CONJOINT GROUP THERAPY AND STANDARD INDIVIDUAL THERAPY FOR ALCOHOLICS AND THEIR PARTNERS

by

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ABSTRACT

Sixteen couples, where one of the partners was an alcoholic, were assigned to either a standard individual therapy condition or a conjoint group therapy condition. Treatment outcome was assessed on alcohol consumption, self-esteem, spouse regard, relationship or marital adjustment, and ratings of social and work functioning. No significant differences were found between the two therapy conditions on alcohol consumption for the alcoholics or on a multivariate analysis of the other dependent measures for both the alcoholics and their partners. Similarly, no significant differences in response to therapy were found between the alcoholics and their partners on the adjunctive measures used. However, both therapy conditions appeared to have significantly improved on all of the dependent measures. This improvement appeared to be roughly parallel. These results were discussed in terms of implications for future research.

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INTRODUCTION

In the past half century of evaluating the treatment of alcoholic populations, the results have been discouraging. An early review of the treatment evaluation literature by Voegtlin and Lemere (1942) revealed a discordant collection of studies with vague, subjective reports of outcomes and severe methodological deficiencies. As Voegtlin and Lemere (1942) caustically noted in their conclusion:

> "It is impossible to conduct a review as extensive as the foregoing without forming some rather definite impressions. The most striking observation is the apparent reticence with which the English speaking psychiatrists have presented statistical data concerning the efficacy of treatment."

Despite this limitation, Voegtlin and Lemere (1942) report an estimated improvement rate ranging from 25% to 75%. Hill and Blane (1967), in their more recent review, reached the reluctant conclusion that:

> "... we are unable to form any conclusive opinion as to the value of psychotherapeutic methods in the treatment of alcoholism."

While the reticence of presenting statistical data, so evident before 1942, no longer remained, Hill and Blane (1967) felt this inability to form any opinion on the value of psychotherapy for alcoholics was due to the failure of research in the area to meet essential requirements of scientific conduct.

This ambiguous situation was followed by three major reviews evaluating the effects of psychotherapy for alcoholic populations. In his review of 58 evaluations between 1951 and 1973, Costello (1975a) found only a 25% rate of success in moderation or termination of drinking at a one year follow-up. Costello (1975b) found a slightly

higher rate of success in moderation or termination of drinking in a similar review of studies with a two year follow-up, but the rate remained low. Emrick (1975), in a similar review, reports higher rates of recovery with treatment, noting 24.5% abstinence rates and a 65.1% total improved rate with more than minimal treatment. While this discrepancy is difficult to fully resolve, Emrick (1975) noted that the sample in his review was a relatively well integrated and stable population, perhaps explaining the higher recovery rate than noted by Costello (1975a, 1975b). Armor, Polich, and Stambul (1976), in their controversial survey of alcohol treatment units, suggest that 70% of clients treated at typical alcoholism clinics improve, but the high attrition in this survey almost certainly inflated this improvement rate. Only 25% of the clients in the Armor et al. (1976) study continued in treatment as long as three months and an even smaller sample was available for six month follow-up. Current research (Moos & Bliss, 1978) pointed out that such a sampling bias tends to exclude those clients who are more likely to show poorer treatment outcome.

While at first glance it appears that the overall efficacy of therapy for alcoholics has either fallen or at least remained stagnant in the past fifty years, it is more likely that the earlier reports cited by Voegtlin and Lemere (1942) contained inflated success rates due to the subjective and unempirical nature of the reports available at that time. Even so, it is difficult to argue that there is convincing evidence of any global improvement in the state of therapeutic approaches to alcoholism. The more recent reviews, with their widely divergent findings, suggest there exists either a broad range of alcoholic populations

who differ greater in responsiveness to treatment, or a broad range of therapies which also differ greatly in affecting some change in alcoholics, or some combination of these two factors. The well known pervasiveness of alcoholism (see Popham, 1956) makes this lack of knowledge about the sources of variation in the treatment of alcoholism even more disturbing.

While the overall reviews have been either inconclusive or somewhat negative, some modes of treatment seem to meet with either consistent success or consistent failure. For example, evaluation of aversive techniques has been generally negative. Miller, Hersen, Eisler, and Hemphill (1973) found no significant improvement of alcoholics treated by electrical aversive conditioning when compared to a pseudo-conditioning control and a group therapy control. Wilson, Leaf, and Nathan (1975) also found no evidence of conditioned aversion of alcoholics to beverage alcohol following conditioned electrical aversion to ethanol. Ewing, Rouse, and Beatrice (1976), while attributing the failure of treatment to the "controlled drinking" goal, also illustrated the ineffectiveness of electrical aversion techniques for reducing alcohol consumption. Some (Rachman & Teasdale, 1969) suggest aversive techniques may be useful in the treatment of alcoholism provided the aversive stimuli are appropriate to drinking behaviour. Consistent with this view, Lamon, Wilson, and Leaf (1977) demonstrated the relative superiority of a nausea-producing procedure in comparison to an electrical aversion procedure in reducing beverage consumption. Even with this evidence, however, the clinical usefulness of aversion techniques may be limited, as "escape" behaviour may still be a highly

probable response. Evidence for this phenomenon can be found in the high drop-out rates which occur with electrical aversion techniques (Hedberg & Campbell, 1974).

Reports on non-aversive behavioural therapy have been more positive. Miller (1972) provided a case report which indicates an alcoholic was able to reduce and maintain his pretreatment alcohol consumption of seven to eight beverages a day to zero to three drinks per day by the use of a behavioural contract. Studies have managed to show drinking could be suppressed to one-half of baseline alcohol consumption by using a time-out procedure; even so, the subject still drank three to eight ounces of 95 proof ethanol daily (Bigelow, Liebson, & Griffiths, 1974; Griffiths, Bigelow, & Liebson, 1974). Another report of a case study (Pickens, Bigelow, & Griffiths, 1973) illustrated the achievement of abstinence by using time-out from social activity. More promising evidence from an evaluation by Hedberg and Campbell (1974) illustrates an abstinence or controlled drinking goal can be met by two-thirds of subjects participating in diverse behavioural therapies. Sobell and Sobell (1973, 1976) indicated that the use of individualized behaviour therapy resulted in significantly greater improvement than more traditional treatment. This improvement was found not only in alcohol consumption, but in adjunctive areas such as employment. Vogler, Compton, and Weissbach (1975) indicated a comprehensive behavioural treatment programme significantly improved outcome for alcoholics when compared to a group of alcoholics receiving alcohol education, alternatives training, and behavioural counselling. Most recently, Miller (1978) demonstrated reduced alcohol consumption across

three behavioural treatment strategies, although there were no significant differences between the three treatment strategies.

While these results imply considerable promise for non-aversive behavioural therapy in alcoholism, Hamburg's (1975) comment that broad spectrum approaches based on an analysis of specific stimuli which trigger excessive drinking are more effective than conventional methods may be optimistic; caution seems more appropriate while awaiting further replications. The illustration of a lack of significant differences between a group of alcoholics receiving treatment and a group receiving only advice (Edwards, Orland, Egert, Guthrie, Hawker, Hensman, Mitcheson, Oppenheimer, & Taylor, 1977) pointed out the low level of clinical impact current conventional therapy has on alcoholism and emphasizes the need for caution in the evaluation of therapy.

Conjoint marital psychotherapy for alcoholics is an example of a recently developed treatment for alcoholics which, some reports indicate, may have some promise (Esser, 1968, 1970). Conjoint psychotherapy, as the name implies, is psychotherapy carried on with two or more family members in a combined fashion. In this report, the conjoint therapy under consideration is oriented toward the alcoholic and the spouse or living partner of the alcoholic. Thus, the conjoint therapy considered here is more generic than marital therapy, but does not involve as many family members as does conjoint family therapy. Early indications that this therapeutic orientation may be appropriate come from findings that eleven of eighteen wives of alcoholics experience a mental disorder severe enough to require hospitalization following the cessation or decrease in the husband's drinking (Macdonald, 1958).

Other reports, as Kogan and Jackson (1965), point out the wives of alcoholics are no more disturbed than wives of other people seeking mental health services. Even so, Jackson's (1956) report defined the effects of a family member's alcoholism on the family unit, and pointed to a long stressful process of disorganization and reorganization.

Evaluations of conjoint or family therapy for alcoholics have been generally promising, but most reports are marred by methodology which prevents attribution of outcomes to the process of therapy. Early reports, as Macdonald's (1958) description of prophylactic group therapy for wives of alcoholics, while being descriptive and largely subjective, did note sporadic attendance and a lack of "group cohesiveness." After this generally unsuccessful and problem-filled treatment, Macdonald (1958) recommended the group be more structured and the therapist take a more active role. Additionally, although Macdonald (1958) does not dwell on the point, the attendance of the two spouses was found to correlate .804. Other early reports, as Vogel (1957), Burton (1962), and Sands and Hanson (1971), shared this vague and unempirical quality of early articles. Vogel (1957) only mentions some advantages to mixed groups for alcoholics. Burton (1962), in his description of group counselling for alcoholic husbands and nonalcoholic wives, does advocate the development of measurement techniques. Sands and Hanson (1971) describe in some detail the treatment process involved in psychotherapeutic groups for alcoholics and their relatives, but provide no data to indicate the results of such an approach. Gliedman (1957) attempted to evaluate such an approach by following nine alcoholic families through a progression of intake, concurrent treatment, combined treat-

and follow-up on the monthly expenditures on alcohol. Not suprisingly, as therapy progressed there was a general reduction of monthly expenditures for alcohol. Even so, three of the nine couples were unable to be contacted at the combined or conjoint stage of therapy. Another couple was lost at follow-up. Of the five couples completing the progression and follow-up, three showed marked improvement. In another, more systematic study by Gliedman, Rosenthal, Frank, and Nash (1956), concurrent but separately conducted group meetings of alcoholics and their wives had more positive effects. Nine married alcoholics and their wives were evaluated by a drinking checklist, a symptom checklist, an adjective checklist, and a social ineffectiveness scale. Of the seven couples who completed therapy, five improved on the drinking checklist and on the symptom checklist. There was only slight modification of social ineffectiveness, but positive changes on the adjective checklist. Esser's (1971) evaluation of conjoint family therapy with fourteen alcoholic families indicated most families were better integrated after therapy. Esser's (1971) report must be regarded as more puzzling than most, as it is unclear how many families constitute "most" and what criterion indicates "better integrated." Essentially, Esser has continued the tradition of early research evaluating conjoint therapy without a control or comparison group, and compounded this deficiency with neglect of object measures. This is made more unusual by the recent nature of the report.

However, attribution of these generally positive results (Gliedman, 1957; Gliedman et al., 1956; Esser, 1971) to therapy is difficult to accept as there was no comparison group. A similar report by Meeks and

Kelly (1969), evaluating a family therapy approach, also found positive results, noting all of the five families who completed the treatment showed evidence of improved relating, healthier communication, and increased mutual support. Also, either abstinence or a reduction in drinking frequency occurred in all of the families. While Meeks and Kelly's (1969) results seem impressive, the lack of a comparison condition and objective outcome measures of known reliability made both the improvement of the families questionable and the contribution of therapy to the apparent improvement unknown. Smith (1969), in another early report, did describe evidence indicating that attendance of the wife of an alcoholics in therapy was associated with better outcome for the alcoholic. In this study, however, the patients made the selection of spouse attendance or non-attendance in therapy, leaving the possibility that the two groups are not truly equivalent. In this case, for example, it may be possible that the group choosing not to involve the spouse did so because of greater difficulties in their marriages, and, hence, have a poorer prognosis.

In another study with objective outcome measures and a comparison condition, Cadogan (1973) found marital treatment effectively influenced the development of abstinence when compared to a group not receiving marital therapy, but found no significant differences in communication or family functioning. This latter finding is surprising in light of the reports of the association between family functioning and alcohol consumption (Burton & Kaplan, 1968; Bromet & Moss, 1977). While Cadogan's (1973) findings are best regarded as essentially sound, until these results are replicated, there should be caution in accepting the

findings completely. In particular, it is not clear whether the marital treatment described by Cadogan's (1973) work would generate more improvement than an individually oriented treatment of similar duration and intensity.

Along this line, Hedberg and Campbell's (1974) comparison of four behavioural treatment modalities for alcoholism, found marital therapy for alcoholics to be the most effective modality. Recalculation of their results on slightly different criteria eliminated this difference and illustrates the weak nature of the effect, however. By combining the goal attained and much improved categories of Hedberg and Campbell's (1974) data, both systematic desensitization and behavioural family counselling resulted in a 87% total improved rate. Statistical analysis by Fisher's exact probability test for the original, most supportive data reported by Hedberg and Campbell (1974), performed by the present author on the number of patients in the "goal attained" category for behavioural family therapy and systematic desensitization, achieved only $p = .29$, well above conventional levels of significance. Behavioural family therapy does exceed conventional levels of significance ($p = .02$) when compared to electrical shock treatment, but this finding is not unexpected. Thus, close examination of these results does not justify the conclusion that behavioural family therapy is more effective than other behavioural modalities; even so, the results do seem to show that behavioural family therapy is at least as effective as other behavioural methods.

