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A population description of married clients at Connaught Clinic who have completed the three-week phase of the program at Connaught Clinic and who are living with their spouses.

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A POPULATION DESCRIPTION OF MARRIED CLIENTS AT CONNAUGHT CLINIC WHO HAVE COMPLETED THE THREE-WEEK PHASE OF THE PROGRAM AT CONNAUGHT CLINIC AND WHO ARE LIVING WITH THEIR SPOUSES

by

John R. Shriver

A research project submitted to the School of Social Work of the University of Windsor in partial fulfillment for the degree of Master of Social Work

September, 1977

Windsor, ONTARIO, Canada

Research Committee

Professor Robert G. Chandler, Chairman

Professor Stan Monaghan, Member

Dr. Martin Morf, Member

ABSTRACT

There were four objectives of this research project. The first was to describe the population of married clients at Connaught Clinic who had completed the three-week phase of the program there and who were living with their spouses. The second was to compare the level of the communication between the clients and their spouses with the clients' drinking involvement over the three months preceding their filling out the questionnaire. The third was to compare the couples' marital communication with the drinking frequency of the clients' spouses. The fourth was to compare the spouses' drinking frequency with the clients' drinking involvement.

The sample consisted of 21 clients and their spouses. The 21 came from a list of 30 randomly selected clients and a second list of 30 replacements also randomly selected. All 60 persons were contacted or attempted to be contacted. Each person on both lists indicated at time of intake that he or she was living with a spouse. Each had completed the clinic's three-week program by April 15, 1977. The method of data collection was a questionnaire administered by the researcher. There were in the final sample 18 male and 3 female clients.

The data revealed a mean age for the clients of 42.7, and for the spouses a mean age of 41.7. The greatest number of clients and spouses were in the 35-44 age bracket.

A majority of clients, 52.3%, did not go beyond grade 10, and 71.4% of the spouses did not go beyond grade 10. However, 9,6% of the clients either attended some university or college or graduated from college. None of the spouses had done so.

In terms of occupation, none of the clients was unemployed, and the greatest percentage of them, 42.9%, held skilled jobs. Of the spouses, 4.8% were unemployed, and over half were housewives (11).

The mean for length of cohabitation was 19.1 years, with the greatest percentage in the 10-19 years bracket.

The greatest percentage of clients, 38.1%, stated that their problem drinking began before they were 20. Almost a majority, 47.6%, said their problem drinking began by the time they were 20.

Over half the clients, 52.4%, had been abstinent over the previous three months. When the respondents were divided between high and low drinking involvement, 66.7% had a low drinking involvement. Of the spouses, 61.9% claimed abstinence. When the spouses were divided between high and low drinking frequency, 76.2% had a low drinking frequency.

Clients, in regard to follw-up help, and spouses, in regard to help sought relative to the clients' drinking, both used almost exclusively agencies already recognized in the field of alcoholism treatment. Generally, the

researcher felt that the ongoing programs of A.A. and Alanon were under utilized.

The Marital Communication Inventory (MCI) was the instrument used to measure the levels of marital communication. As couples, clients and spouses had a mean score of 82.48. A perfect score was 138. Clients had a mean score of 84.67 and spouses 80.45. There was no significant difference between the mean scores for clients and spouses. The items of the MCI were divided among 15 categories. The couples showed their most problematic areas to be the use of destructive and damaging communication, the use of an irritating tone of voice, and lack of clarity of their messages. Their least problematic areas were that they had few complaints about being understood, that they felt engaged in the marital relationship, that they made frequent and deliberate attempts to converse, that they gave and received affection, that they felt free to pursue their own interests, and that they had little problem discussing family finances.

There was a significant relationship between the level of marital communication of the couples and client drinking involvement. Also, the spouses' overall scores on the MCI were significantly related to client drinking involvement. Significant relationships with drinking involvement were found, too, for couples' scores on Categories 1-9, couples' scores on Bienvenu's 19 items, client scores on

Categories 1-9, spouses' scores on Bienvenu's 19 items, and couples' scores on Categories 10-15.

In regard to the individual categories, in relation to client drinking involvement, couples' scores on Category 3 were significantly related. Scores on Categories 8 and 9 for couples, clients, and spouses were very significantly related to client drinking involvement.

Finally, scores for couples on Categories 14 and 15 were significantly related to drinking involvement.

No significant relationship was found between spouses' drinking frequency and level of marital communication, nor between drinking frequency of spouse and client drinking involvement.

The researcher recommended more emphasis in the program at Connaught Clinic be put on follow-up, particularly long-term follow-up. Along with this, he recommended enlistment of other agencies to work with treated alcoholics and their spouses besides the traditional alcoholism-oriented agencies.

Recommended also were research projects on alcoholics which would study other relationships as well as the marital relationship and other systems than the couple system. Strongly recommended was research in the area of alcoholism and marriage which would use one or more control groups to provide a means of comparing the communication between an alcoholic and spouse. Finally, a study was recommended that

would consider change both in drinking behaviour and in marital communication over time.

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CHAPTER I

Problem Identification

Rationale for the Study

The alcoholic who has undergone treatment faces many difficulties and obstacles in maintaining sobriety or in resisting returning to problem drinking. Partly, these difficulties are due to usually long-established habits of the alcoholic's using alcohol to cope with stress, partly to an addiction, be it physical or psychological, and partly to the fact that the alcoholic returns to a scarcely altered environment with stress, pressure, and other inducements to drink very similar to those he or she encountered before treatment. Thus, for many alcoholics, treatment amounts to no more than an interruption in their drinking and general living.

Some of the preceding paragraph is based on the belief that alcoholics learn to use alcohol in a destructive manner and are, therefore, able to unlearn this kind of usage or even the use of alcohol at all. By the same token, however, their learning not to use alcohol needs to be sufficiently reinforced to become stable. This reinforcement treatment programs are seldom designed to provide. Although there is a variety of programs in Canada and the United States, they are generally short-term relative to the long and ongoing process of recovery. It seems that only Alcoholics Anonymous (A.A.) both recognizes the necessity of long-term treatment and bases its program on this need.

In fact, "long-term" is an understatement because, in the view of A.A., treatment through attendance at A.A. meetings is intended to be life-long.

Alcoholics Anonymous, the largest and best known program for alcoholics, still resembles other programs in that their long-term treatment concentrates heavily on the alcoholic alone to change his or her way of thinking. Neither A.A. nor any other facility, to the knowledge of this writer, necessarily involves persons from the alcoholic's environment in the treatment of alcoholism. The other side of the coin is an organization like Alanon which offers support to relatives of alcoholics, but which excludes the alcoholic.

