Family Treatment of Alcoholism

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Introduction

During the past two decades, behavioral scientists have become increasingly interested in family influences related to the etiology, maintenance, and treatment of alcoholism. For the most part, however, empirical research has been concerned with family variables related to the onset and course of abusive drinking, with few efforts aimed at developing and evaluating family oriented alcoholism treatment. Thus, a brief review of the general family interaction and alcoholism literature will be presented before discussing the theoretical, empirical, and clinical literatures that specifically address treatment issues.

The Family Interactions of the Alcoholic

Much of the existing literature relevant to families of alcoholics has focused on individuals within the family matrix. In contrast, studies that

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examine the family as a unit, either as an influence in the etiology and perpetuation of abusive drinking or as a system disturbed by the effects of alcoholism, are still largely absent.[1] This individual emphasis can be traced to traditions that defined alcoholism as a moral deficit or medical problem, as well as to the psychodynamic focus of early clinical and empirical reports.[2-4] The latter influence was most apparent in early descriptions of alcoholics' wives as "disturbed" personalities who sought to dominate or punish their spouses.[2-4] Later, environmental perspectives cast wives as "victims" whose disturbances were the result of the accumulative stress of living with alcoholics.[5-6] Nevertheless, this research focus was still individual rather than interpersonal; research linking marital interactions with abusive drinking has only begun to develop during the past two decades.

Most relevant to this developing interest in the interpersonal aspects of alcohol abuse, the late 1960s and early 1970s witnessed the emergence of several observational studies of the interactions of alcoholics and their families. As noted in Jacob and Seilhamer's[1] recent evaluation of this literature, this interaction perspective offers several possibilities for clarifying the association of family factors and alcohol abuse. First, descriptions based on empirical data can dispel myths and misinformation generated by reports gathered within clinical contexts and based on small, unrepresentative samples. Second, to the extent that interaction research can provide further understanding of affective interchanges, problem-solving styles and their effectiveness, dominance patterns, and parent–child socialization practices that are associated with drinking and nondrinking situations, it is increasingly likely that treatment and prevention programs will be founded on more substance and less supposition than currently seems to be the case.

A major advance in family interaction research pertaining to alcoholism was reflected in the programmatic studies by Steinglass and his colleagues. This research effort began with several studies that included observations of inpatient alcoholics during sober and intoxicated phases. Results of these investigations suggested that the affective and structural characteristics of relationships in these drinking "gangs" were dramatically altered during drinking periods. For Steinglass, these observations confirmed the significance of reciprocal effects involving alcohol and interpersonal interaction, and led to a preliminary model of alcoholism based upon family systems theory.[7,8]

Steinglass' research then moved on to assessments of marital pairs in an experimental treatment program during which couples were housed in

apartment-like settings where alcohol was freely available.[9] Results from this effort indicated that intoxicated behaviors were both more exaggerated and more restricted in range than interactions displayed during sober states. Furthermore, striking differences in patterns of interaction were observed between sober and intoxicated periods—differences that appeared to serve important "adaptive" functions for the couple. According to Steinglass, if alcohol effectively reduced tension or solved a problem, short-term family stability could be achieved, and as a result, the change from sober to intoxicated interactional states could serve to stabilize an unstable system. However, because the family's problems were chronic, the solution provided by alcohol was only temporary.

More recent work by Steinglass and his colleagues has involved exploration of the "life-history model of alcoholism," a model that emphasizes a macroscopic, longitudinal view of drinking patterns, and suggests that periods of sobriety and active drinking form a cycle in the lives of most alcoholics.[10] In contrast with the maintenance model, which describes rapid changes from sober to intoxicated states with associated changes in patterns of interaction, the life history model suggests that three important phases—dry, wet, and transitional—appear and reappear many times over a 20–30 yr period. A key implication of this broader framework is that the alcoholic family fails to progress along a normal developmental course characterized by greater complexity and differentiation.