Case studies by Miller (1974, 1976) suggest that marital therapy may be effective for alcoholics. In addition, Burton, Kaplan, and

Hudd's (1968) report that alcoholic couples receiving group therapy have a much higher follow-up rate than other modalities must be regarded as an impressive effect. Ewing, Long, and Wenzel (1961) demonstrated that concurrent therapy resulted in greater improvement when compared to male alcoholics coming for individual therapy, but the results only approached statistical significance ($\chi^2 = 3.46$, $p = .10$). It appears that Janzen (1977) accurately summarized the advantages of family involvement in the treatment of alcoholics by citing the longer attendance with family involvement and the positive association between a stable marriage and success in treatment. Neither of these advantages imply any unique theoretical advantage for family therapy, however.

Not all reports illustrated these positive effects. Pixley and Stiefel (1963), in their evaluation of group therapy designed for wives of alcoholics, encounter many of the same difficulties cited by Macdonald (1958), especially at the onset of the group. In particular, Pixley and Stiefel (1963) report early problems with attendance, minimal interaction, and a recurrent theme of "who had it worse." Despite these early problems, Pixley and Stiefel (1963) also state that the therapists felt both the marital relationship and the husband's drinking improved, but no data was presented to substantiate this attribution. Even if data were available, that lack of a control again prevents any attribution of improvement to the therapy. Pattison, Courlas, Patti, Mann, and Mullen (1965) also encountered less positive results for diagnostic-therapeutic intake groups for the wives of alcoholics. In this study, the one-visit phenomenon reappears (as

with Macdonald, 1958) and iatrogenic effects -- antagonistic feelings of the husband toward the involvement of the wife -- seemed to occur. Pattison et al. (1965) attributed part of these negative findings to the socioeconomic characteristics of the wives. However, the occurrence of similar problems in Pixley and Steifel (1963) suggests the lack of true conjoint therapy may be responsible for the negative findings. Pattison et al. (1965) alluded to this possibility in their recommendation of involving the spouse at the inception of therapy. While these reports are generally negative, the conclusions should be regarded with skepticism due to the early date of the reports (all before 1965) and the retrospective nature of the reports. An appropriate interpretation at this time appears to be psychotherapy for alcohol-involved couples needs to be both well planned and truly conjoint for best results.

Research in the area of family process supports the idea of familial interaction having functional significance for alcoholism. Burton and Kaplan (1968) describe the relationship between excessive behaviour and family pathology as seeming to be one of mutual reinforcement. In demonstrating that reduction of marital conflict was associated with reduction of drinking, Burton and Kaplan (1968) have provided support for their view. Bromet and Moos (1977) replicated this finding by showing a more positive family milieu was associated with greater improvement in the functioning of the alcoholic member.

Similar results were found in a report by Orford, Oppenheimer, Egert, Hensman, and Guthrie (1976) which demonstrated that a composite measure of marital cohesion was predictive of outcome classification

for alcoholics, with cohesive marriages more likely to have good outcome. While job status and self-esteem were not independent of marital cohesion, partially controlling for the contribution of job status and self-esteem did not change the predictive value of marital cohesion for outcome. Orford et al. (1976) noted that the retrospective nature of their study makes judgement of causal direction uncertain; it was possible that good outcome in treatment improved marital cohesion. Additionally, it is possible that a third unknown correlate accounted for these results. Other reports, as Kogan and Jackson (1965), noted that wives of alcoholics report more current stress than control wives. Some reports, as McCord (1972) have argued that the nature of the interaction between the couple is the crucial element. McCord (1972) argued that alcoholism results from a challenge to poor self-esteem.

Some recent investigations also imply that interaction between couples may have functional significance for alcohol consumption. Steinglass, David, and Berenson (1977) indicate that alcohol consumption in alcoholic couples seemed to elicit behaviour from the spouse which could have functional significance for alcohol consumption. While the report by Steinglass et al. (1977) was from direct observation of intoxicated behaviour in an inpatient environment, the observations were not blind and cannot be called truly systematic. However, other reports, as the Weiner, Tamerin, Steinglass, and Mendelson (1971) observation of a father and son during experimental intoxication, also imply that the familial interaction has functional significance for maintaining alcohol consumption. Hersen, Miller, and Eisler (1973), in noting the spouse of an alcoholic increases duration of looking at

the partner while discussing alcohol, further noted that this attention may be a functional element maintaining intoxication.

In addition to the evidence of family pathology in alcoholics, and the positive, but experimentally flawed evaluations of family or marital therapy for alcoholics, there are important theoretical reasons suggesting conjoint family or marital therapy may be effective for alcoholics. First of all, marital treatment in general has been an effective and successful modality for problems in communication and conflicts in living (Jacobson, 1977; Wieman, 1974). Second, since Miller, Hersen, Eisler, and Hilsman (1974) demonstrated interpersonal stress increased operant responding for alcohol, it seems that the reduction of marital conflict might also decrease alcohol consumption. Third, as pointed out by Pattison (1968, 1976), Gerard (1962), and Miller and Caddy (1977) reduction or even eliminiation of alcohol consumption in alcoholics does not yield social, vocational, or psychological improvement. It seems therapy needs to be specifically oriented towards these areas if improvement is to be expected. Fourth, involvement of a significant other might increase the generalizability of therapy as well. Fifth, several reports (Miller, 1976; Azrin, 1976; Hunt & Azrin, 1973) describe comprehensive psychotherapies for alcoholics utilizing marital or family components in the therapy. As these programmes appear to be effective, the relative contribution of marital therapy to the effects may be significant. Finally, the work by Steinglass and his associates indicates that the interaction between couples may have functional significance for alcohol consumption.

In light of the substantial weight which these theoretical and

pragmatic arguments seem to carry, the further evaluation of the efficacy of conjoint marital therapy appears to be warranted. The purpose of this report will be to investigate the efficacy of conjoint marital therapy for alcoholics and their partners in an outpatient setting. In particular, this study will allow for examination of changes in drinking patterns for the alcoholic and changes in psychological functioning for both the alcoholic and the alcoholic's partner. Further, thus study will compare the conjoint group to a standard individual outpatient treatment of alcoholic couples. While ethical considerations have ruled out the use of a no-treatment control group, reports on the rate of spontaneous recovery in untreated alcoholics (Emrick, 1975; Smart, 1975) will be used to compare the progress of the alcoholics receiving therapy. Considerable caution must be exercised in considering this latter comparison as an indicator of treatment efficacy, as the samples may not be representative. However, such a comparison may yield important information, as current evidence is beginning to clarify the rate of recovery in untreated alcoholics (Armour, Polich, & Stambul, 1976; Emrick, 1975; Emrick & Stilson, 1977; Smart, 1976). In addition, this comparison avoids the difficulty of being unable to evaluate recovery rates, a problem noted by Bebbington (1976). As other extensive reports indicate that psychotherapy can be efficious (Bergin, 1971; Glass & Smith, 1977), this evalution will compare two therapeutic approaches to alcoholism.

METHOD

Subjects

Sixteen couples with one of the partners experiencing problems related to alcohol use applying for outpatient counselling at an alcohol treatment centre were consecutively assigned to either conjoint therapy or standard individual outpatient therapy. These two therapies are referred to as conjoint and standard in this report, respectively. Of the 16 identified patients, referred to as alcoholics in this report, 14 were male and 2 were female. The average age was 40 years for males and 38.6 years for females. The modal reported education was high school completed, with high school and other training the next largest category, and college education the third largest category. All of the clients had at least some high school. Seven of the couples had experienced one or more separations prior to involvement in treatment. Thirteen of the couples were married, while the remaining three couples were in a stable common-law relationship. Two couples were separated at the start of treatment. There were no significant differences between the clients assigned to standard therapy and the clients assigned to conjoint therapy on the measures of age, previous separations, relationship status at intake, or education when evaluated by Fisher's exact test. Table 1 summarizes this information. The couples were recruited by a mailing to practitioners and agencies having contact with potential clients, radio advertisements in the local urban area, and from the normal referral sources for the agency. The spouse or partner of the alcoholic is referred to as the partner in this report.

Table 1

Demographic and Relationship Status of Standard and and Conjoint Therapy on Intake

Areas	Therapy	
	Standard	Conjoint
Mean age in years	37.88	40.00
Education (No. completing)		
University graduate	2	2
High school & other training	3	4
High school completed	9	10
Some high school	2	0
Primary only	0	0
Previous Separations		
Yes	4	3
No	4	5
Status at Intake		
Separated	2	0
Married	5	5
Common-law	1	3

Procedure

Prior to active involvement in treatment, the clients were asked to sign consent forms agreeing to participate in a telephone or in-person follow-up at one month, six months, and one year after treatment. The clients were also asked to agree not to change the status of their relationship until the completion of treatment. At this time prior to treatment, the clients completed the Alcohol and Drug Counselling Information Form and an adjective checklist for describing the real self, ideal self, real spouse or partner, and ideal spouse or partner. The Alcohol and Drug Counselling Information Form gathered information on work functioning, social functioning, relationship, and alcohol or drug use. This procedure was repeated at the end of treatment. In addition, the Marital Adjustment Scale (MAS) was also administered post-treatment. Appendix A contains these documents. The one month follow-up was used to obtain collaborated estimates of alcohol consumption, if any, and to insure that all of the post treatment measures had been completed. At the six month and one year follow-up, the couple was again interviewed to obtain collaborated estimates of alcohol consumption; additionally, the Alcohol and Drug Counselling Information Form, the MAS, and the Guttman Self-Esteem Scale were administered.

Treatment

The conjoint therapy was begun with an all-day session lasting 8 hours followed by 8 subsequent evening sessions lasting 1½ hours each. The general goal of the conjoint treatment was for the client to reach an understanding of how they came to be the persons they were and to

describe what changes the client would like to see in friends, work, family, and love life. Questionnaires were used as a guide to the kind of information utilized (see Appendix A). The Family Constellation questionnaire was designed to obtain a description of the client in relation to other members of his or her family. The second questionnaire was designed to obtain information on how the client would like the situation to be changed in the areas of friends, work, and close relationships. Both the alcoholic and the spouse were expected to come to the group sessions, and all but one couple completed the 8 sessions. Attention was devoted to communication between the couple, with exercises used to increase the use of "I" statements, expression of feelings, and feedback or reflection. Role play of particular situations and modelling of specific examples by the therapists were used to develop these communication skills. Whenever possible, exercises were drawn from recent events or situations which had occurred in the couple's life. For both the alcoholic and the alcoholic's partner, assertiveness was also developed by similar methods. This condition has been called conjoint therapy in this report.

In the standard therapy condition, the clients were seen over a period of time ranging from 3 to 14 weeks, with a mean of 7.43 weeks. Clients in this condition were seen on an open-ended rather than a session-specific basis. The general goal in the standard treatment condition was to establish an interpersonal relationship between the patient and the counsellor. The sessions were held in an individual rather than group setting and the therapeutic focus was on the alcoholic, although the spouse or partner could and sometimes did attend

therapy sessions. Case records indicate spouse or partner attendance in 29% of the standard treatment sessions. The standard therapy condition also devoted some attention to exploring what changes the clients would like to see in significant areas of their life. Thus, the greatest difference in treatment was in mode rather than method -- individual versus group, and conjoint versus separate. Both conditions were administered by the two same therapists, with no clear expectation that either treatment was superior to the other. The follow-up interviews and the post-treatment collaborating interviews of alcohol consumption were conducted by the author.

Dependent Measures: Reliability and Validity

The dependent measures were alcohol consumption, ratings of work functioning and social functioning, relationship ratings, real-ideal self discrepancy scores, and real-ideal spouse or partner discrepancy scores.

Alcohol consumption. The alcohol consumption was measured by a self-report questionnaire[1] administered pre- and post-treatment. An interview with the couple at one month, six months, and one year follow-up was used to verify alcohol consumption or abstinence. Clients were instructed to fill out the questionnaire in as much detail as possible.

Some reports (notably Guze, Tuason, Stewart, & Picken, 1963; Summers, 1970; Miller, 1976) have been critical of self-reported

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[1]We are grateful for the social life section from a questionnaire used by Victoria Life Enrichment, and the permission of Charles Aharan, Ph.D., of that agency for the use of that section.

alcohol consumption, although these same studies reported substantial correspondence between alcohol consumption and other criteria. Miller (1976), for example, reported a correlation of $r = .76$ between self-report and urine tests. Guze et al. (1962) reported a 26% disagreement between relatives' reports and male alcoholic criminals, which indicates 74% agreement. Summers (1974) does show 14 of 15 alcoholics changes their responses to half or more of questions when reinterviewed in two weeks. However, in Summers' study, several subjects were interviewed when intoxicated and the author noted the sample was not a representative one. Other reports indicated a great deal of consistency of self-reports even over long periods of time (Guze & Goodwin, 1972), especially when the alcohol problem is extensive. The most decisive and best-designed evaluations (Sobell, Sobell, & Samuels, 1974; Sobell & Sobell, 1975) indicated considerable agreement between self-reports and primary information sources such as arrest records and similar records. These reports indicated consistency was 92% when compared across different interviews. In addition, only 14% of the answers obtained in the interviews were discrepant from official records, such as arrest records. These findings indicated that self-report under appropriate circumstances is a reliable and valid method to establish the clinical status of drinking patterns.

In this study, drinking reports of the alcoholic were collaborated by the partner, with agreement on the level of alcohol consumption occurring in 13 of the 14 jointly conducted post-treatment interviews, or 93%. Additionally, the reports of alcohol consumption reported on the post-treatment questionnaire agreed substantially with the amount

reported in the one-month follow-up interview, although this task was made easier by the large number of subjects who were not drinking. For the subjects who were drinking, the difference between the number of drinks per week estimated from the questionnaire and the number of drinks per week reported in the interview did not differ by more than 3 drinks per week. In the single case of disagreement, the higher report of alcohol consumption was used.