There are practical reasons for this separation of alcoholic and environment in terms of treatment. one is that alcoholics have often become estranged from family, friends, and job, if not from society as a whole, by the time they seek help. Another is that there is a widespread attitude that the alcoholic's problem drinking is strictly his or her problem, and, for this reason, persons in the alcoholic's life do not see any role for themselves in the treatment. A third reason, which is found in any problem of a social nature, is that, even if a person does see himself or herself as involved in the problem, there is a reluctance to admit this to others, a necessity in order to seek treatment from a third party. For Alanon, there is the discouraging fact that very few alcoholics are willing to seek help for themselves so that Alanon's efforts are directed mainly at helping relatives cope with an alcoholic family member or employee who probably will never stop drinking. Finally, there is the practical reason of expense. It seems less costly to treat an individual by himself than that person along with several others.

This is by no means meant to be an exhaustive list as there are other factors that block the involvement of significant persons in the treatment of the alcoholic.

Despite these and other practical obstacles, there is clearly a challenge to those interested in a fuller treatment of alcoholism to build bridges over the gap between the alcoholic and his or her environment. This would seem to be a job which social workers are well equipped to carry out, and this is the felt need of this writer. Specifically, this writer sees the alcoholic's family, when there is one, as the most important element in the environment, in particular the spouse. To this writer, involvement of the spouse on a regular basis in treatment is both practical and vital.

Since the Connaught Clinic, where the writer had his practicum during the year 1976-1977, holds the belief, also, that the influence of the spouse is great and that he or she probably could benefit from counselling on alcoholism, the writer felt the need to survey the population of married clients who had completed the three-week phase of the program at Connaught Clinic in order to describe this population in terms of their marital relationships. Also, since how well the alcoholic is recovering is of primary interest in connection with both treatment and the marital relationship, information on present drinking involvement was also needed. It was also a felt need to learn what kind of follow-up help was used by the client and what help was sought by the spouse relative to the client's drinking. For purposes of description it was felt necessary to find out certain demographic data about the client and spouse. Finally, the writer felt it necessary to compare the

quality of the marital relationship with drinking involvement.

To be a researchable problem, a felt need must, first, be part of a situation, rather than merely a feeling of the participants; second, it must involve an issue requiring a solution; third, more than one solution must be possible (Ripple, 1960, p. 33).

Because the Connaught Clinic does encourage a client's spouse to participate during intake and in the structured form of Significant Others meetings during the three-week phase, there is the situational significance of learning about the population of clients still living with spouses. Ideally, the survey would have included a before-treatment testing, and reasons for not doing this will be presented in Chapter III.

The second criterion for a researchable problem, the presence of an issue demanding solution, is met by the fact that, according to estimates at Connaught Clinic, over half of the clients who complete treatment relapse into problem drinking. Also, studies on the alcoholic and the family have indicated the family environment, especially the marital relationship, as a contributing factor to the relapse (McCord & McCord, 1960).

Finally, the third stipulation that there be more than one possible solution is met by there being no way to predict either the outcome of the survey nor whether or not there will be a significant association between the marital relationship and recovery.

In the process of problem identification, the following problems have emerged as researchable. First, what are the characteristics of the population of clients at Connaught Clinic who are living with their spouses? The characteristics of interest here are marital relationship, patterns of

communication, use of follow-up help by the client, use of help related to the client's drinking by the spouse, demographic data, and present drinking involvement of each spouse. The second problem is an investigation of the association between marital relationship and the client's present drinking behaviour. A third is the association between marital relationship and the drinking of the client's spouse. Finally, -- is there an association between the spouses drinking behaviour and the client's? Any other problems of association among the variables will be treated as secondary to the above.

The Setting

Since the sample of subjects for this study was drawn from a population of clients at Connaught Clinic, some description of the clinic's program is in order. Because the Connaught Clinic has been described in detail in two recent theses done for the School of Social Work at the University of Windsor (Smith, 1976; Palanek & Selby, 1976), comments here will be brief.

The program is made up of the three phases of intake, three-week intensive phase, and follow-up of five weeks. Usually, intake consists of at least two interviews, one of them including a significant other person. If, at the end of the intake phase, the client wishes to go on, he is almost always accepted into the three-week part of the program. No client, to the knowledge of this writer, has been accepted onto the three-week phase without having had any intake interviews. The client enters this second phase as a member of a group, around twelve persons, that meets at the clinic five days a week from 9:00 to 4:00 or 4:30 for three

weeks. This phase is made up basically of two parts, didactic and counselling. The latter is in the form of group and individual. The purpose of this phase of the program is to furnish clients with tools to use to learn to live, ideally, alcohol free. Certain rules exist which the clients must adhere to, e.g., no missed time and no alcohol, or they may be deselected, that is, removed from the present group. After the three-week phase comes a five-week follow-up program during which the group meets one evening a week. Often, individual or couple counselling is offered in addition. Once the five-week period (for a few months it was an eight-week period) has finished, the clinic's door is always open for a client to seek further individual counselling or even to re-enter the program. Through mailed questionnaires, the clinic tries to keep in touch with alumni (those who completed the intensive phase) for over a year.

In view of the very large practical obstacles to setting up programs for treating alcoholics that would also include significant others to any great extent in this treatment, the program at Connaught Clinic is oriented toward the alcoholic as the proper and the only necessary client. Nevertheless, the staff at the clinic urge at least one conjoint interview between a prespective client and his or her spouse during intake, but this has not been made a requirement for a person's entering the program. Also, there is a three-meeting Significant Others program conducted concurrently with the three-week phase of the clinet's treatment, but attendance here, likewise, is voluntary. Couple counselling is frequently offered as part of follow-up to the three-week phase, but the use of any follow-up help at all is strictly the decision of the client. Of course, as far as the

clinic staff is concerned, the use of any of the treatment process is entirely the client's decision, but de facto most of the client's energy is committed to the three-week intensive phase, and there is the sanction of deselection of the client by the staff if the client does not adhere to certain rules. No such sanction exists for follow-up, and client participation in this is consistently much lower. It is, then, entirely possible for a client to be seen apart from spouse or any other significant person from intake through completion of treatment. Nevertheless, many spouses and other significant persons do take advantage of the services offered at Connaught Clinic. As was said earlier, the clinic staff and this writer have felt the need to learn more about couples with an alcoholic member in order to work more effectively with clients and their spouses in this important aspect of treatment.

Summary

This chapter described the process of identifying the problems for research for this thesis in the area of marital relationships of alcoholics. Also, there was a brief description of the efforts of the staff at Connaught Clinic to involve the clients' spouses in the treatment program.

CHAPTER II

REVIEW OF LITERATURE

This chapter will deal with the theoretical basis of this study and with some of the previous research on married alcoholics and their spouses. This review is selective, concentrating on the influence of the spouse on treatment and is intended to be a point of reference for the thesis.

Systems Theory

In the opinion of this writer, there are two apparently radically different theoretical approaches to understanding and treating alcoholism. One shall be called individualistic and the other systems. The former is characterized by the belief that problem drinking, once it becomes problem drinking, belongs to the drinker exclusively. Problem drinking, in this view, is a disease (Jellinek, 1960) or is a behaviour the alcoholic has learned (Conger, 1956, pp. 296-305) or is a result of certain personality traits (Krimmel, 1971, pp. 55-60). In contrast, alcoholism in terms of systems theroy may not only be any or all of these things, but it is also a functional part of the social system of which the alcoholic is a member.