Without question, the work of Steinglass has been a major influence in the study of family interaction within the alcoholism field. At the same time, it must be acknowledged that his work was based on small, highly selective samples that lacked normal control groups and were uncontrolled for possible confounds, such as the co-occurrence of other psychiatric disorders in the alcoholic or spouse. Moreover, the data used to generate early conceptual models were based on impressionistic clinical summaries, and Steinglass' later efforts did not directly assess the acute effects of alcohol on family interchanges. Taken together, these limitations raise questions about the stability and interpretability of obtained results.

During the past several years, a number of studies have reported on the marital interactions of alcoholics (*see* Jacob & Seilhamer), three of which involved experimental drinking as part of the procedures.[11–13] In general, these efforts involved small sample studies offering provocative hypotheses and empirical findings, but were limited by their preliminary nature. Jacob et al.,[13] for example, reported alcoholic couples to be more negative and to

display less problem-solving behavior than normal controls, and to exhibit more negative communication in drink vs no drink sessions. Confidence in these findings, however, is limited by a small sample and the absence of appropriate comparison groups.

Another early study conducted by Billings et al.[11] included alcoholic couples, distressed (nonalcoholic) couples, and normal controls. A major finding was that alcoholic and distressed couples engaged in less problem-solving and in more negative and hostile behaviors than nondistressed controls, but that alcoholic and nonalcoholic distressed couples were not significantly different from one another. Again, methodological shortcomings, such as minimal alcohol consumption during drinking sessions, and the failure to assess participants' psychiatric status, limits confidence in these results.

An experimental study by Frankenstein et al.[12] controlled the alcohol consumption of subjects by administering fixed doses prior to interaction sessions. Analyses indicated that couples demonstrated more positive interaction in the drink vs no drink situation, a finding that resulted primarily from the spouses' change between sessions. Additionally, the alcoholics talked more than their spouses when drinking, and also tended to express more problem-solving statements when drinking, whereas this cross-sectional effect was not found for spouses. Upon closer examination, it appears that discrepancies between the Jacob et al.[13] and Frankenstein et al.[12] studies may be attributed largely to design characteristics. Specifically, critical differences are apparent in the amount and administration of alcohol, the presence versus absence of alcohol during ongoing interactions, and the application of coding schemes to marital interactions (*see* Jacob and Seilhamer[1], for elaboration of these issues).

In an effort to address the limitations of these early drinking studies, Jacob and his colleagues initiated a multi-faceted research program involving families of alcoholics as well as psychiatric and normal control groups.[14-16] In contrast to earlier studies, this effort was characterized by rigorous selection criteria, a carefully designed experimental drinking procedure, and a comprehensive battery of observational and report procedures. Although a variety of data was collected and analyzed, several findings are of particular interest in the current context. Specifically, normal couples were found to have exhibited higher rates of congeniality and positivity than both groups of disturbed couples, whereas alcoholic couples were found to have displayed more negative behavior than normal or de-

pressed groups. Further examination of these data revealed that, when the alcoholics were analyzed according to drinking style,[16] steady and episodic drinkers displayed significantly different patterns of marital interaction. Most importantly, in the drinking condition, steady drinkers and their wives exhibited a higher rate of problem-solving behavior, whereas episodic drinkers and their wives exhibited reduced levels of problem-solving behaviors. Overall, these data suggest that the marital interactions of the steady drinkers are consistent with the "adaptive consequences" model of Steinglass, in that alcohol consumption facilitated problem solving, a function vital to the preservation of the family system. In contrast, the interactions of the episodic drinkers may reflect a "coercive control" mechanism, whereby the alcoholic avoids conflictual issues by behaving in a hostile manner while drinking.

Family Oriented Treatment of Alcoholism

In a recent review, McCrady[17] identified three theoretical perspectives that underlie most models of family oriented alcoholism treatment: disease perspectives, which view alcoholism as a "family disease," family systems perspectives, which view alcoholism as an important organizing principal for family life and which focus on reciprocal relationships between alcohol and family interactional behavior, and behavioral perspectives, which view alcoholism as maintained by multiple systems of reinforcement, including the family.[17] In her review, McCrady also discussed the substantial gap between clinical and empirical bases of practice; namely, that although treatment approaches derived from family disease and family systems perspectives are the most widely used, these models suffer from a lack of rigorously controlled evaluation studies. In contrast, behavioral models are not as widely used in treatment settings, although the best controlled outcome studies have involved evaluations of this theoretical/clinical perspective.[17]

