

Nagging and Other Drinking Control Efforts of Spouses of Uncooperative Alcohol Abusers: Assessment and Modification

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This article presents a conception of spouse drinking control and an approach to assessment and modification to reduce the customary drinking control efforts of spouses of alcohol abusers unmotivated to enter treatment. Modification of the nonalcoholic spouse's customary drinking control is offered as an important early step in helping to prepare him or her to become a positive rehabilitative influence. Based on its use in unilateral family therapy with 68 spouses of uncooperative alcohol abusers, procedural guidelines, criteria for use, and two case examples from a crossover experimental dyad are described. Also presented are clinical results illustrating the success of the program, benefits and conditions relating to its use, and areas of possible application.

Virtually all spouses with partners who drink too much have tried to influence the drinker to reduce or stop the drinking through such means as nagging and complaining about the drinking, withdrawing from the drinker, or threatening the drinker if he or she doesn't stop. The wives' attempts to influence drinking behaviors have been described by Wiseman (1980) as their "home treatment" for their husbands' drinking. Other have conceptualized the spouses' efforts variously as one means of coping with the drinking (e.g., see Orford et al., 1975; Schaffer & Tyler, 1979), as an early stage of adjustment to the drinking (e.g., see

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Jackson, 1954, 1956; Richards & Bascue, 1978), as evidence of the spouses' overinvolvement in the drinking situation (e.g., see Burnett, 1984; Johnson, 1986), as part of a power struggle between the marital partners (Shapiro, 1977–1978), and as a symptom of the spouses' codependency with the drinker (e.g., see Cermak, 1986; Schaef, 1986).

Common to all spouse efforts to influence drinking is the intention to bring about a reduction or cessation of the drinking. There have been few studies that provide relevant evidence on this issue and those that have been conducted present a mixed picture, at best (e.g., see Homila, 1985; Orford et al., 1975; Schaffer & Tyler, 1979; Wiseman, 1980). If spouse efforts to control drinking of a marital partner prior to his or her entry into treatment serve to reduce or stop the partner's drinking, it has not yet been demonstrated. Such "home remedies," however, may interfere with treatment of the drinker and with his or her continuing sobriety, and may be associated with dysfunctional behavior for the spouse and the marriage, as described later.

This report presents a description of a treatment program to modify the behavior of the spouse of an alcohol abuser that is intended to control or reduce the quantity and/or frequency of drinking in certain situations, designated "drinking control" (DC) behavior. The program was developed as one of several components of a unilateral approach to alcohol abuse in which a cooperative spouse was assisted to influence the alcohol-abusing partner to stop drinking, enter an alcohol treatment program, or both (Thomas, 1989; Thomas & Santa, 1982; Thomas, Santa, Bronson, & Oyserman, 1987). This report presents a rationale for, and role of, a program to modify the spouse's customary approach to DC, procedures for planning, assigning, and monitoring the program, conditions under which to use it, illustrative case examples, practice issues, clinical results to date on its use, and other potential uses of the program.

CUSTOMARY SPOUSE DC AND THE NEED FOR ITS MODIFICATION

DC is viewed as consisting of efforts of a spouse or other family member to reduce the alcohol consumption of a drinker. Such efforts are characteristic of patterns of interaction with the drinker that are part of the "sobriety influence system" that is in operation prior to treatment for the spouse or family member. These DC efforts are very much paced and governed by the frequency and amount of alcohol consumed by the drinker (e.g., see Homila, 1985).

Although spouse DC may have some positive functions prior to treatment, it may be seen as having several important dysfunctional components. First, DC may contribute to maintaining patterns of marital or family conflict about the drinking. The abuser and spouse can easily become engaged in a continuing cycle of drinking and influence attempts, thus escalating levels of marital dissension which, as O'Farrell (1986) indicated, may exacerbate the drinking.

Second, as long as the spouse continues to try to control the drinking, he or she risks remaining emotionally overinvolved in the drinking (e.g., see Burnett, 1984). The spouse may become consumed with feelings of frustration and anger

about the drinking, may relinquish his or her own activities or interests, or forego other opportunities for personal development (Burnett, 1984; Johnson, 1986). Third, the spouse's influence attempts may counter, negate, sabotage, or otherwise interfere with planned treatment-based interventions. Finally, in those cases in which the drinker does stop drinking, the spouse's DC efforts may interfere with maintaining sobriety if he or she continues to employ this largely negative and aversive mode of responding. A relatively stress-free, supportive family milieu has been described as one of the components necessary to maintain nondrinking during the initial recovery phase (Cronkite, Finney, Neknich, & Moos, 1990).