Real-ideal self. A modified version of the "interperception matrix" described by Alexander and Dibbs (1977) was administered pre- and post-therapy. While Alexander and Dibbs (1977) used correlations to evaluate the discrepancy between the real-ideal adjectives, this report used the absolute difference between the real-ideal adjectives checklist, for reasons noted by Osgood (1957, p. 90). The Q-sort of the type used by Alexander and Dibbs (1977) was first introduced by Jack Block in 1952 (Block, 1952; Heusch, Block, & Bennett, 1953), and was found to be correlated .82 with the first Q-sort when repeated after several weeks for a single subject. The modified adjective checklist version used in the present study was found to have a split-half reliability, using the Pearson product moment correlation, of $r = .895$ when tested on 31 undergraduates by the present author (see Appendix B).

Validating data has indicated that narcotic addicts (Allexander & Dibbs, 1977) and alcoholics (Gossop, 1976; Charalampous, Ford, & Skinner, 1976) seem to have a large real-ideal self discrepancy and low self-esteem. Correlations between the Guttman Self-Esteem Scale (Rosenberg, 1963) and the real-ideal self discrepancy was found to be

r = .565, with Fisher's r to Z transformation yielding Z = 5.24, $p < .001$ for this correlation when tested by the current author on a separate sample of 70 undergraduates. In the same sample, no significant difference on discrepancy scores was found between males and females. This finding is consistent with the findings reported by Clarke (1974), although some authors (i.e., Gossop, 1976) have reported lower self-esteem in females than in males. Both a separate sample of alcoholics and the current sample of alcoholics' partners were found to differ significantly from the validating sample of college undergraduates, $F(1,51) = 4.12$, $p < .02$, and $F(1,40) = 9.59$, $p < .005$, respectively. Appendix B summarizes the results of the validation of the real-ideal self discrepancy scores. In general, these findings appear to be consistent with the findings of low self-esteem for drug involved patients (Gossop, 1976; Charalampous, Ford, & Skinner, 1976).

Real-ideal spouse or partner. This was also a modified version of the "interperception matrix" noted above. The discrepancy scores of the real-ideal spouse ratings appeared to have face validity as a measure of marital adjustment or spouse regard. These discrepancy scores were found to be correlated with the MAS, r = -.7897, when the MAS and real-ideal spouse scores were compared for 16 alcoholics and their partners on pre-test.

Marital or Relationship Adjustment. Three scales evaluating marital or relationship adjustment were used in this study. One scale was a brief 7-point scale asking the clients to rate their relationship on a continuum from excellent to totally unsatisfactory. A second scale was similar in general construction, but asked the

clients to rate their relationship in five areas, described as affection, conflict, expression of feelings, closeness, and activity together. The third scale administered was the Locke-Wallace Marital Adjustment Scale (MAS), a well validated and reliable instrument. The MAS has been found to be internally consistent with two components loading highly on marital adjustment. Kimmel and Van de Veen (1974) noted the two factors appear to be sexual congeniality and compatibility. The split half reliability, $\underline{r}$ = .90, and test-retest reliability, $\underline{r}$ = .77, are both high. Also, verbal communication scores have been found to correlate highly ($\underline{r}$ = .91) with the Locke-Wallace MAS (Narran, 1967; Murphy & Mendelson, 1973), implying that marital adjustment and communication are highly related phenomena. The MAS was modified slightly for common-law couples. The measures of MAS appeared to be highly intercorrelatedm as shown in the preassessment intercorrelations in Table 2.

Social Functioning. Social functioning was evaluated by self-report ratings on a 7-point scale ranging from extremely good to extremely poor, with the most favourable rating being seven. The clients also recorded their current level of social activities and recorded the level of activities they would ideally like to establish.

The clients also rated the social life of their partner on the same scale. The intercorrelations between the partners' ratings and the rating of the other partners was low, however ($\underline{r}$ = .25).

Work Functioning. Self-report ratings of work functioning were obtained on a 7-point scale ranging from excellent to totally unsatisfactory. The most favourable rating was seven, with one indicating

Table 2

Correlations between 7-Point Scale of Marital Adjustment (Marital Adjustment), 5-Item Scale Assessment of Relationship or Marital Adjustment (Relationship Rating), and the Marital Adjustment Scale (MAS)

	Marital Adjustment	Relationship Rating
Relationship Rating	0.7904	
MAS	0.7981	0.7804

the least favourable rating. In addition the number of sick days, unproductive days, drinking days, or other days missed from employment was recorded for both the client and the partner. As in the case of social functioning, the spouse or partner of the client also rated social functioning. Again, the intercorrelation was only moderate, $r = .40$.

Data Analysis

In order to compare the efficacy of the two treatment approaches and to assess any differential response of the alcoholics and their partners to therapy, the following analyses were conducted.

Repeated measures ANOVA was conducted between standard and conjoint therapy conditions on the number of drinks per week pre- and post-therapy for alcoholics. Partners of alcoholics were not included as there was no evidence of excessive alcohol use at pre-therapy and therapeutic effort was not directed at reducing drinking for the partners. Outcome for alcoholics on drinking at post assessment was also assessed by comparing the distribution of alcohol intake between standard and conjoint therapy conditions.

Univariate analysis of variance (ANOVA) on the available pre-measures of real-ideal discrepancy scores, real-ideal spouse discrepancy scores, ratings of social functioning, ratings of work functioning, seven point rating of marital adjustment, and the relationship ratings on five items were conducted for the standard versus conjoint therapy conditions. A univariate ANOVA was also conducted on alcohol consumption pre-therapy for the alcoholics in the standard versus conjoint therapy. While this procedure elevates the possibility of

a significant difference being found by chance, it also allows the greatest probability of detecting any pre-therapy differences between the conditions. This analysis was intended to test the degree to which the consecutive assignment resulted in comparable conditions.

A repeated measures MANOVA was conducted between the standard and conjoint therapy conditions on the five dependent measures of real-ideal discrepancy, real-ideal spouse discrepancy, ratings of social functioning, ratings of work functioning, and five-item relationship rating. Both alcoholics and their partners were included in this analysis. This analysis was intended to evaluate any changes occurring from pre- to post-therapy and evaluate any differential effect of the therapy conditions. Univariate analyses were conducted when indicated by MANOVA significance.

Multivariate analysis of covariance (MANCOVA) was conducted between the standard and conjoint therapy conditions, using the pre-therapy scores of each of the respective five dependent measures described above as covariate. This procedure was intended to provide an analysis to adjust or control for any between condition pre-therapy differences, and hence provide a higher power test of therapy effects.

A 2x2x2 MANOVA was used to test for any significant differential response to the therapy conditions by either alcoholics or their partners. The grouping factors were therapy condition (standard versus conjoint), spouse condition (alcoholic versus partner), and time (pre- versus post-assessment). The same five dependent measures were used as in the previous MANOVA.

A contingency table was used to compare outcome of standard and

conjoint therapy on successful treatment. Success was defined as post-treatment drinking of less than 10 drinks per week, where a drink was defined as ½ ounce of 100 per cent ethanol, and a post treatment MAS score above 100. Fisher's exact probability test was used to evaluate the significance of the distribution.

RESULTS

Outcome on Drinking

In comparing the alcoholic clients in the standard and conjoint therapy, no significant differences were found on pre-therapy levels of alcohol consumption. There was a significant decrease in reported alcohol consumption from pre- to post-assessment, $F(1,14) = 29.43$, $p < .01$. However, there were no significant differences between the standard and conjoint therapy conditions on the drinking measures. Tables 3 and 4 illustrate these results.

An additional analysis was conducted where the alcoholics were classified as low consumption or high consumption drinkers at post-therapy assessment. Low consumption was assigned when both the alcoholic and the alcoholic's partner agreed that the post-treatment consumption was less than 10 drinks per week for the alcoholic. In this sample, the remaining alcoholics were all consuming more than 30 drinks per week, and hence were classified as high consumption drinkers. Table 5 shows the differences between the two therapy conditions as being nonsignificant, with Fisher's exact test yielding a $p = .36$.

Outcome on Adjunctive Measures

Analyses of variance between the clients in standard and conjoint therapy were made in the premeasures of real-ideal self discrepancy, real-ideal spouse discrepancy, marital adjustment, relationship rating, ratings of social functioning, and ratings of work functioning. No significant differences were found on five of these six premeasures,

Table 3

Analysis of Variance Table for Drinks per Week

Source	df	Mean Square	F	p
Group	1	4.13	0.00	n.s.
Error	14	871.25		
			29.43	.001
Pre-Post	1	34828.11		
Group x Pre-Post	1	86.79	0.07	n.s.
Error	14	1183.26		

Table 4

Means and Standard Deviations of Drinks per Week

	Group	
	Standard	Conjoint
Pre	$\bar{X}$ = 78.46	$\bar{X}$ = 74.45
	s = 55.14	s = 18.45
Post	$\bar{X}$ = 9.19	$\bar{X}$ = 11.76
	s = 18.66	s = 19.51

Table 5

Number and Percentage of Alcoholics in Low Consumption or High Consumption Drinking Categories at Post-Therapy

	Consumption Level*	
Therapy	Low	High
Standard	5(63%)	3(37%)
Conjoint	6(75%)	2(25%)

*Fisher's exact test $p = .36$, n.s.

but on the relationship rating, the standard therapy condition scored significantly lower than the conjoint therapy condition, $F(1,30) = 4.71$, $p < .05$. While this finding may be due to chance, especially since the two therapy conditions did not differ significantly on any other variables, including other relationship measures, further analysis considered this difference. Table 6 summarizes these pre-therapy scores.

The repeated measures MANOVA comparing the standard and conjoint therapy on the five dependent measures of real-ideal self discrepancy, real-ideal spouse discrepancy, relationship ratings, and ratings of social and work functioning indicated significant changes from pre- to post-assessment, $F(5,26) = 7.75$, $p < .0001$, significant group differences, $F(2,26) = 4.73)$, $p < .003$, and no significant interaction (see Table 7).

Univariate analyes were conducted to examine which of the dependent variables contributed to the significant pre- to post-therapy differences. There was a significant pre- to post-therapy improvement on the real-ideal self discrepancy, $F(1,30) = 19.86$, $p < .0001$, as shown in Tables 8 and 9. There was a similar significant reduction in real-ideal spouse discrepancy scores, as illustrated by Tables 10 and 11, $F(1,30) = 4.57$, $p < .05$. The relationship ratings illustrated a similar pre-to post-therapy improvement, $F(1,30) = 11.20$, $p < .002$, for pre- to post-therapy assessment, as did the ratings of social functioning, $F(1,30) = 24.36$, $p < .0001$ (see Tables 12 and 13 and Tables 14 and 14, respectively). Also apparent in the relationship ratings and the ratings of social functioning were the significant differences between the standard and conjoint therapy conditions,

Table 6

ANOVA Tables on Pre-Therapy Scores

Source	df	MS	F	p
Real-Ideal Self Discrepency				
Group	1	0.00	0.00	n.s.
Error	30	403.85		
Total	31			
Real-Ideal Spouse Discrepancy				
Group	1	1250.00	1.25	n.s.
Error	30	1002.33		
Total	31			
Relationship Rating				
Group	1	185.28	4.71	.04
Error	30	39.36		
Total	31			
Marital Adjustment				
Group	1	3.78	1.66	n.s.
Error	30	2.28		
Total	31			
Ratings of Work Functioning				
Group	1	3.13	1.54	n.s.
Error	30	2.03		
Total	31			
Ratings of Social Functioning				
Group	1	4.50	2.63	n.s.
Error	30	1.71		
Total	31			

Table 7

MANOVA Table on Adjunctive Measures

Wilks Summary Table

Source	Wilks Lambda	df	approx. F	df	p
Group	.5224	5,1,30	4.73	5,26	.003
Pre-Post	.4014	5,1,30	7.75	5,26	.0001
Group x Pre-Post	.8581	5,1,30	0.86	5,26	n.s.
Error	.0005	5,30,30			

Bartlett-Box Homogeneity of Dispersion Test

Standard vs. Conjoint

Pre	Df1 = 15	Df2 = 3623.7	F = 0.99	n.s.
Post	Df1 = 15	Df2 = 3623.7	F = 1.50	n.s.