The remainder of this section will present an overview of the three treatment models described above. Following a brief description of the theoretical underpinnings for each model, empirical outcome studies will be reviewed. Because well-controlled evaluations are largely absent for the disease and family systems models, the majority of studies reviewed will focus on the outcomes of behaviorally-based treatment. In particular, the

research programs of McCrady[18] and O'Farrell[19] will be highlighted. This section relies heavily on McCrady's[17] comprehensive review, and readers who desire a more extensive discussion of treatment models and empirical outcome studies are referred to her work. The chapter concludes with suggestions for future research.

Disease Models

Currently, there is widespread interest in disease models in alcoholism treatment settings, and an increase in family programming in treatment settings based on the disease perspective.[17] Contemporary disease models extend the concept of alcoholism from an individual disease to a disease that affects the entire family. The family disease is termed "co-dependence" and is characterized by symptoms such as investing self-esteem in controlling the alcoholic, experiencing anxiety and distortion around issues of intimacy and separation, and enmeshment in dysfunctional relationships.[20] Some family disease models also focus on the family as a system, and include adjustment of family equilibrium, roles, and communication in the treatment process.[21-22] Treatment programs derived from a family disease perspective generally provide separate rather than conjoint therapy for the alcoholic, spouse, and other family members. Treatment usually includes education about the disease concept of alcoholism and education about codependence. Family members are usually referred to self-help groups, such as Al-Anon or Adult Children of Alcoholics, and may participate in individual and group therapy. In addition, there has been an increase in inpatient alcoholism treatment programs that offer short-term residential family therapy.[17]

As already noted, empirical studies assessing the effectiveness of family disease models are largely absent. In her review of this literature, McCrady[17] found only three studies published during the past 10 yr that evaluated family disease oriented programs. Two of the studies evaluated the residential family therapy program at the Hazelden Foundation in Minnesota,[21-22] which offered short-term (about three days) residential treatment for family members. Described as a therapeutic community, the program emphasized Al-Anon concepts, such as detachment, attitude change, and self-help through the sharing of experiences. The program also encouraged client awareness of family systems concepts, such as family equilibrium, family roles, and communication. Thus, the program

encouraged cognitive changes that help family members cope more effectively with the addicted family member's drinking or drug use.

Cognitive change was assessed using a 20 item self-report questionnaire administered before and after program completion. Results suggested that family members made the greatest changes in recognizing that they could not ensure abstinence of the addicted family member, that they were not responsible for the addicted member's use of alcohol or drugs, that all family members had to take primary responsibility for their own problems, and that the cause of substance abuse was less important than changing the behavior and its impact on the family. No data were presented regarding sample demographics, and no other outcome measures for the family were presented (i.e., adjustment in areas other than coping with drinking). Further, no data were presented regarding the influence of family treatment on the alcoholic's drinking or other adjustment.[21]

Laundergan et al.,[22] reported results of a six-month Hazelden follow-up, in which family members completed the 20-item questionnaire, as well as other questionnaires assessing their support group participation, improvements with personal communication, and dealing with feelings. Results indicated that frequent Al-Anon and Alateen attendance was associated with adopting new communication patterns, new ways of dealing with feelings, and maintenance of attitudes developed during treatment. Again, no data were presented regarding the impact of treatment on the addicted family member's functioning.

A third published study involved an evaluation of Al-Anon,[23] focusing on the relationship between length of time nonalcoholic wives participated in Al-Anon, and the frequency of their ineffective or negative coping with spouse drinking. Participants included 123 women attending Al-Anon groups in the Washington DC area. Results indicated that duration of Al-Anon membership was associated with less negative coping, and that total coping was more associated with length of spouse's affiliation with Al-Anon than length of husband's abstinence or length of husband's affiliation with AA. No data were presented regarding the impact of Al-Anon attendance on the drinking behavior or other adjustment of the alcoholic.