Although, as was said above, these approaches seem very different, they are not exclusive of each other. An alcoholic may be physically dependent on alcohol, i.e., be a person with a disease, and one who needs alcohol to cope with life, i.e., one who has learned certain behaviours,

and a person with an immature personality, and a person whose behaviour as an alcoholic is part and parcel of one or more social systems. These four aspects of alcoholism may be present together, but, it is contended here, very unlikely in every possible combination. Rather, this writer maintains, an alcoholic's drinking behaviour is always functional within a system, whereas addiction may or may not be present or there may or may not be significant use of alcohol for purposes of coping or the alcoholic's personality may or may not be significantly different from most other persons'. Thus, one of the differences between systems theory and individualistic theories is that even in the restricted sense of social systems, systems theory is always applicable. There seem to be, however, certain advantages that individualistic theories have when it comes down to devising programs of treatment, and these will be discussed below after describing in summary fashion what systems theory is.

Stated briefly, systems theory asserts that all objects belong to systems, and a system is defined as a set of objects having a relationship among themselves and among their attributes (Watzlawick et al., 1967, pp. 119-120). Thus, objects are the parts of the system, attributes are the properties of the objects, and the relationship is what gives them a togetherness with one another with the result that they act in certain ways as a whole. Although the universe is the ultimate system, and is, perhaps, the only objectively real system, the theory postulates that this universe can be analyzed into subsystems. It is at this point that differentiation between system and environment occurs, and at this point possibly the knottiest problem with this theory comes up. The problem is that the nature or even the existence of subsystems is the subjective

experience (or Gestalt) only of an observer. Thus, at the heart of the theory is a problem of validity inasmuch as by definition there is no objective observer, a person outside of systems. This problem has not been solved, but is dealt with by the observer's saying that he realizes that any set of objects chosen to be described as a system not only belong to other and larger systems, but that the observer acknowledges his own point of view.

With this arbitrariness recognized, the next aspect of the theory is that there are closed systems and open systems. Closed systems are relatively unaffected by an environment, or can be made to be virtually so. These systems are of no concern here because all living matter belongs to open systems which do exchange materials, energy, and information with their environoment (Watzlawick et al., 1965, p. 121). In a human system, human beings are the objects and their attributes are their communicational behaviours; thier relationship, in essence their system, is defined for purposes of study by the observer, who may also be a participant in the system (Watzlawick et al., 1967, pp. 119-120). In the case of this study, the writer as observer has chosen to define the relationship as that of spouses.

In this spouse or couple system, there are two objects, a man and a woman, who are related to each other as spouses, and whose attributes are their communication. They have many other attributes, but these do not enter as relevant to this system. As an interacting pair, these two persons are in a constant and ongoing process of defining the nature of their relationship, not what it is so much as how it is (Watzlawick et al., 1967, p. 121).

Perhaps what distinguishes systems theory from theories characterized above as individualistic, i.e., less systems-conscious, is the rejection of linear cause-effect relationships and the espousal of reciprocal relationship. In the linear cause-effect relationship, there is a logical beginning and necessary preceding links in the chain of events. For example, in the disease concept, a person has possibly inherited certain somatic traits or, through his or her imbibing of alcohol, has produced certain bodily changes with the result that the person becomes an alcoholic. In learning theory, there has been a series of stimulus-response-reinforcement and the effect is an alcoholic habit. This is not far from the systems approach except that it is too microscopic since it can concentrate on only one person at a time. In personality theory, the personality has not developed sufficiently toward maturity; some persons with immature personalities discover that alcohol helps temporarily to overcome the pain or awareness of these deficiencies, and the result is psychological dependence, or alcoholism.

Systems theory does not deny the validity of the above theories as accurately describing the process of becom ing an alcoholic and the condition of being an alcoholic. For by far the greater part, however, these theories concern themselves with what, in psychoanalytic terms, are primary gains, i.e., benefits which a person derives from some behaviour without regard to object-relationships, that is, the satisfaction of a physical need, the reduction of a drive, the filling of a psychological deficiency. In contrast to this, systems theory concentrates on the secondary gains, those benefits (in the mind of the participant or participants) regarding object-relationships. This is graphically

expressed in the concept of games in Transactional Analysis with the alternating and reciprocal roles of Persecutor, or Rescuer and Victim (Berne, 1972).

The properties of open systems dictate the giving up of the use of the cause-effect chain (Watzlawick et al., 1967, pp. 123-128). The properties are three in number. First is that of wholeness, which means that every part of a system is so related to every other part that a change in one part will cause a change in every other part and in the total system. These changes in turn effect changes once more in all parts. Closely related to wholeness is a second property, feedback, which refers to the ability of organisms to modify themselves based on information about their own functioning. Feedback is usually described as a loop in which a person acts, registers the effectiveness of the action, and then changes or does not change the next or future actions in accordance with the information about the previous action. In a system each object or person behaves in this manner with the result that one must look at cause and effect as circular instead of linear. To rephrase what was said above, in terms of wholeness and feedback, the behaviour of each person in an interactional system affects and is affected by the behaviour of every other person in the system, and, moreover, each person is affected by his or her own behaviour (Watzlawick et al., 1967, pp. 31-32).

The third property is that of equifinality. This term refers to the fact that results in a self-modifying system, i.e., one with feedback loops, are not dependent on an absolute or designated original state, but on the nature of the change process. In practical terms, this means

that a future state of a self-modifying organism can not be predicted from its present state because change to a future state depends on the feedback of information, the processing of which is outside of observation and is known only by the ensuing behaviour (Watzlawick, 1967, p. 128). For these reasons, in a systems approach, the focus is on the relationship of persons and their attributes rather than on specific effects.

The writer will now take up more specifically the concept of communication, since it is this aspect of systems theory that is most pertinent to this study. The definition of communication is that it is all behaviour, not only speech, that involves two or more persons (Watzlawick et al., 1967, p. 22). As such, there are several axioms about communication (Watzlawick et al., 1967, pp. 48-71). First, it is impossible not to communicate because one can not not behave. There is no opposite to behaving, at least for a living person. All behaviour in an interactional context has message value. Since a person can not not behave, a person can not not behave in an interactional context without communicating. The corollary to this is that, unless for some reason a person is unaware at all levels of the behaviour of the other, one can not not respond. There is no concern here, theoretically, whether a message received is the same one sent. This is the concern, though, of therapy. A single message, then, is a unit of communication. An interaction is a series of units, and a pattern of interaction is a series that is repeated with little variation.