With the aid of treatment, the nonalcoholic spouse may be assisted to discontinue customary efforts to control the drinking. The potential benefits of such a change include "calming" of the alcoholic family system, a goal endorsed by many family systems theorists (Bepko & Krestan, 1985; Berenson, 1976; Bowen, 1974; Fajardo, 1976), neutralization of the spouse's old influence system, increased emotional distance and detachment of the spouse from the drinking and its impact, and the spouse's increased feelings of independence and empowerment (Burnett, 1984).

The reduction of the spouse's DC is particularly important when preparing the spouse to carry out an abuser-directed intervention. A period of sustained calm prior to and following the intervention can greatly heighten its impact. In general, then, giving up home remedies, such as spouse DC, is seen as necessary in preparing the spouse to become a more positive rehabilitative influence.

REDUCING SPOUSE DC IN UNILATERAL FAMILY THERAPY

In the application of unilateral family therapy to alcohol abuse, cooperative nonalcohol-abusing spouses are assisted to influence their uncooperative partners to stop drinking, enter treatment, or both (Thomas, 1989; Thomas & Santa, 1982; Thomas et al., 1987). Abuser-directed intervention, such as a programmed confrontation or request (Thomas & Yoshioka, 1989), are among the active interventions carried out by the spouse after she or he has been assisted to assume a rehabilitative role.

As part of the induction of the spouse into a rehabilitative role, a modification program to reduce spouse customary DC is carried out. Other treatment modules for the spouse to prepare for the rehabilitative role include: (a) alcohol education; (b) unilateral relationship enhancement (Thomas, Adams, Yoshioka, & Ager, 1990), aimed at reducing marital discord and enhancing the potential of the spouse to mediate change with the drinker; and (c) a disempowering program to facilitate the reduction of spouse behaviors that enable abuser drinking (Thomas, Yoshioka, & Ager, 1992). This DC modification program is not intended or expected to bring about a reduction in the drinking on its own. As indicated, its purpose is to make way for the spouse to assume a more positive rehabilitative role, and, subsequently, to carry out an active intervention intended to influence the abuser to reduce drinking, enter treatment, or both.

THE DC MODIFICATION PROGRAM

The DC component described in the following was used with 68 spouses of uncooperative alcohol abusers during the course of evolving and implementing the unilateral family therapy program for alcohol abuse. Each of these spouses had been screened according to eligibility criteria including an absence of domestic violence, no other drug abuse on the part of either partner, no history of severe emotional disorder, and no immediate plans for marital dissolution.

Introducing the Program and Identifying DC Behaviors

In an early session, the program is initiated by identifying the spouse's DC behaviors that might be potential targets of change. To facilitate the process of identifying potential targets of change, the Spouse Sobriety Influence Inventory (SSII) may be employed, which makes it possible to assess the frequency of 45 DC behaviors.¹ The therapist reviews the spouse's responses on this scale, which should be completed prior to treatment. Each item for which the spouse reports having engaged in the behavior occasionally or more over the past 6 months (i.e., which was given a score of 3 or more) is flagged as a potential target for change, and is listed on a separate piece of paper without any indication of its source.

If the inventory is not used, the spouse is asked for examples of his or her past behaviors that were aimed at reducing or stopping the abuser's drinking. Useful opening questions are: "How do you let the drinker know you dislike his/her drinking?" "How have you tried to get him/her to stop drinking?" All spouse mentions of DC behaviors are listed on a separate piece of paper.

After the preliminary list of target behaviors has been identified, the therapist reviews them with the spouse to obtain examples of how the particular behavior is engaged in and abuser reactions.²

At this point the therapist orients the spouse further to the concept of DC by describing some of the dysfunctions associated with these behaviors. DC is described as part of the spouse's "old sobriety influence system" which we hope to have put aside so that other, more appropriate ways of responding can be initi-

¹ The items of the SSII were inductively derived from instances of spouse influence that occurred in the pilot phase of the project and were worded to refer to readily identifiable behaviors. The inventory is intended as a clinical and research tool. The items fall into one of two scales: (a) the Spouse Drinking Control scale (45 items), which encompasses those actions intended to stop or to thwart abuser drinking and/or drinking opportunities; and (b) the Spouse Sobriety Support scale (7 items), which consists of those actions intended to support nondrinking or sobriety behaviors. For each item, the spouse is asked to indicate how often he or she has engaged in that behavior over the past 6 months. Response options range from *never* (5) to *always* (1), and are reversed in direction for scoring. Psychometric properties of the SSII will be reported elsewhere.