All three of these studies suffer from serious limitations. First, none of the studies involved treatment for the entire family, or assessed the effect of family treatment on the alcoholic's drinking status or other adjustment. Second, family member's adjustment was examined only in terms of their coping with the alcoholic's drinking. Finally, these efforts are seriously

limited because of the lack of appropriate control or comparison groups, and their exclusive reliance on self-reports.

Family Systems Models

Family systems models form the second approach to family-involved alcoholism treatment. These models incorporate many of the core concepts of family systems theory, including organization, homeostasis, circular causality of events, and feedback loops. Central to these models is the concept of the alcoholic family system, conceptualized as an interactional group in which behavior is organized around alcohol.[24] In alcoholic families, certain interactional behaviors may be associated with intoxication. If interactional behaviors that arise during intoxication are adaptive for the family, then abusive drinking itself takes on a functional role of problem solving. Treatment, therefore, is directed toward understanding changes in the family's interactional behavior during the presence vs absence of alcohol, and in helping the family to achieve adaptive consequences without the prior necessity of alcohol.[24,25]

Although family systems models are apparently popular in the alcoholism treatment community, controlled outcome research in this area is virtually nonexistent. To date, only one controlled outcome study has been reported in the literature. McCrady and her colleagues compared individually oriented alcoholism treatment with couples-involved treatment with and without joint hospitalization as part of the treatment.[26,27] The couples therapy in this study was not strictly systems based, but was described as "broadly interactional in focus."[17] This study is particularly noteworthy because it is the only controlled evaluation of the efficacy of joint hospitalization for alcoholics and their spouses.

Participants in this study were 33 couples, each containing one alcoholic spouse who had been admitted to a private psychiatric hospital for alcoholism treatment. Participants were randomly assigned to one of three treatment conditions: couples therapy with joint hospitalization, couples therapy without joint hospitalization, or individual treatment for the alcoholic only. In the joint hospitalization group, the alcoholic and spouse lived together at the hospital for a portion of the alcoholic's hospitalization. During this time, the couple attended all activities and meetings together, and were provided feedback on their interactions, which were observed by the project staff. The couple attended weekly couples group therapy, focusing on

communication, the effect of alcohol on the marriage, and relationship issues. In addition, the alcoholic and spouse each attended weekly individual therapy groups during and after hospitalization. In the second condition, alcoholics and their spouses attended the same therapy groups described above, but the nonalcoholic spouses did not reside at the hospital. In the individual therapy condition, only the hospitalized alcoholic attended a weekly therapy group; the spouse did not participate in treatment.[26]

Six-month followup data suggested that the two couple-involved groups had better outcomes than the individual therapy group in terms of a reduction in quantity and frequency of drinking.[26] At four yr followup, there were no statistically significant differences between the three groups, although trends did suggest better marital adjustment and better drinking status for the joint hospitalization group as compared to the couples therapy and individual treatment groups.[17,27]

A family systems approach was more directly applied in a study reported by Steinglass.[24] This study also incorporated a period of joint hospitalization for alcoholics and their spouses as part of a three-phase treatment program. During the first phase (two weeks prior to hospitalization), couples met three times a week for multiple-couples group therapy, followed by 10 d of joint hospitalization, during which alcohol was freely available. During this time, couples' interactions were observed and videotaped, and daily multiple-couples group therapy was conducted. The observational data were used as an aid in identifying changes in the couples' interactions during sober vs intoxicated states, and in designing specific treatment strategies for each couple. During the last phase, couples completed three wk of twice weekly couples group therapy, followed by six mo of group meetings conducted every six wk. Ten couples completed the program.

Although no statistical analyses were presented, descriptive data for eight couples were reported at six-month followup. Results indicated that outcomes for drinking status and martial functioning were equivocal. For example, although only five of the alcoholics reported decreases in drinking quantity, eight showed changes in patterns and contexts of drinking. In terms of marital functioning, seven couples showed improved communication. However, these changes were often associated with the perception that there were other behavioral difficulties to be addressed, and decreased satisfaction with other areas of the marriage.[24]

Thus, despite the incorporation of family systems concepts in many alcoholism treatment settings, well-controlled studies evaluating the effec-

tiveness of this model are lacking. Although the program reported by Steinglass is unique in its direct application of systems concepts and availability of alcohol during hospitalization, outcome findings are limited because of a small sample, and more importantly, lack of appropriate comparison groups. On the other hand, McCrady's research (although better controlled) was not strictly systems based. As McCrady[17] noted in her review of this small literature, "The controlled studies to date have suggested little beyond demonstrating that intense couples-involved treatment is feasible and may yield better outcomes than individually oriented treatment. Careful outcome studies that examine the process of family systems oriented treatment and that compare the outcomes to appropriate control conditions are simply lacking" (p. 176).