The use of the word "series" might seem to imply a linear progression, but this is true only when the series is punctuated. This leads to the second axiom, which states that participants in an interaction, or an

observer, punctuate an interaction in order to organize the behaviour. This term is used very much as it is in grammar where punctuation indicates an end or pause of one thought and the beginning of a new or additional thought. Systems theory denies the validity of this regarding behaviour, but recognizes that, pragmatically, it is done almost all the time. When a participant punctuates the interaction, he or she means that one behaviour marks the end and another the beginning of a series. For example, a problem drinker and his spouse have a pattern of his getting drunk. This means that, to the drinker, the spouse's becoming angry "causes" him to drink and get drunk. The spouse probably places the pause after her anger so that, to her, the drinker's getting drunk "causes" her anger. As Watzlawick and his colleagues point out (Walzlawick et al., 1967, p. 56), this kind of disagreement over punctuation is the basis of most relationship struggles, and usually leads to charges of "badness" (the irritable spouse) and "madness" (the alcoholic husband).

The third axiom says that there are relationship and content levels of communication. Content refers to the information contained in the message. This is also called the report or factual aspect. The relationship level refers to the manner in which information is conveyed. There can be a discrepancy between the content and relationship levels, and this is explained in the fourth axiom that communication is both digital and analogic at the same time. Our digital communication is the verbal, which is highly complex and syntactically logical. However, we lack adequate words to communicate about relationships. This is done by analogic communication, which is all our nonverbal communication

including the context of digital and analogic communication. The analogic has the semantics of relationship, but the semantics are ambiguous and lack syntax. Digital language, the content of a message, can be and often is contradicted by analogic language. The statement, "I love you," does not communicate love, but is a factual message that the speaker claims something about himself relative to the other. "Love," or the relationship statement, is communicated analogically by the tone of voice, body movement, etc. If the two messages are not congruent, the other participant will likely conclude that the first speaker is saying one thing but means another.

The fifth and final axiom states that interaction is either symmetrical or complementary. Stated another way, relationships are based on equality or difference. "Equality" means that partners tend to mirror each other's behaviour, hence the term "symmetrical." "Difference" means that one partner's behaviour differs from the other's in an opposite fashion so that one behaviour could not easily exist without the other one. Each acts in such a way as to presuppose and to give a rationale for the behaviour of the other. To take the above mentioned example of the alcoholic and his wife, the relationship is complementary if her aggressive anger is met by a passive withdrawal into drunkenness or vice versa. They are relating in a symmetrical manner if both withdraw from each other or if both become aggressively angry. In communication theory neither kind of relationship is considered superior, but a great predominance of one over the other indicates a pathological relationship.

To conclude this section on systems theory, the writer emphasizes again that the nature of the relationship between the couple in the system

is the subject of this study, especially their patterns of interaction. Although at least one symptomatic behaviour, problem drinking, has been and still may be present in their relationship, the point of view here will be to regard it as simultaneously input and output of the system. It was said earlier that systems theory seems to be at a disadvantage to other theories concerning alcoholism when it comes to the pragmatic need of treatment. This disadvantage seems to lie in the lack of a definite starting point or etiological factors the manipulation of which ought to change drinking behaviour for the better. However, in systems theory, intervention at any point or part of the system will affect the whole system, including the drinking behaviour. Yet, this seems inefficient with a problem like alcoholism because alcoholism is not only symptomatic within an interpersonal system, but it is pathological within the person's psychobiological system as well. Thus, intervention must be applied directly to the alcoholic. Therefore, change in programs directed toward the alcoholic is not of concern here. Rather, the primary concern is for continuing recovery after treatment when the alcoholic has fully returned to old interpersonal systems, specifically the powerfully influential couple system. A better understanding of this may pragmatically lead to a broadening of treatment after the time-limited treatment of the alcoholic.

Research on the Alcoholic and Spouse

Since the early 1950's there has been a movement among researchers on alcoholism and clinicians to view alcoholism in a wider context than that of the person alone who, being an alcoholic, is designated as the

true patient. Some writers have sought to understand alcoholism as a function of family dynamics, whether the family be the family of origin or of procreation. As this writer sees this movement, it began as a counterpoint to the disease concept best represented by Jellinek's writing (Jellinek, 1960), and has sought etiological factors and factors supporting alcoholic behaviour in the spouse of the alcoholic. That is, if the alcoholic's spouse, almost always the wife in these writings, did not provoke an already vulnerable man into being an alcoholic, she did support his continuing to be a problem drinker for her own unconscious needs (Whalen, 1953, pp. 632-641; Futterman, 1953, pp. 37-41. See also Edwards et al., 1971, pp. 113-117). Implied and recommended here was that the wife must also be involved in treatment for herself in order to increase the chances of a favourable outcome for the alcoholic.

The approach represented by Whalen and Futterman is called a counterpoint to Jellinek's disease concept, which generally accepts the alcoholic as the real patient, because the attention given to the wife is still with the main goal of helping the alcoholic. In this way, the alcoholic is still the genuine patient, and the marital partner, although she may have severe psychological problems of her own, has significance only as an alleviator or abettor of the alcoholic's problem.

In sharp contrast to the writings of Whalen and Futterman is the work by Jackson and Kogan, often in collaboration. They, feeling that the wife, through her mental disturbance, was being made responsible for her husband's alcoholism, devoted several studies to the wife of the alcoholic. Their basic hypothesis was that being married to an alcoholic contributes largely to the wife's disturbance, and it is not her disturbance

that brings on her husband's alcoholism. Jackson's earlier studies (Jackson, 1956; Jackson, 1959, pp. 403-406; Jackson, 1962, pp. 472-492. See also Edwards et al., 1971, pp. 117-121) demonstrated a pattern of family dynamics which progressively removed or diminished the role in the family of the alcoholic husband. Jackson interpreted this exclusion as the way the rest of the family, usually under the wife's leadership, coped with the cumulative stress caused by an alcoholic husband and father. This pattern was re-examined by Lemert and found to be accurate (Lemert, 1960, pp. 590-610).

Jackson and Kogan then studied the wives of alcoholics under different conditions, viz., when the husband is a recovering alcoholic, when he is an active alcoholic, and when, as active, he is drunk or sober. They also compared these wives to wives of nonalcoholics. In comparing two groups of wives of alcoholics, one group married to abstinent alcoholics, one to drinking alcoholics, they found significantly more anxiety and generalized personality distress in the latter group (Kogan et al., 1963, pp. 227-238). These results tended to show that alcoholic drinking is an independent variable of which the wife's disturbance is a function. When they compared wives of nonalcoholics with wives of alcoholics, they found (Kogan & Jackson, 1963, pp. 627-640), in terms of role expectations, that there was no significant difference between the two groups regarding general concepts of how a husband or wife ought to be. However, there was significant difference in self-perception, with wives of alcoholics' seeing themselves as more submissive and conforming to stereotyped femininity. They also differed in that these wives viewed their alcoholic husbands more unfavourably whether drunk or sober. Although

they had a more favourable opinion of him when sober, this opinion was still significantly lower than that of wives of nonalcoholic husbands. Again, these results support the hypothesis that the wife of an alcoholic is probably not bringing any more personality disturbance into a marriage than any other wife, but after being married to and living with an alcoholic, she reacts to a disappointing marital situation. There is also the suggestion that her comparitively narrow view of herself as a woman might deepen the disappointment.