Table 8

Analysis of Variance Table for Real-Ideal Self Discrepancy

Source	df	MS	F	p
Group	1	5.06	0.01	n.s.
Error	30	492.88		
Pre-Post	1	2525.06	19.86	.0001
Group x Pre-Post	1	5.06	0.04	n.s.
Error	30	127.13		

Table 9

Means and Standard Deviations for Real-Ideal Self Discrepancy Scores

	Group	
	Standard	Conjoint
Pre	$\bar{X}$ = 55.38	$\bar{X}$ = 55.38
	s = 21.00	s = 19.15
Post	$\bar{X}$ = 42.45	$\bar{X}$ = 43.38
	s = 15.30	s = 14.09

Table 10

ANOVA Summary Table for Real-Ideal Partner Discrepancy Scores

Source	df	MS	F	p
Group	1	1785.06	0.90	n.s.
Error	30	1983.60		
Pre-Post	1	506.25	4.57	.04
Group x Pre-Post	1	60.06	0.54	n.s.
Error	30	110.79		

Table 11

Means and Standard Deviations for Real-Ideal Partner Discrepancy Scores

	Group	
	Standard	Conjoint
Pre	$\bar{X}$ = 62.69	$\bar{X}$ = 50.19
	s = 37.18	s = 24.95
Post	$\bar{X}$ = 55.13	$\bar{X}$ = 46.50
	s = 39.12	s = 24.30

Table 12

ANOVA Summary Table for Relationship Rating

Source	df	MS	F	p
Group	1	365.77	5.94	.02
Error	30	61.62		
Pre-Post	1	293.27	11.20	.002
Pre-Post x Group	1	0.02	0.0006	n.s.
Error	30	26.17		

Table 13

Means and Standard Deviations for 5-Item Relationship Rating Scores

	Group	
	Standard	Conjoint
Pre	$\bar{X}$ = 15.44	$\bar{X}$ = 20.25
	s = 4.13	s = 7.85
Post	$\bar{X}$ = 19.75	$\bar{X}$ = 24.50
	s = 7.41	s = 6.48

Table 14

Analysis of Variance Table for Ratings of Social Functioning

Source	df	MS	F	p
Group	1	19.14	10.66	.003
Error	30	1.79		
Pre-Post	1	31.64	24.36	.0001
Pre-Post x Group	1	1.89	1.46	n.s.
Error	30	1.30		

Table 15

Means and Standard Deviations for Ratings of Social Functioning

	Group	
	Standard	Conjoint
Pre	$\bar{X}$ = 3.44	$\bar{X}$ = 2.69
	s = 1.26	s = 1.35
Post	$\bar{X}$ = 5.19	$\bar{X}$ = 3.75
	s = 1.22	s = 1.13

$F(1,30) = 5.94$, $p < .02$ for relationship ratings and $F(1,30) = 10.66$, $p < .003$ for ratings of social functioning. Ratings of work functioning also demonstrated a significant pre- to post-therapy improvement in ratings, $F(1,30) = 6.41$, $p < .02$, with no significant differences between therapy conditions evident. While the analysis of the scores on work functioning appeared to have indicated a significant interaction, $F(1,30) = 4.29$, $p < .05$, multivariate analysis had not indicated any significant interaction or differential therapy effect, thus indicating no significant differential effect for standard or conjoint therapy overall. Tables 16 and 17 illustrate these results. Thus, all five dependent measures indicated significant improvement from pre- to post-therapy assessment, but there were no significant differences between the therapy conditions in affecting improvement. The therapy conditions themselves appeared to be significantly different on a measure of relationship functioning and a measure of social functioning, with the standard therapy condition scoring significantly poorer than conjoint therapy on relationship functioning and significantly better than conjoint therapy on social functioning when both pre- and post-therapy scores were considered. This latter finding, in combination with the earlier finding of pre-therapy differences between the standard and conjoint conditions on the relationship rating indicated the use of a multivariate analysis of covariance to test for differential therapy effects.

To control for these between therapy condition differences, a MANCOVA was conducted, using the respective pre-therapy scores as covariates to compare the standard and conjoint therapy conditions on

Table 16

Analysis of Variance Table for Ratings of Work Functioning

Source	df	MS	F	p
Group	1	0.06	0.03	n.s.
Error	30	2.10		
				.02
Pre-Post	1	7.56	6.41	
Pre-Post x Group	1	5.06	4.29	.04
Error	30	2.28		

Table 17

Means and Standard Deviations for Ratings of Work Functioning

	Group	
	Standard	Conjoint
Pre	$\bar{X}$ = 4.13	$\bar{X}$ = 4.75
	s = 1.54	s = 1.29
Post	$\bar{X}$ = 5.38	$\bar{X}$ = 4.88
	s = 0.96	s = 1.26

the same dependent measures described earlier. Even with this procedure, as Table 18 shows, the differences between the two therapy conditions on the five adjusted post-assessment measures were not significant, $F(5,25) = 0.12$, $p > .05$.

Outcome of Alcoholics and Partners of Alcoholics

A remaining possibility was that either alcoholics or their partners were responding differently for each therapy condition. For example, partners of alcoholics may have shown more improvement in the conjoint therapy condition when compared to the partners in the standard therapy, and the reverse may have been true for the alcoholics. In such a case, the overall outcome would be equivalent, but one therapy would have been superior for alcoholics and the other for their partners. To examine the data for this possibility, a 2x2x2 MANOVA was used on the five dependent measures of real-ideal self discrepancy, real-ideal spouse discrepancy, relationship ratings, and ratings of social and work functioning. The factors used were therapy condition (standard versus conjoint), spouse status (alcoholic versus partner), and time (pre- versus post-assessment). If there was a differential response to therapy, significant interactions would be expected. Examination of the MANOVA table, however, reveals only significant therapy condition and pre-post differences, $F(5,26) = 5.24$, $p < .003$, and $F(5,26) = 8.66$, $p < .001$, respectively, with no significant spouse effect and no significant interactions. Thus, the analysis did not support the hypothesis that the partner or the alcoholic may respond differently in either the conjoint or standard therapy condition. As the earlier analysis examined the pre-post and therapy condition differences, no

Table 18

MANCOVA Table with Pre-Therapy Scores Serving as Covariates

Wilks Summary Table

Source	Wilks Lambda	df	Approx. F	p
Group	.9760	5,1,29	.12	n.s.

further univariate tests were used. Table 19 illustrates the MANOVA results.

Overall Outcome

In addition to the examination of outcome on specific criteria and dependent measures, it seemed useful to compare outcome between standard and conjoint therapy in a more global manner. For this analysis, clients were classified as successful and not successful at post-therapy assessment along two criteria. To be considered successful, clients must (1) score greater than 100 on the post-therapy MAS and (2) be drinking less than 10 drinks per week at post-therapy assessment, where the drinks were defined as previously noted. The results of this analysis, illustrated in Table 20, were tested for statistical significance by Fisher's exact test. This test yielded $p = .16$, somewhat above conventional levels of significance. Thus, this analysis, like the previous analyses, indicated no significant differences in outcome between standard and conjoint therapy conditions.

Table 19

MANOVA Summary Table for 2x2x2 Analysis

Wilks Summary Table

Source	Wilks Lambda	Df	Approx F	Df	p
Group	.4565	5,1,26	5.24	5,22	.003
Pre-Post	.3751	5,1,30	8.66	5,26	.0001
Group x Pre-Post	.8483	5,1,30	0.93	5,26	n.s.
Spouse	.7758	5,1,26	1.27	5,22	n.s.
Spouse x Group	.8960	5,1,30	0.24	5,26	n.s.
Spouse x Pre-Post	.9558	5,1,26	0.51	5.22	n.s.
Spouse x Group X Pre-Post	.8063	5,1,30	1.25	5,26	n.s.
Error	.0014				

Bartlett-Box Homogeneity of Dispersion Test

Standard versus Conjoint

Pre	df1 = 15	df2 = 3623.7	F = 0.99, n.s.
Post	df1 = 15	df2 = 3623.7	F = 1.50, n.s.

Alcoholics versus Partner

Pre	df1 = 15	df2 = 3623.7	F = 1.20, n.s.
Post	df1 = 15	df2 = 3623.7	F = 1.17, n.s.

Table 20

Outcome on Alcohol Consumption and MAS Scores

Group	Outcome*		
	Success	Failure	Total
Standard	7(44%)	9(56%)	16
Conjoint	10(63%)	6(37%)	16
Total	17(53%)	15(47%)	32

*Fisher's exact test p = .16, n.s.

DISCUSSION

The results of this study provided no convincing evidence that the conjoint therapy programme used in this agency significantly improved outcome on either alcohol consumption or adjunctive measures when compared to the agency's more conventional outpatient therapy. Comparison of outcome between spouses (alcoholics versus partners) also did not indicate any significant differences in therapy efficacy, with alcoholics and partners of alcoholics showing similar levels of improvement in both standard and conjoint therapy conditions. While the analyses used to assess for between-therapy differences in efficacy were conservative, the results of the analyses were consistent, indicating no significant differences in outcome for the two therapy conditions on alcohol use, self-esteem, spouse regard, relationship functioning, social functioning, or work functioning.

While there was no evidence of any significant differences in efficacy for the two therapy conditions, there was prominent and statistically significant evidence of improvement for both therapy conditions from pre- to post-therapy assessment. Alcoholics in both therapy conditions significantly reduced their drinking. Both the alcoholics and their partners significantly improved by post-therapy assessment on self-esteem, spouse regard, relationship functioning, and ratings of social and work functioning. While the lack of normative data on some of the areas made the judgement of clinical significance difficult, the data available for self-esteem and marital adjustment did support the interpretation of the improvement as being clinically

significant. In particular, the post-therapy MAS mean of 105 exceeded the general cut-off point of well-adjusted relationships of 100, and the mean real-ideal self-discrepancy score of 43 at post therapy compared favourably with the average real-ideal self discrepancy score of 44, obtained from college undergraduates.

As a programme evaluation of an existing programme and a newer therapeutic approach instituted by the agency, these results were subject to a greater number of limitations on their generality and implications than would have been the case if the comparison had been done on a strictly controlled experimental basis.

Limitations

Alternative explanations may be advanced to explain for the lack of significant between therapy differences. Therapy "packages" of the sort used in this agency programme may not be as appropriate or effective as a more individualized therapy plan (Sobell & Sobell, 1973, 1976). For example, several of the couples involved in this study did not appear to be experiencing serious relationship difficulties, thus perhaps minimizing the effect of the interventions on measures of relationship functioning. In particular, the clients that had been assigned to the conjoint therapy condition scored significantly better than clients assigned to the standard therapy condition on a pre-therapy rating of relationship functioning. Given this difference, it is possible that the clients in the conjoint therapy condition were not in a position to benefit as much from the conjoint intervention as a sample that was experiencing more relationship difficulties. A second problem of interpretation for evaluations of package programmes, is the

possibility of complex interactions between elements of the package. If significant differences are found between the conditions, it would be difficult to determine which element made the greatest contribution to such a between group difference. If no significant differences are found between conditions, it would be possible that different package elements, while having an effect, were cancelling out one another. In this agency, it was possible that the effects of time in therapy, group or individual modality, and the degree of spouse involvement acted in such a way as to cancel out the contribution of one another. For example, perhaps the hours in therapy in the conjoint condition were not sufficient to deal with the increased range of problems dealt with, thus offsetting any advantage of conjoint involvement. A third problem for evaluation of therapy packages is that the specific goals of intervention may be appropriate in a global sense, but miss or ignore specific crucial variables. In this sense, the assessment measures used for this agency included areas as self-esteem and marital adjustment; other areas of interest may include assertiveness or direct assessment of couple-communication process.

Other influences may have affected the internal validity of the study (Campbell & Stanley, 1963). Effects of the pre-assessment and the administration of the dependent measures, while the same for both therapy conditions, may also have influenced or accounted for results by sensitizing the clients to the areas under evaluation. The reliability and validity of these measures appeared to be at least adequate, and in some cases substantial. However, direct behavioural measures would constitute an improvement, but in this agency an attempt

to introduce behavioural methods was found to be so time-consuming as to interfere with service delivery. The influence of regression toward the mean could account for some of the improvement from pre- to post-therapy, because in many cases extreme scores were recorded on pre-assessment. Regression appears to be an unlikely explanation for all of the improvement in this study, however, as there was a reduction of variability of scores as improvement on mean scores from pre- to post-assessment. A more likely possible influence was the consecutive assignment to therapy conditions. While there was no reason to assume that this would result in group differences, pre-assessment evaluation did indicate a significant difference between the therapy conditions on relationship ratings. Statistical control for this pre-therapy difference, while helpful, is not entirely satisfactory, as this initial difference may influence outcome by interacting with the therapy condition. Differential subject mortality can be an influence on outcome, as differential mortality may operate as a selection bias, this did not appear to be the case in this study, though, as only one couple dropped out the of the standard condition and another couple dropped out of the conjoint condition.

Placebo or expectancy effects can often be problems in evaluating outcomes of agencies' therapy programmes. Provision of a non-specific or placebo therapy condition would control for these non-specific effects, but such a condition was not accepted at this agency due to ethical implications. These placebo or expectancy effects are difficult to eliminate from the present study design, but the magnitude and consistency of the results across a variety of measures argue against

giving these factors prominent roles. Hawthorne effects to the new therapy modality can also affect results in outcome studies. A Hawthorne effect to a new modality could increase the effectiveness of outcome, making a marginally significant effect a highly significant effect. To the extent that the innovative modality, the conjoint therapy condition, did not differ significantly from more conventional therapy, despite the potential of a Hawthorne effect, increases the certainty that the appearance of equal therapy effectiveness is true. Provision of a non-specific placebo therapy condition is the usual experimental control for Hawthorne effects. A waiting-list, or similar no-treatment control, is also desirable to assess the efficacy of therapy, in order to control for recovery or improvement which occurs with the passage of time. Cadogan (1973) has indicated that marital therapy for alcoholics and their spouses was superior to a waiting list control for the development of abstinence. Ethical considerations precluded the use of a waiting list control in this agency.