Spouses involved in the research completed this instrument as a part of an assessment battery upon entry into the research (Time 1) and at three subsequent administrations spaced approximately 6 months apart (Times 2, 3, and 4). Copies of the SSII may be obtained from the second author.

² If the SSII is used, a list is prepared from the inventory and is presented to the spouse without indicating that these were the items the spouse responded to earlier as those having been moderately or highly endorsed. The list is described as some examples of the behaviors many spouses living with a problem drinker have employed to try to get the drinker to reduce or stop drinking.

ated. Instances of DC are thereafter referred to as the “old system,” a convenient short-hand concept that is readily understood.

Screening Behaviors

The final list should be screened to eliminate behaviors not specifically related to drinking or its control (e.g., general complaints about the marriage or efforts to change it). In some instances, the DC behaviors of the spouse are intended to avert or reduce danger to the spouse or others occasioned by the drinking (e.g., the spouse refusing to let a child get into a car about to be driven by a drunken marital partner). When there is evident danger of other risks, control efforts related to these factors clearly should be excluded from the DC modification program.

Assigning the Program

The DC behaviors that survive the screening should be specified and appropriate alternative responses identified. Once all behaviors have been screened, the spouse’s willingness to reduce the frequency of the old DC efforts is sought. If the spouse is willing, the therapist selects several items (usually 3) from the list of surviving items that the spouse and therapist believe are among the easiest to change. The spouse is asked to stop the chosen behavior as best as he or she can and to engage in alternative responses.

The spouse also is requested not to reveal the goals of the program to the drinker and to carry it out without any announcement. The spouse is cautioned against anticipating any positive response from the abuser and that the program, by itself, is not expected to bring about changes in the drinking. However, the program is described as having its own benefits for the spouse and as one of many changes that help to prepare the marital relationship for more active intervention to follow.

Monitoring

At the next session, the therapist reviews the behaviors chosen for reduction the week before, and any problems are addressed. If the spouse was able to reduce the frequency of the targeted behaviors sufficiently, additional behaviors are selected from the surviving items and are targeted for the upcoming week. Each week, if the spouse has been doing well in reducing the targeted behaviors, and is willing to take on others, additional selections are made until all behaviors on the list have been targeted for change.

Handling Difficulties and Special Problems

Although the DC modification program should remain more or less intact throughout the treatment period, it may be necessary to make adjustments, depending upon such factors as the number of areas of DC targeted, the rate of spouse progress, and program compliance.

In some instances, the spouse may report that she or he has already stopped engaging in all DC behavior. Rather than avoid doing anything further on DC, the therapist may wish to begin monitoring in an informal way the spouse's possible DC activities. The spouse may have resumed DC efforts or have mistakenly failed to recognize some of his or her actions as attempts to change the drinking. The therapist should be particularly attentive to indirect or nonverbal behavior that conveys disapproval of drinking so that such behaviors can be addressed and included in the program.

The spouse may be reluctant to stop engaging in DC, fearing that, in so doing, there will be an increase in the partner's drinking. Spouses also may worry that by not criticizing the drinking, she or he will be condoning the drinking. The therapist can acknowledge that these concerns are understandable yet indicate that such control behaviors do not promote long-term recovery, they often cause marital conflict, and that DC and its negative effects may interfere with planned abuser-directed interventions that will be conducted later.

The therapist also may need to help the spouse distinguish enabling from DC. Here it can be pointed out that, in contrast to DC, enabling typically involves directly promoting the drinking by serving drinks, for example, or buying alcohol for the drinker.

While successfully trying to reduce DC, some spouses will continue to be preoccupied with related cognitions, such as negative thoughts involving the drinking, or affect, such as anxiety or anger about the abuser's drinking. Some continuing indications of the cognitive and affective correlates of DC are common and are to be expected, at least to some extent, particularly in the early stages of DC modification. As the program continues, however, and there is more and more detachment of the spouse as evidenced by reductions in the overt behavioral aspects of DC, the cognitive and affective correlates likewise abate for most spouses.