Picking up the wife's atypical perceptions of herself and her husband, Kogan and Jackson did further testing and found again no significant change in unfavourable perceptions of the alcoholic husband, be he drunk or sober. They also found that the wife's self-perceptions did not fluctuate according to the husband's drinking or abstinence (Kogan & Jackson, 1964, pp. 555-557). They suggest that these unfavourable perceptions of the husband go beyond his drinking and are related to a generally uncomfortable and unrewarding marital situation. The husband's drinking, they say, worsens the situation, but his stopping does not eliminate the marital problems.

Finally, Kogan and Jackson compared the rate of personality disturbance among wives of alcoholics in remission with wives of active alcoholics and with wives of nonalcoholics (Kogan & Jackson, 1965, pp. 486-495). They hypothesized that the first group would occupy a mid-region between the wives of nonalcoholics as the least disturbed and wives of active alcoholics as the most disturbed. Their hypothesis was confirmed, with the wives of abstinent alcoholics consistently scoring in the middle between the other two groups. Statistically, these wives could not be

distinguished from either of the other two, but wives of drinking alcoholics were significantly more disturbed than wives of nonalcoholics. Kogan and Jackson interpret these results as demonstrating that the wife's disturbance is largely a response to stress due to her marriage to an alcoholic, especially one still drinking. Connecting these results with previous ones, Kogan and Jackson conclude that the wife's personality is far more a dependent variable which responds to the independent variable of the husband's alcoholism, especially active alcoholism. Kogan's and Jackson's work tends to confirm the implication in Jellinek's disease concept that the alcoholic is the true and genuine patient and that any associated problems at home or elsewhere will tend to diminish with his recovery from alcoholism.

A pair of articles by Margaret B. Bailey also tend to confirm Jackson's and Kogan's hypothesis that the mental disturbance of the wife is a result of her husband's alcoholism (Bailey et al., 1962, pp. 610-623; Bailey, 1967, pp. 134-142). She found that the alcoholics most likely to recover were members of couples who had the least amount of stress beyond drinking, specifically, from job insecurity, the police, and infidelity. She also concluded that most women's emotional health improved along with their husbands' overcoming alcoholism.

Along these same lines, Haberman found that symptoms of disturbance in the wife increased when the husband was drinking compared to when he was sober. However, the wives who were less disturbed improved more quickly during the husband's sobriety (Haberman, 1964, pp. 320-232).

The very important longitudinal study done by McCord and McCord on lower class boys in the Boston area deserves mention although it does not

very much concern married alcoholics and their spouses, because it does make interesting suggestions about their marital relationship. The McCords began their work with the goal of gaining a better understanding of juvenile and adult criminality in reltion to the boys' families of origin. They got inconclusive results here, but found much valuable information on the possible connection between the boys' relationships with their parents, their self-concepts, and their developing or not developing alcoholic drinking behaviour (McCord & McCord, 1959; McCord & McCord, 1962, pp. 413-430). The authors found that a significantly greater percentage of boys who became alcoholics rejected their mothers than did boys who did not become alcoholics. Moreover, this rejection seemed independent of the mother's attitude toward the boy. The pre-alcoholic boys also showed a lack of affection toward their siblings. These attitudes, the McCords say, seem to anticipate those found in adult alcoholics toward their wives and children. They describe these attitudes as a denial of dependency, which is a profound conflict within boy and man since the dependency needs persist. The McCords do not speculate as to why these children deny their need to be dependent. Their investigation does, this writer believes, coincide well with Kogan's and Jackson's conclusions that the causes for a man's becoming an alcoholic precede his marriage, even if he manifests alcoholism long after marriage.

Another study, done by Wadsworth, Wilson, and Barker compared alcoholic husbands, who were receiving treatment, with their wives in terms of rating factors which contribute to marital happiness or unhappiness (Wadsworth et al., 1975, pp. 634-644). They found a very

high agreement between spouses in regard to the relative importance of items in both categories. Also, they discovered that, in the minds of each spouse, the mere absence of problem drinking does not contribute much to marital happiness, but its presence was rated as the major cause of unhappiness by both spouses. Thus, they conclude, the absence of drinking does not necessarily decrease other important areas of unhappiness. This study, also, like those of the McCords and Kogan and Jackson, seems to demonstrate that the alcoholic husband's recovery is very little dependent on his wife's changing her behaviour.

To summarize so far, Whalen's and Futterman's belief that the wife's attitudes and behaviour are crucial in her husband's persistance in or recovery from alcoholism is almost completely repudiated by the other works cited. In these latter, the alcoholic spouse is the main reason for marital stress and unhappiness, but even his recovery is no indicator of happiness in the marriage. Strongly implied here is that the wife may need treatment for her own mental disturbance, but, since much of this disturbance is a result of being married to an alcoholic, change in her will have little positive effect on the husband's drinking. These writers seem to deny a reciprocity between the husband's drinking and his relationship with his wife. That is, pathology spreads from alcoholic drinking to other areas, but the reverse, at least as far as the marital relationship is concerned, is insignificant. In addition, even when problem drinking disappears, or is substantially reduced, the other problems in the marriage will very probably continue. Therefore, in terms of treatment of alcoholism, involvement of the wife is irrelevant.

As a final comment before moving on, this writer would like to point

out that the dispute described on the preceding pages over who contributes more to marital distress is a fine example of a dispute over punctuation, not by those usually considered to be participants in the system, but by observers.

From the late 1960's on, several articles have appeared which seem to question some of the conclusions reached above, and seem to ask instead whether in fact the alcoholic's spouse does influence the course of treatment, and, if so, what are the significant factors about her, her alcoholic husband, and their relationship that influence outcome of treatment. These studies mark a more consistent use of systems theory.

Therapy for alcoholism that involves the whole family seems to have started in Europe a little earlier than it did in North America, or at least publication on this subject began sooner. P. H. Esser in the Netherlands was advocating family therapy for alcoholism as early as 1968 (Esser, 1968, pp. 177-182). He agrees with Kogan and Jackson that the whole family is under stress due to an alcoholic member, but he says that looking only to the alcoholic and treating him are not sufficient. The whole family is disturbed and needs to work to restore open communications and resolve role confusion. In a second article in which Esser calls family therapy a new approach in alcoholism treatment, he asserts that abstinence is only a negative benefit of treatment, and, as in his previous article, emphasizes recovery of the family as crucial for a positive recovery of the alcoholic (Esser, 1970, pp. 275-286). Of ten goals he calls important for this positive recovery, seven concern the alcoholic and his family directly. These seven goals overlap a great deal and can be concisely summarized as saying that behaviour of family

members is reciprocal so that not only does the alcoholic introduce stress into the family, but also that the alcoholic reacts to family stress. The contribution of the alcoholic to family pathology, he says, is usually clear and understood, but the effect of other members on each other and the alcoholic is often less easy for the family to accept. This they have to do, Esser says, if they want to recover fully themselves and if the alcoholic is to continue recovering.