Another possible effect not yet fully assessed is the possibility of differential effects in terms of maintenance of improvement. The expectation currently is for increasing rates of relapse as time from therapy increases (Marlatt & Gordon, 1978). One theoretical consideration in the involvement of the spouse of an alcoholic in therapy for the alcoholic, however, is that this spouse involvement may increase maintenance or reduce relapse. Judging from reports on the nature of relapse (Marlatt & Gordon, 1978), this possible increase in maintenance may be especially significant for controlled drinking orientations. Six month and one year post-therapy assessments are planned,

for the programme, which may help to assess possible differences between the therapy conditions on their long-term maintenance.

Questions of generality, or external validity, also affect the interpretation of the results. Generalizing these results to other therapy conditions or programmes having marital or conjoint components for alcoholics and their spouses may not always be valid. This is due both to the differences and variations found in marital or conjoint approaches and to the differences between packages or individualized approaches. Even the provision of pre- and post-therapy assessment may account for some of the changes shown, be reactivity, making generalization to programmes without pre- and post-assessment risky. Marital or conjoint approaches to alcoholics are greatly variable ranging from individual concurrent therapy to a couples group (Sands & Hanson, 1971), to video-taped and role-play practice of adaptive social interactional skills (Miller & Hersen, 1976), or to concurrent but separate group therapy approaches for alcoholics and their wives (Gliedman, Rosenthal, Frank, & Nash, 1956). Although all of these, and other, approaches share spouse involvement, the therapeutic methods differed considerably. Steinglass (1976) reviewed the range of family therapy approaches to alcoholics, and the range appeared to be considerable. Extending the outcome of the present research to other similarly titled, yet different content, therapies must be done with caution.

In addition to validity issues, it may be that the sample size was not sufficiently large to permit a powerful analysis of between-therapy differences. While it is true the data analyses were conservative, increasing power may simply raise the issue of clinical versus

statistical significance. This seemed to be the case here, as the statistical analyses were powerful enough to detect significant evidence of improvement, and even some relatively small between-therapy condition differences on two measures. As Meehl (1978) pointed out in his spirited article, the null hypothesis is always quasi-false and increases in sample size or power may only lead to the gratuitous rejection of the null hypothesis. Of course, it was not the case that this study has established that there are no differences in effectiveness between conjoint or more conventional therapy for alcoholics.

Implications for Future Research

In terms of implications for conjoint therapy for alcoholics, perhaps the results of greatest interest were the indications that the partners of alcoholics seemed to match and in some areas even exceed the alcoholic in terms of psychological deficit. In particular, the partners of alcoholics and the alcoholics themselves experienced highly discrepant real-ideal self descriptions, indicating low self-esteem. The finding that alcoholics experienced low self-esteem relative to a normative sample was not surprising, as Beckman (1978) noted such a relationship recently, but the findings of low self-esteem in partners of alcoholics, while not unexpected, have been less established previously. The other data on social functioning, marital adjustment, and real-ideal spouse discrepancies also seemed to indicate that alcoholics and their partners, in this sample, experienced difficulties in functioning. Ratings in the area of working functioning were the only exception, with both alcoholics and thier partners in this sample reporting favourable functioning. Essentially, alcoholics

and their partners seemed to experience similar levels of psychological distress. Surprisingly, however, partners of alcoholics improved even if the partners were assigned to the standard therapy condition which favoured most therapeutic attention on the alcoholic. This implies that the deficits experienced by the partners of an alcoholic -- low self-esteem and low ratings on relationship measures -- may have improved as the alcoholic improved in functioning. At the same time, the current study did not provide direct evaluation of this possibility, but it does indicate a possible area for further research.

An additional area also merits future attention: the direct examination of the relationship between interpersonal and marital relations on alcohol consumption. In other words, the aspects of the marital relationship that are causal to the alcoholics' problem need to be assessed so that we can determine what the unique focus or goals of marital therapy should be. We could then experimentally examine whether the marital therapy was affecting this specific problem area, and if it was affecting this problem area, what the effects on consumption were. The available research (Steinglass, Davis, & Berenson, 1977; Heisen, Miller, & Eisler, 1973) suggests that spouse attention or friendly, affectionate interaction during intoxication may be important influences. Considerably more research is needed in this area, however. Questions still remain whether interactional patterns are even of crucial importance for therapy. For example, it is possible that spouse involvement could act to increase situational control for the alcoholic (as avoiding high-risk relapse situations) without there being any marital or interaction problems. Future research is needed

to indicate the relative importance of global marital happiness, specific interactional patterns, or unique individual patterns for the functional influence on alcohol consumption.

Other research indicating self-esteem or self concepts of alcoholics may be an appropriate area of intervention (Tomsovic, 1976) has received support from the current study. The alcoholics in this sample demonstrated low self-esteem and both therapy conditions appeared to have improved on self-esteem by post-therapy assessment. However, as there were no between-therapy condition differences, it was not possible to attribute whether the significant improvement in self-esteem was due to the therapy or shared factors influencing the contemporary history of the two therapy conditions.

This lack of significant differences between a conjoint therapy condition and a more conventional individual therapy on the dependent measures used suggests critical future evaluations. This is particularly true as a careful review of the largely enthusiastic literature on spouse involvement in therapy for alcoholics reveals that a non-significant outcome difference is not an unusual finding. Essentially, the lack of significant evaluations of spouse involvement argues for critical assessment of the contribution of spouse involvement in therapy for alcoholics. In particular, spouse involvement needs to be compared to an individually oriented therapy; where the therapy conditions are matched in terms of their relevant dimensions. For example, assertion training may be provided for alcoholics in a group, or with alcoholics and their partners conjointly attending a group. A placebo or non-specific therapy control and a waiting-list or similar no

treatment control conditions would also be desirable. The ethical implications for such a study are, of course, serious. However, the largely equivocal findings to date on the contribution of spouse involvement and the growing popularity of the approach strongly urges the development of such a careful experimental evaluation. The results of this study, however, did not imply that conjoint therapy was without value. For both the standard and conjoint therapy conditions, there were reports of improvement on alcohol consumption for the alcoholics (63% and 75%, respectively) and some evidence of successful treatment for both the alcoholic and the partner on more stringent criteria (49% and 63%, respectively). These results compare favourably to rates of recovery for untreated alcoholics (Armour, Polich, & Stambul, 1976; Smart, 1976), although the difference may be due to selection or sampling factors. Nevertheless, a competing explanation may be that either therapy condition contributed to increased recovery rates. In any case, conjoint therapy appeared to be at least as effective as more conventional therapy. Conjoint therapy in this study had the additional advantage of being conducted in a group setting, and hence, represented somewhat more efficient use of therapist time while appearing not to appreciably affect outcome. However, the inconclusive nature of these results do strongly argue for more rigourous evaluation.

Careful consideration of the outcome measures used in the evaluation of the contribution of spouse involvement in therapy for alcoholics is also indicated. The outcome measures selected by the agency for this evaluation are not the only instruments available. Cromwell and Olson (1976) reviewed the various techniques of evaluation available for

marital and family therapy. Measures of interest for future could include brief scales for evaluating assertiveness, marital communication, and work satisfaction (McLachlan & Waldemann, 1976), and the martial interaction coding system (Hops, Wills, Patterson, & Weiss, 1976). Future research may benefit from the use of direct behavioural assessment, as the marital interaction coding system. Use of direct behavioural assessment may provide greater sensitivity than the self-report assessments used in this programme, because behavioural assessment may avoid some of the problems associated with reactivity to measurement.

Summary

The essential findings of this study, then, indicated significant improvement of both alcoholics and their spouses or partners, but no significant differential effects on this improvement for either conjoint therapy programme or the more conventional therapy programme of the agency involved in this study. This relationship held even when the results of partners and alcoholics were compared separately across therapy conditions. While this design, a two group repeated measures design, controlled for some threats to internal validity, extending these findings to other similar therapies may strain the robustness of the findings (see Campbell & Stanley, 1963). As Cowan (1978) noted, ultimate conclusions about interventions of the sort described here may have to come about slowly and cumulatively, based upon convergent findings. In this sense, the results of this study appeared to be consistent with other research, suggesting that conjoint therapy is a viable approach, but not demonstrating any superiority of conjoint therapy

relative to other approaches. This state appears to argue for a more rigourous experimental evaluation of spouse involvement in therapy for alcoholics.

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APPENDIX A

Forms used during therapy, Consent Forms, Alcohol and Drug Counselling Information Form, Marital Adjustment Scale, Interview Schedule, Guttman Self-Esteem Scale, and outline of therapy plan.

Outline of Therapy Plan for Standard and Conjoint Therapy Conditions

Conjoint Group Therapy

Session One. The first session was an all day (8 hour) group session. Both the alcoholic and the partner of the alcoholic attended. Each member of the group verbally responded to the items on the family constellation questionnaires. Responses to these items were used as a focus of the group dicsussion. When all members had finished with the family constellation questionnaire, the group members responded verbally to the significant areas questionnaire. Responses were again used as a focus of discussion. The constellation questionnaire focused on family experiences in childhood and adolescense. The significant area questionnaire focused on work, friends, parents, relationships, and desired changes in these areas (see the questionnaire for specific items).

Session Two. The second session was a group session lasting 1½ hours. A discussion of the earlier exercises on significant areas and family constellation continued. In this session goal setting was introduced. The participants dicsussed and selected goals in the areas of family life, recreation life, social, and work life.

Session Three. This session continued goal setting, with specific steps and methods to reach the goals defined. Depending on the individual member, some discussion of the family and significant areas continued.

Sessions Four and Five. These sessions introduced communication

and feedback exercises. Assertiveness was introduced, as well as "fair fighting."[1] Role plays were used to practice restating a partner's expression or statement until the partner agreed the statement was accurate. A second role play was used for participants to practice giving negative feedback. The couples were instructed to practice reflecting or paraphrasing partner statements before replying to the statement at home.

Sessions Six and Seven. The sessions continued with communication training. For these sessions, the focus turned to the expression and acceptance of positive statements. Role plays were used for the couple to practice giving and receiving compliments in a straightforward, unapologetic manner. At home, the couples were requested to make three positive or complimentary statements to each other a day. The statements were to be honest and sincere compliments.

Session Eight. The final session, or sessions, depending on the progress, focused on maintenance of change. The session was spent planning for meeting the goals set out earlier. Discussion of the special issues relating to the goals was the main focus of the session. Rehearsal of coping with problematic situations was used in the session.

Standard Individual Therapy

The standard individual therapy was an individually developed therapy plan. The order of the topics described here was typical, but the session-to-session progress varied from individual to individual.

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[1] Bach, G. & Wyden, P. The intimate enemy. New York: Avon Books, 1970.

The number of sessions also varied from individual to individual.

Session One. In the first session, a drinking history and a history of the current specific difficulties of the alcoholic was gathered. Also, a definition of the resources and the strengths of the client was made. Definition of the therapy plan was formulated at this time, with an individualized focus.

Sessions Two and Three. The therapy plan was described. Most cases began with goal setting by the client in response to open-ended questioning. Focus was then on specific steps to meet the goals defined by the client.

Session Four. Communication skills, assertion , and feedback were defined and described at this time. The skills were defined and described and the client was encouraged to try out the skills outside of therapy.

Session Five. This session continued development of communication skills, with the focus on using compliments and feedback. Assignments for practice were given, with the nature of the assignments depending on the individual case. Expression of feelings was encouraged.

Session Six. The session focused on problem definition, delineation of alternatives, assessing the likely outcome of the alternatives, and selection of appropriate alternatives. The problem-solving focused on specific problems or events occurring in the client's life.

Session Seven. The session focused on goal setting, with the emphasis on defining specific steps and anticipating problem areas. Problem areas were rehearsed in the sessions.

Session Eight. The last session was used to anticipate future plans, possible problems, and steps the client might take. The last few appointments were generally tapered, with the appointments being spread out over two weeks or even a month.

FAMILY CONSTELLATION[2]

(15 minutes)

Describe the place where you were growing up as a preadolescent.

How many people were living with you and what was it like?

Do you have sisters or brothers? What birth number are you? oldest? youngest?

Who in your family is most like you? Who is most different?

Who was best at school?

Who was rebellious?

Who used charm to get his/her own way?

Who was critical of others?

Who felt sorry for himself?

Who was least and most outgoing?

What was father like? Who was father's favourite? What did father expect of you? How did you react to this?

What was mother like? Who was mother's favourite? What did mother expect of you? How did you react to this?

[2]Questionnaire was developed by Robert Power of the Alfred Adler Institute of Chicago.

How did your parents get along?_____

_____

Who was dominant, made decisions, etc?

_____

Did they agree on how to bring up the children?

_____

Did they quarrel openly?_____

_____

What things did they disagree about?_____

_____

_____

_____

How would the quarrels end?_____

_____

_____

_____

Which of your parents was closer to you? Why do you think this was so?_____

_____

_____

Were there any other significant people in your house when you were growing up?_____

_____

Were there any significant changes in your family at your adolescence?

_____

_____

_____

Were you informed about what physical and emotional changes you could expect in yourself?_____

_____

How did you experience the changes? What did they mean to you?

_____

Who did you think had it better, boys or girls? Why?_____

_____

_____

_____

SIGNIFICANT AREAS

(10 minutes)

We would like to know from each person here about things they would like to change in significant areas of their lives.

You will be given 10 minutes to answer the following questions in whatever way you like. The 10 minutes is yours and if you choose not to use it all we will wait. We will tell you when time is up. Later in the day write in your answers but for now simply share them with us.