Behavioral Models

Behavioral models are the third approach to family involved alcoholism treatment. Although behavioral models form a distinct treatment approach, there is considerable overlap between behavioral and family systems concepts. For example, behavioral models assume that there is an interdependence between marital interactions and drinking. Marital interactions are viewed as reciprocal—that is, the behavior of each spouse serves simultaneously as a cue and a reinforcer for the other's behavior, including drinking behavior. When the alcoholic spouse drinks, positive changes in couple interaction may occur, which in turn, reinforce abusive drinking. Therefore, recognizing changes in interaction that occur during sober and intoxicated states is an important treatment goal.[17] Numerous behavioral approaches also incorporate techniques of behavioral marital therapy (BMT) into the treatment program. Treatment derived from this approach generally has two related foci; changing alcohol-related interactional patterns that maintain abusive drinking or trigger relapse, and altering general marital patterns, such as increasing the frequency of positive, caring, reciprocal interactions, and improving communication and problem-solving skills.[17,28]

Another key assumption of behavioral models is that alcoholism is maintained by multiple systems of reinforcement, including the spouse and other family members. Because spouses are seen as vital sources of reinforcement, some behavioral approaches have stressed training the spouse in new coping skills that reinforce sobriety, or involving the spouse in therapy-

relevant behavior, such as being present each time the alcoholic spouse takes disulfiram. However, because nonfamily systems of reinforcement are also important, behavioral models include individually oriented behavior change techniques for the alcoholic; for example, identifying cues for drinking, role-playing stressful situations that could result in relapse, and role-playing new behaviors, such as drink refusal.[17]

Most of the empirical research on BMT in the treatment of alcoholism has been conducted by two research groups—one headed by Timothy O'Farrell at the Veterans Administration Medical Center in Brockton, Massachusetts, and the other by Barbara McCrady at the Rutgers Center of Alcohol Studies, in Piscataway, New Jersey. The remainder of this section will focus on outcome studies from these two research programs.

O'Farrell et al.[19] have reported findings from their Class on Alcoholism and Marriage (CALM) project. The goals of project CALM have been the development of BMT procedures for newly abstinent male alcoholics and their spouses, and the careful evaluation of interactional vs behavioral couples group therapy.[19,28] Participants in this study were 34 male alcoholics and their spouses who had been married an average of 16 yr. Couples were randomly assigned to one of three treatment groups:

1. A behavioral marital therapy group, which included Antabuse contracts, and behavioral techniques to increase positive, reciprocal exchanges between partners, and improve communication and problem-solving skills;
2. An interactional couples group, which emphasized mutual support, sharing of feelings, problem-solving through discussion, and verbal insight from both therapists and other group members; or
3. A no couples treatment control.

Although long-term data have not yet been published, results have been presented for the period immediately after treatment.[19] Findings from this study indicated that couples in the BMT group showed significant improvement on overall marital adjustment and communication, that these improvements were significantly greater than no treatment controls, and that those changes tended to be greater than those found in the interactional group. Although all participants showed short-term improvement in drinking status, alcoholics in the BMT group reported significantly fewer drinking days than those in the interactional group.