In Britain, Burton and Kaplan studied a sample of treated alcoholics and their wives to see if the marital relationship was related to the alcoholic's recovery (Burton & Kaplan, 1968, pp. 111-170). They point out that the usual assumption in treatment of alcoholism is that there is a temporal sequence requiring that a change take place in drinking behaviour first before there be any change in any other area. They theorize that for married alcoholics the temporal sequence is irrelevant in that alcoholism and family pathology are mutually reinforcing. Therefore, successful marital counselling ought to have a positive effect on drinking behaviour. They found no significant relationship between a lessening of family pathology, defined by areas of considerable disagreement, and change in drinking. They did find, however, that there was a significantly greater probability that drinking behaviour would improve if the areas of disagreement were few to begin with. Thus, from their sample, a minimum amount of strength in the marital relationship seemed necessary for the spouse to achieve and maintain a positive outcome.

B. J. Clifford, also in Britain, surveyed the wives of rehabilitated alcoholics to determine if therewere identifiable differences between wives of alcoholics who resisted alcohol and wives of persistent alcoholics (Clifford, 1960, pp. 457-460). Clifford found that they differed greatly

in all areas observed. Wives of recovering alcoholics were very concerned about the effect of the husband's drinking on their family; the other wives were indifferent. Wives of the rehabilitated accepted some responsibility, usually in the form of specific acts, for their husband's drinking; the other wives felt none. The former group also sought ways to cure their husband's drinking, including psychiatric help for themselves; the latter group was consistently cynical and sceptical about any chance of cure. The wives of recovering alcoholics, although they felt inadequate to handle the stress at first, gained a sense of adequacy, while the other group was not aware of any inadequacy at all. The former group felt keenly the loss of social status; the latter did not. The former were aware of their husband's dependency upon them; the latter denied any such thing. Clifford does paint a picture of dramatic difference in attitude and action between these two groups of wives, and, since the groups were closely matched, the implication that the wife can influence the outcome of treatment is persuasive. Clifford's study also seems to corroborate Burton's and Kaplan's in that both say that a marital relationship that has some strength to it to begin with is conducive for the alcoholic's recovery.

C. G. Smith, in a study of the effectiveness of a program for wives of alcoholics being treated at the Royal Edinburgh Hospital, hypothesized that patients whose wives attended the program would do better in treatment than those patients whose wives did not attend (Smith, 1969, pp. 1039-1042). Smith assumed that the program could contribute to the wife's being a positive influence. With the two groups of attenders and non-attenders, self-selected and not differing in regard to length of marriage, age of

husband, number of children, attempted suicide, extramarital affairs or social class, he found that at six months after treatment, eleven of the fifteen husbands of attenders were abstinent and only one of the eight husbands of non-attenders. At sixteen months, he tested three variables of social stability, treatment outcome, and the wife's attendance. The results were that social stability and attendance were significantly related to outcome, but that stability and attendance were not related to each other. He concluded by saying that a wife's attendance in the program was a favourable prognostic sign. This did not mean that the program itself was an independent variable. Since attendance was voluntary, attendance was possibly an indicator of caring and responsibility on the part of the wife, which qualities might be the influential ones rather than what she may have got out of the program.

In an article on family therapy with families of recovering alcoholics, Meeks and Kelly state that, with alcoholism as with any problem affecting a family, treatment loses effectiveness if the sick family member is treated in isolation from the rest of the family (Meeks & Kelly, 1970, pp. 399-413). For them, the alcoholic and his family form a unit, the members of which affect each other mutually. They understand any resistance to the alcoholic's recovery as resistance of the family unit to disturbance of their present equilibrium. This is much like what Jackson said about a family's gradual exclusion of the alcoholic and its establishing thereby a balance not so dependent on the alcoholic. Meeks and Kelly say that this new equilibrium is still, though perhaps subtly so, dependent on the alcoholic's continuing in his new role. In this way, Meeks and Kelly do not emphasize the drinking behaviour as much as they do the continuing

threat to family equilibrium both by the drinking and therapeutic intervention. They found that with a very small sample of five families, with whom they met weekly for a year, all families showed improvement in relating, communicating, and supporting one another. Of the five alcoholics, two remained abstinent and the three others did not have any serious relapses. Thus, for this group, regular family therapy for a year was effective, but since there was no control group and the sample was so small, these results are not generalizable.

A much more disciplined approach was taken by J. B. Rae in a study on the influence of wives on treatment outcome of alcoholic patients being treated at the same hospital (Rae, 1972, pp. 601-612). The final sample of fifty-eight couples was divided into four categories according to the post-treatment drinking behaviour of the husband. over a two year period. The categories are: abstinent for two years, abstinent for eighteen months of the two years, never abstinent, but improved, and no improvement. The first two categories were classified as treatment successes, the latter two as treatment railures. Moreover, both spouses completed the card form of the MMPI soon after the husband had entered the hospital. These profiles were dichotomized as being psychopathic deviates (Pd) or not (NPd). The couples in the sample included all four possible pairings: Pd/Pd, Pd/NPd, NPd/Pd, and NPd/NPd. At the time of the study, two years after treatment began, forty-nine marriages were still intact, nine were not. Of men considered successfully treated, a total of thirty-five, thirty-one were still with their wives. Of the twenty-three whose treatment was not successful, eighteen were still living with their wives. The difference between the two groups of men

was not significant in regard to the couple's staying together and success in treatment. Thus, simply staying together is not related to treatment outcome. Rae found it very difficult to isolate the variable of personality profile, but found that it did matter significantly when there were problems of social instability, usually related to employment, and sexual disturbance between the spouses. Couples with a NPd wife handled and coped with these problems better, Rae suggested, so that he found that a decline in social instability was positively related to successful treatment outcome.

D. A. Cadogan conducted a study similar to those of Esser and Meeks and Kelly (Cadogan, 1973, pp. 1187-1194). Like those researchers, he contends that in treating alcoholics treatment is less effective if significant family members are not involved, since, he found, marital conflict and active alcoholism are positively associated. He recommends that marital therapy, here as with any troubled family, concentrate on clarifying communication, understanding family equilibrium, uncovering dormant conflicts, and correcting pathological family interaction. Cadogan found that therapy of this sort effectively influenced the development of abstinence. He cites the first three months after specialized treatment for alcoholism as most crucial for solidifying the goal of abstinence and the development of rational methods of problem solving to replace drinking. He maintains that the former depends largely on the latter and that the latter is fostered and supported by the family. Cadogan capsulizes the problem as a self-defeating process, especially between the spouses, of the family's fearing to depend on the alcoholic and the alcoholic's withdrawing in fear of being depended upon.

This is a self-defeating pattern if the couple or family want to change or feel the need to change. Change, in Cadogan's opinion depends on recognition on the part of all parties of the nature of the family relationship.