1. Friends

   Who are your friends?(no names) What sort of people are they?

   How do you think you come across to people?

   What would you like to see different about your friendships? What could be more fulfilling for you with your friends?

2. Work

   What kind of a worker are you? How do your co-workers see you?

   What do you like and dislike about your job?

   What would you change about your work if you could?

   What job would you like to do if you could change?

How did your parents get along?_____

_____

Who was dominant, made decisions, etc?

_____

Did they agree on how to bring up the children?

_____

Did they quarrel openly?_____

_____

What things did they disagree about?_____

_____

_____

_____

How would the quarrels end?_____

_____

_____

_____

Which of your parents was closer to you? Why do you think this was so?_____

_____

_____

Were there any other significant people in your house when you were growing up?_____

_____

Were there any significant changes in your family at your adolescence?

_____

_____

_____

Were you informed about what physical and emotional changes you could expect in yourself?_____

_____

How did you experience the changes? What did they mean to you?

_____

Who did you think had it better, boys or girls? Why?_____

_____

_____

_____

3. Love

Whom do you love? Who are the most important people in your life?

What problems do you experience in your relationships?

What does masculine or feminine mean to you?

How do you feel you measure up to your own ideas of what masculine or feminine should be?

ALCOHOL AND DRUG COUNSELING

INFORMATION FORM

It is essential for us to obtain certain basic information from everyone who participates in our program. This information helps us gain a complete understanding of your current situation and aids in our evaluation of our treatment program.

In order to gather this information as quickly as possible, we would like you to complete this questionnaire. You may find some of the questions quite difficult to answer. Some will be difficult because it will be hard to remember the answer, and some may be difficult because they are personal and perhaps even painful. The questionnaire is very comprehensive and therefore quite long.

Please answer all questions by filling in the blanks or checking the appropriate space. All information you provide, written or otherwise, is strictly confidential and will not be revealed to anyone without your written approval.

DATE _____

NAME _____/_____
(Last) (Given)

ADDRESS _____

_____

PHONE _____ DATE OF BIRTH _____/_____/_____
Day Month Year

NAME AND ADDRESS OF A PERSON THROUGH WHOM YOU COULD ALWAYS BE REACHED _____

_____

SPOUSE/PARTNER'S NAME _____

EMPLOYMENT

This section has to do with work situations. If you are a housewife, treat your housework as your job.

1. Please indicate the number of days off work in the last twelve months.

_____ Sick days
_____ Drinking days
_____ Unproductive days
_____ Suspension
_____ Other (specify)

2. During the past twelve months I would rate my work productivity as:

/_____/_____/_____/_____/_____/_____/_____/
Excellent Very Good Good Satisfactory Poor Very Poor Totally Unsatisfactory

3. Please indicate the number of days off work for your spouse in the last twelve months.

_____ Sick days
_____ Drinking days
_____ Unproductive days
_____ Suspension
_____ Other (Specify)

4. During the past twelve months I would rate my spouse's work productivity as:

/_____/_____/_____/_____/_____/_____/_____/
Excellent Very Good Good Satisfactory Poor Very Poor Totally Unsatisfactory

SOCIAL LIFE

1. Listed below are activities with other people which go together to make what most people call a social life. Please indicate the frequency of your participation in these activities during the past twelve months in the column labelled "now". Record what your ideal social life would be in the "ideal" column.

   Use only one column per category.

	Daily		Times/week		Times/month		Times/year		Never	
	Now	Ideal	Now	Ideal	Now	Ideal	Now	Ideal	Now	Ideal
Entertain Friends										
Visit friends										
Recreational activity with others (cards, bowling)										
club meetings										
parties										
talking to people in bars, beverage rooms										
church related activity										
Other										

2. Over the past 12 months my social life has been:

Extremely good	very good	good	average	poor	very poor	extremely poor

3. My spouse's social life over the past 12 months has been:

Extremely good	very good	good	average	poor	very poor	extremely poor

ALCOHOL USE

When did your alcohol use begin? _____

Frequency: In the last 12 months the number of times I drank more than 10 ounces of distilled liquor/day (or more than 25 ounces of wine or more than 12 beers/day)

_____ 1-11 days/year
_____ 1-4 days/month
_____ 1-6 days/week

Typical Consumption per day

Distilled		How often		Wine		How often	
More than 15 oz.	___	1-11/yr.	___	More than 25 oz.	___	1-11/yr.	___
10-14 oz.	___	1-4/mo.	___	12-25 oz.	___	1-4/mo.	___
6-9 oz.	___	1-6/wk.	___	6-11 oz.	___	1-6/wk.	___
1-5 oz.	___	daily		1-5 oz.	___	daily	___
0 oz.	___			0 oz.			

Specific drink(s) _____ Specific wine(s) _____

Beer		How Often	
More than 24	___	1-11/yr.	___
12-24	___	1-4/mo.	___
6-12	___	1-6/wk.	___
1-6	___	daily	___
0	___		

Specific beer(s) _____

Used in combination with:

_____ Barbiturates (phenobarbital, secobarbital)
_____ Tranquillizers (Valium, Librium)
_____ Amphetamines (diet pills)
_____ Opiates (coedine, heroin)
_____ Coffee, tea (more than 6 cups/day)
_____ Other
_____ None

Specify: Substance _____

How taken: Oral _____ Injected _____ Other _____

Frequency: _____/day _____/week

Dose: _____mg

RELATIONSHIP

This section pertains to your relationship to your partner.

1. Partner or spouse and I are currently: living together separated

2. We have been married (living together) ____years ____ months ____weeks

3. We have been separated _____ times

4. Our current separation has been for ____ years ____ months ____ weeks

5. How many times have you moved in the past two years _____

All in all over the past 12 months I would rate my relationship as being:

Excellent	very good	good	satisfactory	poor	very poor	totally unsatisfactory

All in all over the past 12 months, I feel that my spouse/partner would rate his/her relationship with me as being:

Excellent	very good	good	satisfactory	poor	very poor	totally unsatisfactory

Please rate the following areas of your relationship by circling the word that best describes your relationship in the past twelve months.

1. Our expression of affection to each other has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

2. The degree of conflict or arguments in our relationship has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

3. The general degree of expression of feelings in our relationship has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

4. Our degree of cohesiveness or closeness has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

5. The degree of our activity together has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

ADJECTIVE CHECKLIST MATRIX

Check the degree of agreement you have with the following descriptions. There are no right or wrong answers, and your first response is usually the best. Ask for clarification if you are unsure of the instructions.

I. I am_____.

1. ABSENT MINDED

1	2	3	4	5
never	rarely	sometimes	often	always

2. ACTIVE

1	2	3	4	5
never	rarely	sometimes	often	always

3. AMBITIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

4. ANGRY

1	2	3	4	5
never	rarely	sometimes	often	always

5. ASHAMED

1	2	3	4	5
never	rarely	sometimes	often	always

6. BORED

1	2	3	4	5
never	rarely	sometimes	often	always

7. BOSSY

1	2	3	4	5
never	rarely	sometimes	often	always

8. CALM

1	2	3	4	5
never	rarely	sometimes	often	always

9. CAPABLE

1	2	3	4	5
never	rarely	sometimes	often	always

10. CARRIES OUT PLANS

1	2	3	4	5
never	rarely	sometimes	often	always

11. CAUTIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

12. CHARMING

1	2	3	4	5
never	rarely	sometimes	often	always

13. COMPETITIVE

1	2	3	4	5
never	rarely	sometimes	often	always

14. COMPLAINING

L	2	3	4	5
never	rarely	sometimes	often	always

15. CONFIDENT

1	2	3	4	5
never	rarely	sometimes	often	always

16. CONSIDERATE

1	2	3	4	5
never	rarely	sometimes	often	always

17. CRUEL

1	2	3	4	5
never	rarely	sometimes	often	always

18. DECISIVE

1	2	3	4	5
never	rarely	sometimes	often	always

19. DEPENDENT UPON OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

20. EASILY PERSUADED

1	2	3	4	5
never	rarely	sometimes	often	always

21. FAIR

1	2	3	4	5
never	rarely	sometimes	often	always

22. FEMININE

1	2	3	4	5
never	rarely	sometimes	often	always

23. FRANK

1	2	3	4	5
never	rarely	sometimes	often	always

24. FRIENDLY

1	2	3	4	5
never	rarely	sometimes	often	always

25. HAPPY

1	2	3	4	5
never	rarely	sometimes	often	always

26. HARDWORKING

1	2	3	4	5
never	rarely	sometimes	often	always

27. HELPFUL

1	2	3	4	5
never	rarely	sometimes	often	always

28. HELPLESS

1	2	3	4	5
never	rarely	sometimes	often	always

29. IMAGINATIVE

1	2	3	4	5
never	rarely	sometimes	often	always

30. IMPATIENT

1	2	3	4	5
never	rarely	sometimes	often	always

31. INDEPENDENT

1	2	3	4	5
never	rarely	sometimes	often	always

32. INTELLIGENT

1	2	3	4	5
never	rarely	sometimes	often	always

33. IRRITABLE

1	2	3	4	5
never	rarely	sometimes	often	always

34. JEALOUS

1	2	3	4	5
never	rarely	sometimes	often	always

35. MASCULINE

1	2	3	4	5
never	rarely	sometimes	often	always

36. MATERIALISTIC

1	2	3	4	5
never	rarely	sometimes	often	always

37. MESSY

1	2	3	4	5
never	rarely	sometimes	often	always

38. ON TOP OF SITUATIONS

1	2	3	4	5
never	rarely	sometimes	often	always

39. OPEN ABOUT FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

40. PLANS AHEAD

1	2	3	4	5
never	rarely	sometimes	often	always

41. QUIET

1	2	3	4	5
never	rarely	sometimes	often	always

42. REASONABLE

1	2	3	4	5
never	rarely	sometimes	often	always

43. RELIGIOUS OR SPIRITUAL

1	2	3	4	5
never	rarely	sometimes	often	always

44. SHY

1	2	3	4	5
never	rarely	sometimes	often	always

45. SILENT

1	2	3	4	5
never	rarely	sometimes	often	always

46. SULLEN

1	2	3	4	5
never	rarely	sometimes	often	always

47. SECRETIVE

1	2	3	4	5
never	rarely	sometimes	often	always

48. SELF-CRITICAL

1	2	3	4	5
never	rarely	sometimes	often	always

49. SENSITIVE TO OTHERS FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

50. SEXUALLY-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

51. STRONG-WILLED

1	2	3	4	5
never	rarely	sometimes	often	always

52. STUBBORN

1	2	3	4	5
never	rarely	sometimes	often	always

53. SUCCESS-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

54. SUPPORTIVE TO OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

55. SUSPICIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

56. SYMPATHETIC

1	2	3	4	5
never	rarely	sometimes	often	always

57. TRICKY

1	2	3	4	5
never	rarely	sometimes	often	always

58. TRUSTWORTHY

1	2	3	4	5
never	rarely	sometimes	often	always

59. WARM

1	2	3	4	5
never	rarely	sometimes	often	always

60. WORRIED

1	2	3	4	5
never	rarely	sometimes	often	always

ADJECTIVE CHECKLIST MATRIX

Check the degree of agreement you have with the following descriptions. There are no right or wrong answers, and your first response is usually the best. Ask for clarification if you are unsure of the instructions.

