction at home on two occasions. In some of these assessment sessions the counselors were absent to allow for more "natural" interaction. On the basis of these assessments, specific behavioral goals were set and achieved by means of social skills training, assertive training, and contracting. Follow-up at 9 months indicated that the husband had taken Antabuse each day and was completely abstinent. Improvements also were noted in the interactions of the couple (videotaped in the clinic) and in their day-to-day behavior at home.

Hunt and Azrin (1973) and Azrin (1976) included a behavioral marital counseling procedure as part of their community-reinforcement program for State Hospital alcoholics. Rigorous evaluation of the treatment program, of which the marital counseling procedures were a part, showed it to be clearly superior to a less intensive, more traditional hospital program for alcoholics. This is the first study in which marital counseling was based on a behavioral treatment package previously used with non-alcoholics. Homework assignments and various structured tasks taught couples to pinpoint pleasing and displeasing spouse behaviors and to request desired changes. Instruction in negotiation, compromise, and informal contracting was used to facilitate behavior change at home.

Hedberg and Campbell (1974) in an experimental clinical study compared among outpatients the therapeutic efficacy of behavioral marital counseling, systematic desensitization, covert sensitization, and aversion therapy. At 6 months follow-up, behavioral marital counseling was found to be the most effective treatment with 74% of 15 alcoholic patients achieving their goal (either abstinence or controlled drinking); an additional 13% showed "much improvement." For those who chose abstinence as their goal, behavioral marital counseling was, by far, superior to all other treatments. Communication training, instructions in the principles of learning, contracting, and assertive training were all part of the marital treatment. The sequencing, frequency and total number of treatment sessions was the same for all patients irrespective of the type of therapy received.

Although none of these studies are as rigorous as one might wish and many of them are merely case studies, we can see from our review of the literature that behavioral marital therapy in combination with social and vocational behavioral alcoholism treatment produces better results with State Hospital alcoholics than does traditional alcoholism treatment (although time in therapy was not equal for the two treatments). In addition, when intensity of treatment is held constant, behavioral marital therapy (BMT) for outpatient alcoholics is not only superior to three alternative behavioral treatments but clearly exceeds the outcome statistics in the nonbehavioral literature. Finally, BMT (with the exception of a study treating only the wife) has had positive results in 29 of 31 cases treated. BMT for alcoholics and their wives, one must conclude, shows promise and deserves the further serious attention of behavior therapists. We should develop and rigorously evaluate behavioral marital treatment packages for alcoholics and their wives. Once such a package has been developed, there are a number of questions and issues that should be investigated.

Now, before concluding with questions relevant to future research, I would like to tell you about a research project that my colleague, Dr. Henry Cutter, and I recently submitted for funding. Married alcoholics undergoing inpatient treatment for alcoholism, in the design of this study, are randomly assigned to a no marital treatment control condition or to 12 weekly sessions of either a behavioral couples group (Liberman, Levine, Wheeler, Sanders & Wallace, 1976) or a nonbehavioral interactional couples group. This latter nonbehavioral treatment is included in order to compare the behavioral methods of marital therapy with the most frequently used alternative. Measures of marital, drinking, vocational and emotional adjustment taken pre and post therapy (and at 2, 6, and 12 month follow-ups) are used to evaluate treatment outcome. The marital measures include samples of couple interaction videotaped in the clinic and at home and a variety of self-report measures developed by BMT researchers. Drinking behavior is measured by standardized self-report instruments, collateral reports, and breath alcohol tests in the community.

Table 2 of your handout describes the behavioral couples group in greater detail; Table 3 lists the dependent variable measures. I look forward to communicating the results of this proposed project to you at a future date.

There are a series of questions and issues that future research must address if this seemingly fertile field for treatment and research is to bear fruit.

1. What does a BMT package add to alcoholism treatment?

   Rigorous studies which specifically evaluate marital treatment using random assignment, equal time in treatment for experimental and control groups, appropriate outcome measures, and sufficient follow-up are needed.

2. How does a BMT package compare in terms of effectiveness to other frequently used marital treatments for alcoholics and their spouses? The greater structure and presumably greater cost in therapist and client time and effort needed for BMT as compared to alternative marital treatments require the use of additional appropriate treatment comparisons.
3. For whom is BMT a sufficient treatment for alcoholism and for whom are additional non-marital treatments needed? What are these additional therapeutic inputs and who needs them? Job-finding help for the unemployed and specific training in controlled drinking for those with such a goal may be two such inputs. In addition, alcoholics whose drinking is triggered by uncomfortable thoughts and feelings related to events outside the marriage may benefit from relaxation training and stress inoculation training.
4. Individual differences in acceptance of and response to BMT should be studied.
5. After rigorous evaluative studies demonstrate the efficacy of a BMT package, then the importance of specific components of the package can be evaluated for specific sub-groups of alcoholics and their wives. When the literature reaches this level of sophistication, the following may be significant questions:
    a. Is a treatment focused only on alcohol-related interaction patterns without intensive therapy for other areas of the marital relationship sufficient for some alcoholics and their wives?

b. For which married alcoholics should controlled drinking be a goal? How important is the wife's full acceptance of such a goal? When should controlled drinking be pursued through a marital agreement and when should it be pursued through a self-control program (with or without wife involvement) for the problem drinker.

c. How does a single couple BMT intervention compare to a couples group format and are there differences in who does best in which type of therapy?

d. Do some wives need desensitization or some other intervention to help them adopt a more positive attitude toward the alcoholic husband before BMT can be used?

e. Procedures need to be developed and evaluated to deal with common objections to marital therapy found among some alcoholics and their spouses (Hunt & Azrin, 1973, 94-95).

Now, in closing, I will return to some general points that do not refer to the specific components of a BMT treatment package.

6. Investigators and therapists in this area should become and remain familiar with the literature on behavioral approaches to marital conflict (cf Jacobson & Martin, 1976), sexual dysfunction (LoPiccolo & Lobitz, 1973), sexual enhancement, (LoPiccolo & Miller, 1975), and parent-child problems (Patterson, 1971). These bodies of literature may suggest useful assessment and treatment procedures for BMT with alcoholics. In addition, university clinic investigators

in these other areas could benefit from the application of their work to the more problematic alcoholic population.

7. Now, BMT studies should use the assessment and evaluation procedures Linda Sobell suggested yesterday (Sobell, 1977) with the marital measures being those suggested by leading BMT researchers (Weiss & Margolin, 1977). However, these marital measures are quite complex, time-consuming and not specifically tailored to marriages of problem drinkers. Thus, we need to develop simple, inexpensive, reliable and valid measures of marital adjustment for problem drinkers. One such measure is Hunt and Azrin's (1973) use of the number of weekends spent in a structured social activity outside the home during a follow-up period; the behaviorally treated group with overall superior outcome also did much better on this measure. In addition, a recent retrospective alcoholism treatment outcome evaluation found family participation in social and recreational activities to be one of the few family environment characteristics associated with positive treatment outcome (Moos, Bromet, Tsu & Moos, 1977).

8. Finally, we need extensive further study of the relationship between drinking behavior (controlled and uncontrolled) and marital and family behavior.

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