The research program of McCrady and her colleagues has focused on identifying the active components of spouse-involved outpatient alcoholism

treatment.[17,18] Participants in the Project for Alcoholic Couples Treatment (PACT) study were 45 alcoholics and their partners. Couples were randomly assigned to one of three experimental conditions:

1. Minimal spouse involvement (MSI), in which the spouse was present for all therapy sessions, but all interventions were directed toward teaching the alcoholic behavioral skills to achieve and maintain abstinence;
2. Alcohol-focused spouse involvement (AFSI), in which the alcoholic was taught the skills in the MSI condition, and the spouse was taught skills to reinforce abstinence, respond more effectively in drinking situations, and decrease behaviors that cued drinking; or
3. Alcohol-focused spouse involvement plus behavioral marital therapy (ABMT), which included all the skills of the AFSI condition, plus BMT techniques to increase the frequency of positive couple interactions, and improve communication and problem-solving skills.

Extensive measures on drinking behavior, marital satisfaction and communication, and psychological, interpersonal, and occupational functioning were administered at baseline, during treatment, and at 6-, 12-, and 18-mo followups.[17,18]

During treatment, there was a substantial dropout rate in the MSI condition, with only 67% of participants in this condition completing five or more sessions, and less than 50% completing treatment. In contrast, dropout rates for the other two conditions were less than 20%. When only those completing the treatment were compared, individuals in the MSI and ABMT conditions significantly decreased the frequency of drinking. Participants in the AFSI condition did not report comparable decreases in drinking.[17,18] Results from the longer term followups indicated that, in general, ABMT couples had the most positive treatment outcomes. For example, marital satisfaction was higher in the ABMT group, there were fewer marital separations, and more positive and less negative affect. Time trend analysis of relapse showed that participants in the ABMT condition gradually decreased their drinking over time following treatment, whereas those in the MSI only condition showed the more usual pattern of a gradual increase in drinking over time. According to McCrady and her colleagues, this pattern suggested that BMT had its primary impact during the posttreatment maintenance phase. Behavioral approaches seem to be associated with helping couples manage relapse episodes, thus providing motivation and encouragement for continued work towards long-term sobriety.[17]

In addition to the PACT project, McCrady has also been involved in the Butler Environmental Treatment of Alcoholism Project (Project BETA). Participants in this study were 229 alcoholics who were randomly assigned to one of three experimental treatment groups:

1. Individually-focused behavior therapy;
2. Behavior therapy with spouse or another significant other involved; or
3. Behavior therapy with spouse/significant other involved, and techniques to enhance occupational functioning.

Similar to the PACT project, extensive assessments were conducted on drinking status and interpersonal and occupational functioning.[17]

Data have been reported for 92 participants who have completed 12 months of followup. Of most interest to the current review, analyses have shown a pattern of gradual improvement in drinking status, similar to the results obtained in the PACT study. Again, time trends for the three groups were significantly different and showed an interesting "cross-over" effect—participants in the individually-focused condition had better outcomes for the first six months, but showed a subsequent decline in abstinent days throughout the followup. In contrast, participants in the two spouse-involved conditions showed smaller decreases in abstinent days over the first six months, but a gradual increase in abstinent days thereafter.[17]

Future Directions

This review has focused on three contemporary models of family oriented alcoholism treatment: family disease, family systems, and behavioral models. As noted, there is a substantial gap between the popularity of these models in clinical settings and the treatment outcome literature.[17] Disease and family systems models, although common in practice, suffer from a lack of controlled evaluation studies. In contrast, several well-controlled evaluations of behavioral models have been reported (e.g., McCrady, O'Farrell, and their respective colleagues), yet these models currently enjoy less popularity in treatment settings. Another gap exists between the developing alcoholism and family interaction literature and theoretical/clinical models of family-involved alcoholism treatment. Although the interaction literature is accumulating a substantial empirical base with particular relevance to treatment issues, these findings have yet to be applied to treatment models. Thus, basic treatment outcome research is needed for family disease and family systems oriented programs, and better communication and translation of findings is

needed between treatment settings, empirical treatment outcome studies, and the more general alcoholism literature.

Future efforts should also include the longitudinal assessment of couples and families throughout the long-term process of recovery. The behavioral literature suggests that treatment that includes BMT produces better long-term, although not necessarily short-term, outcomes than interactional or individually oriented therapies.[17,18] In turn, it has been suggested that BMT is associated with helping couples cope more effectively with relapse, thus producing better long-term outcomes. However, these observations are still preliminary in nature and need replication before they can be accepted with confidence. Further, as McCrady[17] has noted, no treatment outcome studies have examined the actual process of long-term recovery. Future efforts might compare the process of recovery in couples with and without relapse, or across different treatment modalities.