Two recent studies conducted in Britain under the direction of Jim Orford will conclude this section on previous research. The first study considers the association between coping behaviour of wives of alcoholics and drinking outcome (Orford et al., 1974, pp. 1254-1267. See also James & Goldman, 1971, pp. 373-381). The purpose of this study was the identification of coping behaviours which contribute either to good or to poor recovery of the alcoholic. Orford found that coping through avoidance of the problem, sexual or fearful withdrawal or the taking of special action to prevent drinking, such as pouring the liquor down the drain, were all associated with poor outcome. In fact, the only association of coping with favourable outcome they found was the wife's doing any or all of the above as little as possible. The researchers were dissatisfied with this project as being very helpful and recommended a study to examine the family as a system instead of trying to isolate the behaviour of one member, as they did with the wife.

In their second study, Orford and his colleagues attempted such a study (Orford et al., 1976, pp. 318-339). Their purpose was to determine the degree of association between aspects of the marital relationship of male alcoholics at time of treatment and the subsequent outcomes of their drinking problems. A subpurpose was to identify one or more factors that are to a high degree predictive of outcome. This study considered change or no change in drinking behaviour, but did not consider change in the

marital relationship. They found that poor prognosis was significantly related to the following factors: 1) the wife's reporting that little affection was given or received; 2) the husband's expecting his wife to use few favourable adjectives to describe him when he is sober; 3) The wife's using few favourable adjectives to describe her husband when he is sober; 4) the husband's reporting little participation in family life compared to his ideal; 5) the wife's agreement with the husband's report of little participation; 6) the wife's thinking that the husband would use many hostile-dominant adjectives about her; 7) both being pessimistic about the future of their marriage. Prediction of favourable outcome is made on the absence or low amount of presence of these seven factors. The researchers concluded saying that patient-focused and symptom-focused treatment is unlikely to be sufficient for achieving and maintaining a favourable outcome to the alcoholic's drinking problem unless marital cohesion is already high. If it is not, then helping a couple build cohesion is a possible and, perhaps, a necessary goal in the treatment of alcoholism.

As an additional note, an experimental study done by Stephen L. Gorad on the communicational styles of alcoholics and their wives (Gorad, 1971, pp. 475-489) showed that 1) the alcoholic's communication was characterized by responsibility avoidance, 2) the wife's by responsibility acceptance, and 3) their interaction is marked by an inability to function as a unit for mutual benefit. This study was based on communication systems theory. This kind of communication is also that described by Claude Steiner who defines the alcoholic's style as consistent nonverbal contradiction of verbal statements. In particular, the alcoholic praises another person

in comparison to himself on the report level, but takes away the praise on the relationship level so that in effect he says that neither he nor the other person is any good.

To summarize this part, the review of research on the alcoholic and his or her spouse began with some writers' identifying the nonalcoholic spouse, almost always the wife, as a major cause of the alcoholic's problem drinking. This was followed by studies that emphasized the marital stress caused by the problem drinking to which the nonalcoholic spouse reacted by becoming mentally disturbed. Finally, some researchers have been approaching the marital couple as a system. Rather than calling one spouse the abettor of the other's drinking or the perpetrator of frequently unbearable marital stress, these writers have attempted to identify interactional factors especially related to alcoholic drinking.

Summary

This chapter has presented a review of the literature on systems theory, concentrating on communication theory as a species of systems theory, and selected research on the married alcoholic and spouse. The review of systems theory was intended to provide the orientation of the thesis, and the review of previous research was directly related to the research question and hypotheses of this thesis.

CHAPTER III

RESEARCH DESIGN

Basic Questions

In the process of problem formulation, the basic question that has emerged is: How does the nature of the marital relationship between alcoholic and spouse influence the alcoholic's recovery after treatment for alcoholism? This basic question on the nature of the relationship and recovery has been focused by concentration on patterns of communication between the partners and drinking behaviour, the pattern over the three-month period preceding the administration of the instrument. The reader is referred to the section on methodology in this chapter for explanation of these two aspects of the basic question.

In order to answer this question, the researcher had first to gather descriptive information on both patterns of communication and on current drinking behaviour. Since both the researcher and the Connaught Clinic, whose population of married clients was studied, felt the need to have an organized body of information on this population, it was decided to describe the population in terms of the marital relationship, as it is revealed in patterns of communication. As a treatment facility, the clinic also felt the need to know the current state of the client's drinking involvement with the result that this, too, was included as part of the description. Besides these two areas, other kinds of information were desired as well, specifically, demographic data, sources of follow-up help

used by the client, and sources of help sought by the spouse related to the client's drinking. As an addition to these, the researcher felt the need to learn about the frequency of drinking done by the client's spouse.

This information has been gathered both to describe the population of married clients and for purposes of testing hypotheses about the correlation of marital relationship with recovery from alcoholism. The hypothesis-testing part of the study is based on systems theory, of which communication theory is a part, and on reports of previous research. Systems theory, to review it briefly, states that when a set of objects are related to one another in any way they form a system which is capable of acting and being acted upon as a whole. For this reason, a change in one part results in change in all parts. In a human system, such as a marital pair, behaviour of one affects the other, and their behaviour is always reciprocal. Until recently, researchers on alcoholism had, at least for purposes of research, regarded behaviour as unilateral within the husband-wife dyad. Either the nonalcoholic spouse encouraged or caused the alcoholic to drink excessively due to the nonalcoholic's allegedly unconscious need to have a debilitated spouse or it was the alcoholic who introduced the main stress within the system. Currently, the attitude of some researchers is more in accordance with communication-systems theory in that both partners are regarded as participants in a system functioning in a way that is probably dissatisfying to both. In the systems approach, alcoholism is the symptomatic behaviour that is usually most obvious, but it is not the only one.

In systems theory, any system less than the universe is part of a larger system and stands in certain relationships to other systems. Here,

the couple system of the marital dyad has been selected, but it must be kept in mind that there are other systems of which each or both partners are members. The alcoholic is not an alcoholic only in relation to the spouse. However, this researcher assumes that this system is the most intimate system and one of the most influential systems so that a study of it relative to alcoholic behaviour will produce important information on alcoholism. This is also supported by the literature as well as being predicted by the theory. As a final word on the systems approach, the researcher wishes to point out that there is no rejection expressed here of other theories on alcoholism, either regarding etiology or treatment. The alcoholic, as an organism, is a system. Since this is so, it is both theoretically and practically necessary to treat alcoholism as a disorder of the human being's psychobiological system. In this paper, though, it is the social system of the marital pair that is being investigated.

Research Question and Hypotheses

From the problem formulation process, systems theory, and the literature, one research question and three hypotheses have been formulated.

Research Question

What are the characteristics of the population of clients at Connaught Clinic who are living with their spouses? The characteristics of interest here are the following ones.

1. Overall level of communication between the spouses.
2. Patterns of communication between the spouses.

3. Demographic data.
   a. Age of each partner.
   b. Length of time of cohabitation.
   c. Age at which drinking became a problem for the client.
   d. Education of each partner.
   e. Occupation of each partner.
4. Drinking involvement of client over previous three months.
5. Drinking frequency of client's spouse.
6. Follow-up help used by client.
7. Help sought by client's spouse related to client's drinking problem.