II. Ideally, I would like to be _____.

1. ABSENT MINDED

1	2	3	4	5
never	rarely	sometimes	often	always

2. ACTIVE

1	2	3	4	5
never	rarely	sometimes	often	always

3. AMBITIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

4. ANGRY

1	2	3	4	5
never	rarely	sometimes	often	always

5. ASHAMED

1	2	3	4	5
never	rarely	sometimes	often	always

6. BORED

1	2	3	4	5
never	rarely	sometimes	often	always

7. BOSSY

1	2	3	4	5
never	rarely	sometimes	often	always

8. CALM

1	2	3	4	5
never	rarely	sometimes	often	always

9. CAPABLE

1	2	3	4	5
never	rarely	sometimes	often	always

10. CARRIES OUT PLANS

1	2	3	4	5
never	rarely	sometimes	often	always

11. CAUTIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

12. CHARMING

1	2	3	4	5
never	rarely	sometimes	often	always

13. COMPETITIVE

1	2	3	4	5
never	rarely	sometimes	often	always

14. COMPLAINING

L	2	3	4	5
never	rarely	sometimes	often	always

15. CONFIDENT

1	2	3	4	5
never	rarely	sometimes	often	always

16. CONSIDERATE

1	2	3	4	5
never	rarely	sometimes	often	always

17. CRUEL

1	2	3	4	5
never	rarely	sometimes	often	always

18. DECISIVE

1	2	3	4	5
never	rarely	sometimes	often	always

19. DEPENDENT UPON OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

20. EASILY PERSUADED

1	2	3	4	5
never	rarely	sometimes	often	always

21. FAIR

1	2	3	4	5
never	rarely	sometimes	often	always

22. FEMININE

1	2	3	4	5
never	rarely	sometimes	often	always

23. FRANK

1	2	3	4	5
never	rarely	sometimes	often	always

24. FRIENDLY

1	2	3	4	5
never	rarely	sometimes	often	always

25. HAPPY

1	2	3	4	5
never	rarely	sometimes	often	always

26. HARDWORKING

1	2	3	4	5
never	rarely	sometimes	often	always

27. HELPFUL

1	2	3	4	5
never	rarely	sometimes	often	always

28. HELPLESS

1	2	3	4	5
never	rarely	sometimes	often	always

29. IMAGINATIVE

1	2	3	4	5
never	rarely	sometimes	often	always

30. IMPATIENT

1	2	3	4	5
never	rarely	sometimes	often	always

31. INDEPENDENT

1	2	3	4	5
never	rarely	sometimes	often	always

32. INTELLIGENT

1	2	3	4	5
never	rarely	sometimes	often	always

33. IRRITABLE

1	2	3	4	5
never	rarely	sometimes	often	always

34. JEALOUS

1	2	3	4	5
never	rarely	sometimes	often	always

35. MASCULINE

1	2	3	4	5
never	rarely	sometimes	often	always

36. MATERIALISTIC

1	2	3	4	5
never	rarely	sometimes	often	always

37. MESSY

1	2	3	4	5
never	rarely	sometimes	often	always

38. ON TOP OF SITUATIONS

1	2	3	4	5
never	rarely	sometimes	often	always

39. OPEN ABOUT FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

40. PLANS AHEAD

1	2	3	4	5
never	rarely	sometimes	often	always

41. QUIET

1	2	3	4	5
never	rarely	sometimes	often	always

42. REASONABLE

1	2	3	4	5
never	rarely	sometimes	often	always

43. RELIGIOUS OR SPIRITUAL

1	2	3	4	5
never	rarely	sometimes	often	always

44. SHY

1	2	3	4	5
never	rarely	sometimes	often	always

45. SILENT

1	2	3	4	5
never	rarely	sometimes	often	always

46. SULLEN

1	2	3	4	5
never	rarely	sometimes	often	always

47. SECRETIVE

1	2	3	4	5
never	rarely	sometimes	often	always

48. SELF-CRITICAL

1	2	3	4	5
never	rarely	sometimes	often	always

49. SENSITIVE TO OTHERS FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

50. SEXUALLY-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

51. STRONG-WILLED

1	2	3	4	5
never	rarely	sometimes	often	always

52. STUBBORN

1	2	3	4	5
never	rarely	sometimes	often	always

53. SUCCESS-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

54. SUPPORTIVE TO OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

55. SUSPICIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

56. SYMPATHETIC

1	2	3	4	5
never	rarely	sometimes	often	always

57. TRICKY

1	2	3	4	5
never	rarely	sometimes	often	always

58. TRUSTWORTHY

1	2	3	4	5
never	rarely	sometimes	often	always

59. WARM

1	2	3	4	5
never	rarely	sometimes	often	always

60. WORRIED

1	2	3	4	5
never	rarely	sometimes	often	always

ADJECTIVE CHECKLIST MATRIX

Check the degree of agreement you have with the following descriptions. There are no right or wrong answers, and your first response is usually the best. Ask for clarification if you are unsure of the instructions.

III. My Spouse is _____.

1. ABSENT MINDED

1	2	3	4	5
never	rarely	sometimes	often	always

2. ACTIVE

1	2	3	4	5
never	rarely	sometimes	often	always

3. AMBITIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

4. ANGRY

1	2	3	4	5
never	rarely	sometimes	often	always

5. ASHAMED

1	2	3	4	5
never	rarely	sometimes	often	always

6. BORED

1	2	3	4	5
never	rarely	sometimes	often	always

7. BOSSY

1	2	3	4	5
never	rarely	sometimes	often	always

8. CALM

1	2	3	4	5
never	rarely	sometimes	often	always

9. CAPABLE

1	2	3	4	5
never	rarely	sometimes	often	always

10. CARRIES OUT PLANS

1	2	3	4	5
never	rarely	sometimes	often	always

11. CAUTIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

12. CHARMING

1	2	3	4	5
never	rarely	sometimes	often	always

13. COMPETITIVE

1	2	3	4	5
never	rarely	sometimes	often	always

14. COMPLAINING

L	2	3	4	5
never	rarely	sometimes	often	always

15. CONFIDENT

1	2	3	4	5
never	rarely	sometimes	often	always

16. CONSIDERATE

1	2	3	4	5
never	rarely	sometimes	often	always

17. CRUEL

1	2	3	4	5
never	rarely	sometimes	often	always

18. DECISIVE

1	2	3	4	5
never	rarely	sometimes	often	always

19. DEPENDENT UPON OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

20. EASILY PERSUADED

1	2	3	4	5
never	rarely	sometimes	often	always

21. FAIR

1	2	3	4	5
never	rarely	sometimes	often	always

22. FEMININE

1	2	3	4	5
never	rarely	sometimes	often	always

23. FRANK

1	2	3	4	5
never	rarely	sometimes	often	always

24. FRIENDLY

1	2	3	4	5
never	rarely	sometimes	often	always

25. HAPPY

1	2	3	4	5
never	rarely	sometimes	often	always

26. HARDWORKING

1	2	3	4	5
never	rarely	sometimes	often	always

27. HELPFUL

1	2	3	4	5
never	rarely	sometimes	often	always

28. HELPLESS

1	2	3	4	5
never	rarely	sometimes	often	always

29. IMAGINATIVE

1	2	3	4	5
never	rarely	sometimes	often	always

30. IMPATIENT

1	2	3	4	5
never	rarely	sometimes	often	always

31. INDEPENDENT

1	2	3	4	5
never	rarely	sometimes	often	always

32. INTELLIGENT

1	2	3	4	5
never	rarely	sometimes	often	always

33. IRRITABLE

1	2	3	4	5
never	rarely	sometimes	often	always

34. JEALOUS

1	2	3	4	5
never	rarely	sometimes	often	always

35. MASCULINE

1	2	3	4	5
never	rarely	sometimes	often	always

36. MATERIALISTIC

1	2	3	4	5
never	rarely	sometimes	often	always

37. MESSY

1	2	3	4	5
never	rarely	sometimes	often	always

38. ON TOP OF SITUATIONS

1	2	3	4	5
never	rarely	sometimes	often	always

39. OPEN ABOUT FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

40. PLANS AHEAD

1	2	3	4	5
never	rarely	sometimes	often	always

41. QUIET

1	2	3	4	5
never	rarely	sometimes	often	always

42. REASONABLE

1	2	3	4	5
never	rarely	sometimes	often	always

43. RELIGIOUS OR SPIRITUAL

1	2	3	4	5
never	rarely	sometimes	often	always

44. SHY

1	2	3	4	5
never	rarely	sometimes	often	always

45. SILENT

1	2	3	4	5
never	rarely	sometimes	often	always

46. SULLEN

1	2	3	4	5
never	rarely	sometimes	often	always

47. SECRETIVE

1	2	3	4	5
never	rarely	sometimes	often	always

48. SELF-CRITICAL

1	2	3	4	5
never	rarely	sometimes	often	always

49. SENSITIVE TO OTHERS FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

50. SEXUALLY-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

51. STRONG-WILLED

1	2	3	4	5
never	rarely	sometimes	often	always

52. STUBBORN

1	2	3	4	5
never	rarely	sometimes	often	always

53. SUCCESS-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

54. SUPPORTIVE TO OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

55. SUSPICIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

56. SYMPATHETIC

1	2	3	4	5
never	rarely	sometimes	often	always

57. TRICKY

1	2	3	4	5
never	rarely	sometimes	often	always

58. TRUSTWORTHY

1	2	3	4	5
never	rarely	sometimes	often	always

59. WARM

1	2	3	4	5
never	rarely	sometimes	often	always

60. WORRIED

1	2	3	4	5
never	rarely	sometimes	often	always

ADJECTIVE CHECKLIST MATRIX

Check the degree of agreement you have with the following descriptions. There are no right or wrong answers, and your first response is usually the best. Ask for clarification if you are unsure of the instructions.

IV. Ideally, I would like my spouse to be _____.

1. ABSENT MINDED

1	2	3	4	5
never	rarely	sometimes	often	always

2. ACTIVE

1	2	3	4	5
never	rarely	sometimes	often	always

3. AMBITIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

4. ANGRY

1	2	3	4	5
never	rarely	sometimes	often	always

5. ASHAMED

1	2	3	4	5
never	rarely	sometimes	often	always

6. BORED

1	2	3	4	5
never	rarely	sometimes	often	always

7. BOSSY

1	2	3	4	5
never	rarely	sometimes	often	always

8. CALM

1	2	3	4	5
never	rarely	sometimes	often	always

9. CAPABLE

1	2	3	4	5
never	rarely	sometimes	often	always

10. CARRIES OUT PLANS

1	2	3	4	5
never	rarely	sometimes	often	always

11. CAUTIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

12. CHARMING

1	2	3	4	5
never	rarely	sometimes	often	always

13. COMPETITIVE

1	2	3	4	5
never	rarely	sometimes	often	always

14. COMPLAINING

L	2	3	4	5
never	rarely	sometimes	often	always

15. CONFIDENT

1	2	3	4	5
never	rarely	sometimes	often	always

16. CONSIDERATE

1	2	3	4	5
never	rarely	sometimes	often	always

17. CRUEL

1	2	3	4	5
never	rarely	sometimes	often	always

18. DECISIVE

1	2	3	4	5
never	rarely	sometimes	often	always

19. DEPENDENT UPON OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

20. EASILY PERSUADED

1	2	3	4	5
never	rarely	sometimes	often	always

21. FAIR

1	2	3	4	5
never	rarely	sometimes	often	always

22. FEMININE

1	2	3	4	5
never	rarely	sometimes	often	always

23. FRANK

1	2	3	4	5
never	rarely	sometimes	often	always

24. FRIENDLY

1	2	3	4	5
never	rarely	sometimes	often	always

25. HAPPY

1	2	3	4	5
never	rarely	sometimes	often	always

26. HARDWORKING

1	2	3	4	5
never	rarely	sometimes	often	always

27. HELPFUL

1	2	3	4	5
never	rarely	sometimes	often	always

28. HELPLESS

1	2	3	4	5
never	rarely	sometimes	often	always

29. IMAGINATIVE

1	2	3	4	5
never	rarely	sometimes	often	always

30. IMPATIENT

1	2	3	4	5
never	rarely	sometimes	often	always

31. INDEPENDENT

1	2	3	4	5
never	rarely	sometimes	often	always

32. INTELLIGENT

1	2	3	4	5
never	rarely	sometimes	often	always

33. IRRITABLE

1	2	3	4	5
never	rarely	sometimes	often	always

34. JEALOUS

1	2	3	4	5
never	rarely	sometimes	often	always

35. MASCULINE

1	2	3	4	5
never	rarely	sometimes	often	always

36. MATERIALISTIC

1	2	3	4	5
never	rarely	sometimes	often	always

37. MESSY

1	2	3	4	5
never	rarely	sometimes	often	always

38. ON TOP OF SITUATIONS

1	2	3	4	5
never	rarely	sometimes	often	always

39. OPEN ABOUT FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

40. PLANS AHEAD

1	2	3	4	5
never	rarely	sometimes	often	always

41. QUIET

1	2	3	4	5
never	rarely	sometimes	often	always

42. REASONABLE

1	2	3	4	5
never	rarely	sometimes	often	always

43. RELIGIOUS OR SPIRITUAL

1	2	3	4	5
never	rarely	sometimes	often	always

44. SHY

1	2	3	4	5
never	rarely	sometimes	often	always

45. SILENT

1	2	3	4	5
never	rarely	sometimes	often	always

46. SULLEN

1	2	3	4	5
never	rarely	sometimes	often	always

47. SECRETIVE

1	2	3	4	5
never	rarely	sometimes	often	always

48. SELF-CRITICAL

1	2	3	4	5
never	rarely	sometimes	often	always

49. SENSITIVE TO OTHERS FEELINGS

1	2	3	4	5
never	rarely	sometimes	often	always

50. SEXUALLY-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

51. STRONG-WILLED

1	2	3	4	5
never	rarely	sometimes	often	always

52. STUBBORN

1	2	3	4	5
never	rarely	sometimes	often	always

53. SUCCESS-ORIENTED

1	2	3	4	5
never	rarely	sometimes	often	always

54. SUPPORTIVE TO OTHERS

1	2	3	4	5
never	rarely	sometimes	often	always

55. SUSPICIOUS

1	2	3	4	5
never	rarely	sometimes	often	always

56. SYMPATHETIC

1	2	3	4	5
never	rarely	sometimes	often	always

57. TRICKY

1	2	3	4	5
never	rarely	sometimes	often	always

58. TRUSTWORTHY

1	2	3	4	5
never	rarely	sometimes	often	always

59. WARM

1	2	3	4	5
never	rarely	sometimes	often	always

60. WORRIED

1	2	3	4	5
never	rarely	sometimes	often	always

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, of your present marriage. The middle point, "happy", represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who are very unhappy in marriage, and on the other, to those few who experience extreme joy or felicity in marriage.

Very unhappy	Happy	Perfectly happy

State the approximate extent of agreement or disagreement between you and your mate on the following items. Please circle the appropriate number.

2. Handling family finances:

1	2	3	4	5	6
always agree	almost always agree	occasionally agree	frequently disagree	almost always disagree	always disagree

3. Matters of recreation:

1 2 3 4 5 6

4. Demonstrations of affection:

1 2 3 4 5 6

5. Friends:

1 2 3 4 5 6

6. Sex relations:

1 2 3 4 5 6

7. Conventionality (right, good, or proper conduct):

1 2 3 4 5 6

8. Philosophy of life:

1 2 3 4 5 6

9. Ways of dealing with in-laws:

1 2 3 4 5 6

Please check the appropriate space:

1. When disagreements arise, they usually result in: husband giving in _____, wife giving in _____, agreement by mutual give and take _____.