Another area of study deserving greater research attention involves the issue of client–treatment matching for family oriented alcoholism treatment. Briefly, recent reviews of the alcoholism treatment literature[29] suggest that no particular treatment approach has been found to be consistently superior to any other. Furthermore, it has been suggested that this lack of consistency may be largely the result of the differential impact of different treatment approaches on particular alcoholism subtypes, and that outcomes would improve if these subtypes were matched with appropriate treatments.

The importance of client–treatment matching in alcoholism treatment has been supported by both the literature on alcoholism typologies and the general psychotherapy literature. Review of the alcoholism literature, for example, indicates that a large proportion of alcoholics can be grouped into two major subtypes, the first characterized by an episodic style of drinking, high levels of social impairment, and greater antisocial and hostile tendencies, and the second by a more continuous drinking style, less social impairment, and possibly passive or unassertive tendencies.[16,30,31] Of particular interest to the current review, Jacob and Leonard[16] have found that these two types of alcoholics appear to establish very different marriages, one characterized by negativity and less effective problem-solving ("episodic drinkers") and the other by increased stability associated with periods of heavy drinking ("steady drinkers").

The general psychotherapy literature indicates that there are parallels to the two alcoholism subtypes among patients with nonalcoholic psychopathologies. For example, Beutler and his colleagues[32,34] have described sub-

groups of nonalcoholic patients who rely on "externalizing" vs "internalizing" coping styles, the former characterized by acting out, impulsivity, inability to delay gratification, and active resistance to external demands, and the latter by tendencies toward anxiety, passivity, and withdrawal in response to stress. Most importantly, Beutler and his colleagues have suggested that a behavioral approach is more effective for externalizing patients than a broader, family systems oriented approach, and that the opposite pattern is true for internalizers.[33,35] If applied to the previously described alcoholism subtypes, these conceptualizations and findings suggest several treatment dispositions. For example, episodic drinkers, whose drinking behavior disrupts family functioning, might benefit more from behavioral approaches that focus primarily on individual behavior change. On the other hand, steady drinkers may benefit more from therapy that addresses the stabilizing function of alcohol on family process, i.e, family systems or interactionally-oriented therapy. Research that directly and systematically explores these possibilities is needed.

Finally, most existing treatment programs and outcome studies focus on marital, rather than family treatment. The lack of research on family treatment seems to be primarily the result of the lack of manualized family treatment programs. Treatment manuals facilitate evaluation research by enabling researchers to specify the appropriate intervention for a particular treatment condition, to measure the expected effects of that intervention, and to provide a clearly delineated model that can be subjected to replication by independent investigators. Most relevant to this interest, Gonzalez et al.[36] have developed a treatment manual for their Multiple Family Discussion Group (MFDG), an intervention for families and patients experiencing a chronic, disabling medical illness. Based on a family systems perspective, MFDG was developed to address family issues that are generic to chronic medical illness, including the stressors associated with the illness, and the changes in family structure and process that occur as family members cope with the illness. This model is noteworthy in two respects. First, it provides a generic view of chronic illness in the family that could be applied to alcoholism as well as other disorders, and second, it provides an excellent example of a manualized family treatment program that is open to evaluation and replication. Future efforts should focus on developing similar manuals for other family approaches for the treatment of alcoholism.

In summary, the past two decades have witnessed increased attention to family factors related to the etiology and perpetuation of alcoholism, and

a rapid increase in family programming in alcoholism treatment settings.[17] Despite the relative lack of controlled treatment evaluation research, reviews of existing outcome studies show, rather consistently, a small but positive benefit of involving family members in alcoholism treatment.[17,37] Particularly encouraging, several research teams have recently initiated more programmatic efforts, which in time, should promote the development of accumulative findings and a better integration of clinical and empirical literatures. Hopefully, such efforts will strengthen the research base on which family treatment can be developed, and in so doing, provide greater insight into the family's role in understanding and treating alcoholism.

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