However, in some cases, spouses will persist in having intense negative thoughts or feelings about the drinking, despite successful reduction of the targeted DC behaviors. In such cases, it may be necessary to address detachment directly and more broadly to assist the spouse further to "back off," "let go," and achieve greater emotional distance from the drinking and its effects (e.g., Leite, 1987).

METHODS

In the pilot and evaluation phases of the research, the first case in each successive pair of the total of 68 spouses enrolling in the program was assigned to receive 6 months of immediate treatment and the second case received 6 months of treatment delayed for 6 months. Each such pair of spouses represented a crossover experimental dyad. In the case examples presented in the following, Case X received immediate treatment and Case Y received delayed treatment. Efficacy of the treatment was measured by changes in DC scores of targeted behaviors measured by the SSII at enrollment and three successive 6-month intervals.

Case X

Mr. and Mrs. X were both professionals in their late thirties, with three young children. Mr. X, a Vietnam veteran, had a long history of excessive drinking prior to Mrs. X's participation in the project. At that time, Mr. X had increased his drinking notably and had become increasingly hostile and secretive about the drinking. During the course of the first few sessions, Mrs. X described her intense frustration and feelings of anger toward her husband and his drinking, attributing her frequent headaches to the stress that the drinking created.

In an early session, the therapist introduced the concept of DC as one aspect of her old sobriety influence system and reviewed the list of the DC items which Mrs. X had endorsed at the higher level on the Spouse Drinking Control scale of the SSII given to her before treatment. In discussing the list, Mrs. X expressed reservation about the idea of eliminating the influence behaviors, contending that her husband would interpret such reductions as approval of the drinking. The therapist presented the advantages of reducing the DC and Mrs. X then agreed to participate in the DC modification program.

After screening the items on her list of potential targets, the therapist and Mrs. X found that a total of 4 items were appropriate for the DC modification. The behaviors for 3 were targeted for the coming week. These were refusing to talk to the drinker because of the drinking (Item 38), ignoring the drinker to get back at him (Item 52), and saying that if the drinker loved her and/or the children, he'd stop drinking (Item 39). After specifying instances of these, she was asked to do her best to stop engaging in these behaviors.

The following week, Mrs. X reported that she had felt more in control of herself and in a better emotional state. Because she had not had difficulties with reducing the 3 targeted behaviors, she was asked to begin to target the 4th behavior (arguments about drinking-related problems, Item 24).

In monitoring Mrs. X's progress over the weeks, there was some variation in her ability to refrain from the control behaviors. Overall, however, she was able to sustain a reduction and reported a more pleasant home environment, fewer physical symptoms, and less stress.

Concurrent with work on the DC modification, the therapist and Mrs. X together planned a programmed request, an abuser-directed intervention deemed to be appropriate in her situation. In response to her carefully scripted and delivered request for him to enter treatment for his drinking, Mr. X entered an inpatient program for his alcohol use.

Case Y

In their mid-sixties, Mrs. Y was employed part-time outside the home and Mr. Y was retired. Mrs. Y reported that overall they both found their relationship to be rewarding and loving. A long-time heavy drinker, Mr. Y had slowly increased his drinking since his retirement several years earlier.

Mrs. Y had endorsed a total of 19 items on her pretreatment scale. Review of these during the second session suggested that 3 of them were particularly

problematic as they almost always resulted in the couple's arguing. These were: expressing disapproval of the drinking (Item 2); asking the drinker before he goes out to drink less (Item 5); and trying to get the drinker to reduce his/her drinking while at a social function (Item 12). The therapist introduced the concept of DC as involving part of the old sobriety influence system and Mrs. Y readily agreed to try to refrain from engaging in the 3 behaviors. Weekly review of her progress indicated that she had discontinued the behaviors altogether.

At the 10th session, Mrs. Y expressed concern about continuing the program because she noted that Mr. Y was drinking more heavily since the program began and seemed to have more blackouts and other alcohol-related symptoms. The therapist reminded Mrs. Y that the purpose of the DC modification was not to reduce Mr. Y's drinking but to help set the tone for the programmed request that they were then planning. After brief discussion, Mrs. Y concluded that, in the meantime, she would continue with the program and allow Mr. Y to experience the full effects of his drinking.

Several weeks later, following delivery of her programmed request, Mr. Y consented to have an alcohol evaluation at which time it was recommended that he begin outpatient treatment, a recommendation to which he agreed and carried out.