2. Do you and your mate engage in outside interests together? All of them _____, some of them _____, very few of them_____, none of them _____.

3. In leisure time do you generally prefer: to be "on the go" _____, to stay at home _____? Does your mate generally prefer: to be "on the go" _____, to stay at home _____?

4. Do you ever wish you had not married? Frequently _____, occasionally _____, rarely_____, never_____.

5. If you had your life to live over, do you think you would marry: the same person_____, marry a different person_____, not marry at all_____?

6. Do you confide in your mate: almost never_____, rarely_____, in most things_____, in everything_____?

RELATIONSHIP ADJUSTMENT SCALE

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, of your present relationship. The Middle point, "happy", represents the degree of happiness which most people get from the relationship, and the scale gradually ranges on one side to those few hwho are very unhappy, and ondthe other, to those few who experience extreme joy or felicity in the relationship.

Very unhappy			Happy			Perfectly happy

State the approximate extent of agreement or disagreement between you and your partner on the following items. Please circle the appropriate number.

2. Handling finances:

1 always agree	2 almost always agree	3 occasionally agree	4 frequently disagree	5 almost always disagree	6 always disagree

3. Matters of recreation:

1	2	3	4	5	6

4. Demonstrations of affection:

1	2	3	4	5	6

5. Friends:

1	2	3	4	5	6

6. Sex relations:

1	2	3	4	5	6

7. Conventionality (right, good, or proper conduct):

1	2	3	4	5	6

8. Philosophy of life:

1	2	3	4	5	6

9. Ways of dealing with in-laws:

1	2	3	4	5	6

.....cont'd.....

Please check the appropriate space:

1. When disagreements arise, they usually result in: male giving in_____, female giving in_____, agreement by mutual give and take_____.

2. Do you and your mate engage in outside interests together? All of them_____, some of them_____, very few of them_____, none of them_____.

3. In leisure time do you generally prefer: to be "on the go" _____, to stay at home_____? Does your mate generally prefer: to be "on the go"_____, to stay at home_____?

4. Do you ever wish you had not been involved as a couple? Frequently_____, Occasionally_____, rarely_____, never_____.

5. If you had your life to live over, do you think you would establish a relationship with: the same person_____, marry a different person_____, not marry at all_____?

6. Do you confide in your mate: almost never_____, rarely_____, in most things_____, in everything_____?

MARITAL ADJUSTMENT TEST

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, of your present marriage. The middle point, "happy", represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who are very unhappy in marriage, and on the other, to those few who experience extreme joy or felicity in marriage.

0	2	7	15	20	25	35
Very Unhappy			Happy			Perfectly Happy

State the approximate extent of agreement or disagreement between you and your mate on the following items. Please check each column.

		Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
2.	Handling family finances	5	4	3	2	1	0
3.	Matters of recreation	5	4	3	2	1	0
4.	Demonstrations of affection	8	6	4	2	1	0
5.	Friends	5	4	3	2	1	0
6.	Sex relations	15	12	9	4	1	0
7.	Conventionality (right, good, or proper conduct)	5	4	3	2	1	0
8.	Philosophy of life	5	4	3	2	1	0
9.	Ways of dealing with in laws	5	4	3	2	1	0

10. When disagreements arise, they usually result in: husband giving in 0, wife giving in 2, agreement by mutual give and take 10.

11. Do you and your mate engage in outside interests together? All of them 10, some of them 8, very few of them 3, none of them 0 .

12. In leisure time do you generally prefer: to be "on the go"_____, stay at home_____? Does your mate generally prefer: to "on the go"_____, stay at home_____? (Stay at home for both, 10 points: "on the go" for both, 3 points; disagreement, 2 points).

Marital-Adjustment Test (cont'd)

13. Do you everwish you had not married? Frequently 0, occasionally 3, rarely 8, never 15.

14. If you had your life to live over, do you think you would: marry the same person 15, marry a different person 0, not marry at all 1 ?

15. Do you confide in your mate: almost never 0, rarely 2, in most things 10, in everything 10?

ALCOHOL AND DRUG COUNSELING FOLLOW-UP FORM ' MO. 6 MO. 1 YR

NAME_____ DATE_____

ADDRESS (if new)_____PHONE (if new)_____

1. How have t.ings been going?

I. DRINKING

1. I'd like some idea about how your drinking has been.

you	your partner/spouse
____ No drinking this month	_____ No drinking this month
____ Some drinking this month	_____ Some drinking this month

2. If drinking, what was last week like?

for you-	for your spouse/partner
Monday	Monday
Tuesday	Tuesday
Wednesday	Wednesday
Thursday	Thursday
Friday	Friday
Saturday	Saturday
Sunday	Sunday

If drinking, go through the week day by day to get the person's description of the specific number, kind, and amount of drinks consumed.

3. Was this a typical week for you? For your spouse/partner?

EMPLOYMENT

This section has to do with work situations. If you are a housewife, treat your housework as your job.

1. Please indicate the number of days off work in the last month.

_____ Sick days
_____ Drinking days
_____ Unproductive days
_____ Suspension
_____ Other (specify)

2. During the past four weeks I would rate my work productivity as:

Excellent	very good	good	unsatisfactory	poor	very poor	totally unsatisfac-

3. Please indicate the number of days off work for your spouse in the last month.

_____ Sick days
_____ Drinking days
_____ Unproductive days
_____ Suspension
_____ Other (specify)

4. During the past four weeks I would rate my spouse's work productivity as:

Excellent	very good	good	unsatisfactory	poor	very poor	totally unsatisfactory

SOCIAL LIFE

1. Listed below are activities with other people which go together to make what most people call a social life. Please indicate the frequency of your participation in these activities during the past four weeks in the column labelled "now". Record what your ideal social life would be in the "ideal" column.

   Use only one column per category.

	Daily		Times/week		Times/month		Times/year		Never	
	Now	Ideal	Now	Ideal	Now	Ideal	Now	Ideal	Now	Ideal
Entertain Friends										
Visit friends										
Recreational activity with others (cards, bowling										
club meetings										
parties										
talking to people in bars, beverage rooms										
church related activity										
Other										

2. Over the past month my social life has been:

Extremely good	very good	good	average	poor	very poor	extremely poor

3. My spouse's social life over the past month has been:

Extremely good	very good	good	average	poor	very poor	extremely poor

RELATIONSHIP

This section pertains to your relationship to your partner.

1. Partner or spouse and I are currently: living together_____ separated_____

2. We have been married (living together) ____years ____ months _____ weeks

3. We have been separated_____times

4. Our current separation has been for ____ years ____ months ____ weeks

5. How many times have you moved in the past two years _____

All in all over the past month I would rate my relationship as being:

Excellent	very good	good	satisfactory	poor	very poor	totally unsatisfactory

All in all over the past month, I feel that my spouse/partner would rate his/her relationship with me as being:

Excellent	very good	good	satisfactory	poor	very poor	totally unsatisfactory

Please rate the following areas of your relationship by circling the word that best describes your relationship in the past month.

1. Our expression of affection to each other has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

2. The degree of conflict or arguments in our relationship has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

3. The general degree of expression of feelings in our relationship has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

4. Our degree of cohesiveness or closeness has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

5. The degree of our activity together has been:

Ideal	Very Good	Good	Average	Poor	Very Poor	Totally Unsatisfactory

Below are 10 descriptions. Read each one and decide whether or not it might apply to you. Rate your degree of agreement or disagreement using the numbers from the scale pictured below.

1----------2----------3----------4
strongly agree agree disagree strongly disagree

1. On the whole, I am satisfied with myself. ___

2. At times, I think I am no good at all. ___

3. I feel that I have a number of good qualities. ___

4. I am able to do things as well as most people. ___

5. I feel I do not have much to be proud of. ___

6. I certainly feel useless at times. ___

7. I feel that I'm a person of worth, at least on an equal plane with others. ___

8. I wish I could have more respect for myself. ___

9. All and all, I'm inclined to think I am a failure. ___

10. I take a positive attitude toward myself. ___

Date _____

I, _____, agree to participate in counseling at Alcohol and Drug Counselling. I also agree to follow-up contacts at one month, six months, and one year after counseling. This follow-up will be either by telephone or in person, at the convenience of the participant, and will take about twenty minutes. The follow-up will allow you to give feedback on the counseling and will assist counseling effectiveness. The follow-up information, like all information you give, will be confidential.

Signature _____

DATE_____ NAME_____

PRE POST 6 MO. 1 YEAR

1. ALCOHOL USE: DRINKS PER WEEK
   COMMENTS ON PATTERN_____

2. MARITAL ADJUSTMENT: MARITAL RATING (1-7)_____.
   : RELATIONSHIP AREAS (5-35)_____.
   : MAS (0-200) _____.

   COMMENTS_____

3. SELF-ESTEEM: DISCREPANCY SCORE _____.

   COMMENTS_____

4. REAL-IDEAL PARTNER: DISCREPANCY SCORE _____.

   COMMENTS_____

5. WORK FUNCTIONING: (1-7) _____.

   COMMENTS_____

6. SOCIAL FUNCTIONING: (1-7) _____.

   COMMENTS_____

By_____

Correlation Matrix for Adjunctive Dependent

Measures on Post-Assessment

	Relationship Rating	Social Rating	Work Rating	Real-Ideal Rating
Social Rating	0.32			
Work Rating	0.58	0.24		
Real-Ideal Self	-0.18	-0.36	0.08	
Real-Ideal Partner	-0.51	-0.33	-0.37	0.17

APPENDIX B

Consistency and Validity of the Real-Ideal Self Discrepancy Score

In order to establish the use of the real-ideal self discrepancy score as a useful clinical measure, it was necessary to evaluate the internal consistency of the adjective checklist, the correlation of the adjective checklist with other measures, and to test for differences between populations who were likely to differ on the quality the adjective checklist asserts to measure. Alexander and Dibbs (1977) described the real-ideal discrepancy as a measure of self-esteem, which was consistent with the use of that aspect of the Q-sort and also has a certain amount of face validity. To further evaluate the reliability and validity of the adjective checklist version of this measure, three separate comparisons were made. In the first comparison, an odd-even item correlation was made for 31 college undergraduates. In the second comparison, the adjective checklist was administered to 22 alcoholics applying for outpatient counselling at an alcohol treatment centre on intake, and these results were compared ot the total scores of the 31 college undergraduates described previously. These alcoholics were not participants in the research described in this thesis. Also, the first 11 partners of alcoholics participating in the thesis research were compared to the undergraduate sample at this time. Finally, a separate sample of 70 undergraduates was administered the adjective checklist and the Guttman Self-Esteem Scale (Rosenberg, 1963). If the adjective checklist was in fact measuring what has been called self-esteem, it was expected that (1) the odd-even correlation would be substantial, (2) that both alcoholics and their partners would

score significantly higher than college undergraduates on the real-ideal self discrepancy score, and (3) there would be a positive and significant correlation between the Guttman Self-Esteem Scale and the real-ideal discrepancy score. In all administrations, the subjects were told that the questionnaires were being evaluated or pre-tested as to their usefulness. It was also explained that the questionnaires would have no effect on their status as either students or clients, and serious attention to the questionnaire was encouraged.

Results

1. The correlation between the scores based on the odd-even responses to the adjective checklist correlated highly, $r = .895$. The mean discrepancy score for odd items ($\bar{X} = 22.20$) and even items ($\bar{X} = 20.11$) appeared to be similar.

2. Both alcoholics and partners of alcoholics were found to differ significantly from college undergraduates on real-ideal self discrepancy scores, $F(1,51) = 4.12$, $p < .05$ and $F(1,40) = 9.59$, $p < .005$, respectively, when analyses of variance were used to compare the clinical groups with the undergraduates. The mean discrepancy scores were 44.35 for college undergraduates, 52.77 for alcoholics, and 60.18 for partners of alcoholics.

3. The correlation between the Guttman Self-Esteem Scale and the real-ideal discrepancy score was $r = -.565$, a moderate, but statistically significant correlation when evaluated by Fisher's r to Z transformation ($Z = 5.24$, $p < .001$). On this sample, an ANOVA was run between males and females for the real-ideal discrepancy score, and the differences were not significant, $F(1,68) = .005$, n.s.

Conclusions

This pre-testing evaluation of the real-ideal adjective checklist indicated that the checklist was internally consistent, differentiated between groups who were expected to differ on self-esteem, and correlated moderately with another measure of self-esteem. The consideration of the real-ideal self discrepancy score as a measure of self-esteem or self-regard, then, seemed to be a reasonable use of the measure.

Of course, it must be added that this pre-testing should not be considered ultimate validation of this measure, but only that it supported the use of the measure. The moderate correlation between the Guttman Self-Esteem Scale and the adjective checklist was a case in point. Examination of the scores indicates a limited range of scores for the Guttman scale, ranging from 0 to 4, while the adjective checklist discrepancy scores ranged from 20 to 75. A similar examination of the correlation of the Guttman scale with the adjective checklist measure may yield more useful information if tested on a clinical population. In general, however, the real-ideal discrepancy appeared to be a reasonable measure of self-esteem or self-regard. Further exploration of the validity of the measure would probably still be fruitful, however.