CLINICAL RESULTS

The DC modification program was successful in reducing the targeted DC behaviors (see Figure 1). For both cases, DC targeted behavior scores of the SSII fell during and in the interval immediately after treatment. For Case X (immediate treatment), the score reductions took place in Intervals 1–2 and 2–3 whereas in Case Y (delayed treatment) the scores fell in Interval 2–3 and remained reduced during Interval 3–4. Similar results were found for both cases for DC behaviors that were not targeted and for total DC scores.³

Among the 68 cases enrolled in the larger study, the number of items targeted in DC modification interventions range from 2 to as many as 20, with the typical number being 3–6. Only occasionally did all the items survive the screening and become targets for intervention. When a large number of items were identified as targets for change, a few spouses attempted to reduce them all concurrently, but typically behaviors were targeted 3 at a time.

Overall, the DC program was readily implemented and well received by the spouses. Although there was variation in the degree to which the programs were carried out, most of the participating spouses were willing to try to reduce the DC identified in the assessment.

³ More generally, the results for this crossover experimental dyad are directly comparable to those found for the 43 spouses who received unilateral treatment in the evaluation phase of the research, as tested by repeated-measures ANOVAs. The reductions in DC could not be attributed to reductions in abuser drinking associated with the unilateral treatment programs as indicated by an ANCOVA, with reductions in abuser drinking as the covariate. These and other outcomes of the experiment to evaluate the unilateral approach go beyond the focus here and will be reported elsewhere.

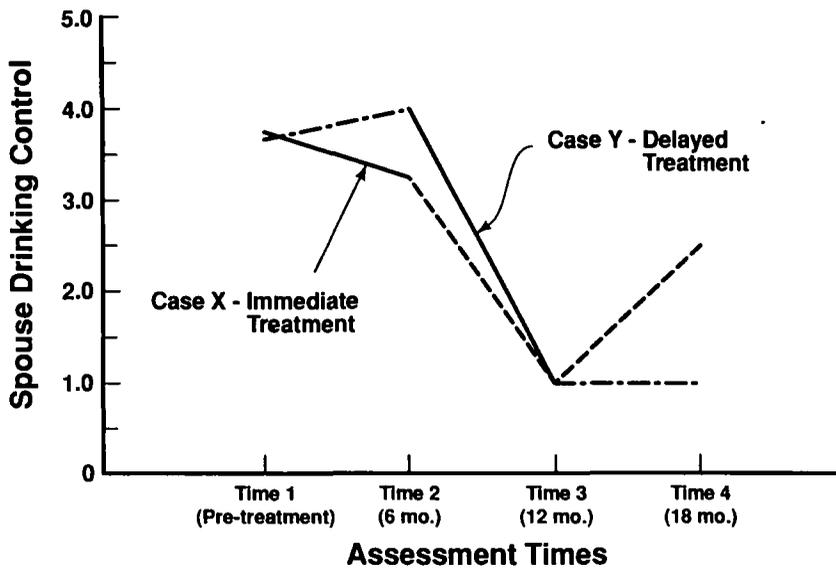


Figure 1. Mean Spouse Drinking Control Scores of targeted behaviors of Cases X and Y of the same cross-over dyad, by assessment times.

DISCUSSION

Although the spouses in this research were judged to be good candidates for a DC program and the program served to reduce DC as intended, we anticipate that such a program may not be relevant for some spouses of alcohol abusers. Thus, some spouses already may have stopped engaging in DC efforts. Others may be unable to put aside their anger enough to relinquish their DC attempts, and some may be too fed up with the abuser's drinking and the marriage to try to make changes as a means to reduce conflict and to work with the therapist toward getting the abuser to do something about the drinking.

When it is suitable for the spouse, DC modification has several applications when considered in relationship to other possible foci of spouse treatment. First, it may be employed as part of a larger treatment program, such as that described here and elsewhere (Thomas, 1989; Thomas et al., 1987; Thomas & Ager, in press). In this connection, DC programs may be used, once the drinker has entered the recovery phase, with spouses who are trying to support sobriety, with other family members besides the spouse, or with friends, employers, or coworkers. Considered more generally, programs to reduce dysfunctional DC attempts analogous to the DC modification program may have application, along with other treatment efforts, to assist spouses and other family members with other problems, such as abuse of other substances, eating disorders, and marital or family conflict. Second, DC programs and related programs to reduce unwanted influence may be the sole focus of intervention whenever a client engages in dysfunctional influence attempts that may be disruptive to an interpersonal relationship and interfere with problem resolution.

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