There are a number of concepts above that need to be defined.

"Client" is defined for purposes of this study as anyone who has completed the three-week phase of the program at Connaught Clinic through April, 1977. Although the clinic regards this as only one phase in the treatment, it is the only part attendance at which is supported by sanctions at the clinic or from outside agencies such as the courts. Accordingly, it is regarded by clients as the main and most significant treatment.

"Spouse" refers to a person of the opposite sex with whom the client is living as a marital partner. They may be legally married or living commonlaw.

Formally defined, "communication" means all behaviour that takes place between two or more persons (Watzlawick et al., 1967, p. 48). Operationally, it means here those behaviours mentioned in the Marital Communication Inventory (MCI).[1] For a discussion of the MCI and those behaviours, the

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1. The MCI, copywrited by Millard Bienvenu, 1968, is used by permission of: Family Life Publications, Inc., 219 Henderson Street, P.O. Box 427, Saluda, North Carolina 28773

reader is referred to the section on methodology in this chapter. The "level of communication" is defined in that same section.

"Pattern" is defined formally as a series of messages between two persons which is repeated. Operationally, it refers to the categories into which the items on the MCI are grouped. For a discussion of these categories, the reader is again referred to the section on methodology in this chapter.

"Follow-up help," for purposes of this study refers to any sources used by the client after the three-week phase.

"Help related to the client's drinking problem" refers to any sources which the spouse may have sought out.

"Drinking involvement" is defined operationally as being "abstinent," "normal," "controlled" or "uncontrolled." For further discussion of this concept, the reader is referred to the section on methodology in this chapter.

"Drinking frequency" means here "abstinent," i.e. no alcohol at all "seldom," i.e., once a month or less, "occasional," i.e., two or three times a month, "weekly," i.e., once or twice a week, or "daily," i.e., practically every day. More is said about this in the section on methodology.

Hypothesis One

Those couples that have a low degree of drinking involvement by the client over the preceding three months have a higher level of communication than those couples in which the client has a high degree of drinking involvement.

This is the major hypothesis that seeks to define the association

between the couple's communication and the client's drinking. Drinking is assumed to be a destructive form of communication that, according to the theory, will be accompanied by other destructive forms. It is not the researcher's intention to punctuate the communication so as to say drinking brings on other forms of poor communication or vice versa. The hypothesis predicts merely that, for a couple with an alcoholic member, the better the communication, the lower the alcoholic's drinking involvement. This hypothesis is also suggested in the literature.

Hypothesis Two

Those couples that have a lower frequency of drinking by the spouse have a higher level of communication than couples with a spouse who has a higher frequency.

The rationale for this hypothesis is that the recovering alcoholic often declares that seeing others drink stirs up the desire to do the same. This researcher assumes that, for this reason, drinking by the clinet's spouse is destructive communication, which is predicted to be accompanied by other forms of poor communication.

Hypothesis Three

More spouses who have a high drinking frequency have marital partners who have a high drinking involvement, than do those spouses who have a low drinking frequency.

Since these behaviours have already been called poor forms of communication, the prediction here is that in this regard couples will have a symmetrical relationship.

Methodology

The means of gathering information to answer the research question and to test the hypotheses was a questionnaire made up of four parts, administered to each couple of the sample by the researcher. Since there was a difference between the partners regarding sex and treatment for alcoholism, there were some differences between the questionnaires given to each. Each member filled out the same Part I, which is Bienvenu's MCI. For ease of using personal pronouns and of referring to the respondent's partner, there was one form for a woman and one for a man. The items, though, are otherwise identical. Likewise, Part II on demographic features was identical for both except that the client was asked, in addition, at what age problem drinking began.

Part III for the client concerned drinking involvement. Part IV for the client concerned use of follow-up help. Part III for the spouse was on drinking frequency, and Part IV asked about help sought by the spouse related to the client's drinking.

Marital Communication Inventory

This 46-item questionnaire (See Appendix A) was developed by Millard Bienvenu (Bienvenu, 1969; Bienvenu, 1970, pp. 26-31) and was copyrighted in 1968. It has been used here by permission of Family Life Publications, Inc. The inventory is intended to test for patterns of communication between a marital couple. Bienvenu has, in the opinion of this researcher, adequately established the validity of the MCI, having used it with close to a thousand couples (Bienvenu, 1969). He found that of the forty-six items, forty-five discriminated between the top and bottom quartiles at the .01 level of confidence, using the chi-square test. The remaining item

discriminated at the .05 level. Because he got similar results from several different samples, the reliability of the test seems confirmed. Among the forty-five items at the .01 level or better are nineteen items which discriminated powerfully between the uppermost and lowest quartiles at the .001 level (Bienvenu, 1970, pp. 28-29). These items are, in order of discriminating power, though all at the .001 level, numbers 5, 4, 20, 29, 19, 11, 44, 27, 33, 8, 23, 9, 22, 45, 21, 31, 30, 24, and 46.

All of the forty-six questions can be grouped into categories. Of the fifteen categories used here, only the first nine have items specifically assigned to them by Bienvenu (Bienvenu, 1970, pp. 28-29), and those items are only the nineteen items discriminating at the .001 level of confidence. Therefore, the placement of the other twenty-seven questions throughout the fifteen categories has been done by the researcher (See Appendix B for a register of the categories). The descriptive terms of all the categories are Bienvenu's.

Taking the categories one-by-one, the first one refers to the use of destructive and damaging communication. This comprises items 5, 9, 29, and 7 (See Appendix A for the wording of the items). It is assumed that answers to these questions will reveal whether there is a pattern of destructive and damaging communication. Bienvenu reasons that good communication is selective in the sense that some feelings and attitudes ought not to be verbalized, or if verbalized, done so in a way that does not harm communication. In this way, insulting and nagging are not good avenues to two-way communication. There is support in the literature that this would be an important pattern of communication to test for. Udry says that sheer volume of communication is not crucial to a good

relationship, but that selective communication probably is (Udry, 1966, pp. 279-280). He goes on to assert that some thoughts, desires, and attitudes do become destructive when communicated, especially when they are about things that can not be changed. There is need, then, for a fruitful control and direction of communication. Blood also points out the destructiveness of nagging and its reciprocal, hostility, which, unless stopped, continue to feed on one another (Blood, 1962, pp. 224-227). Number 7 has been added by this writer to this first category since it refers to nagging behaviour on the part of the respondent.

The second category asks whether the other person's voice is irritating. This has only one item, number 4. However, this item ranks second only to number 5 in discriminatory power. The significance of this aspect of communication has been persuasively set forth by Shipman (Shipman, 1960, pp. 203-209).

The third category concerns difficulty in dealing with angry feelings and with disagreements between the spouses. Included here are items 11, 10, 24 and 21 from among the .001 level items, to which this writer has added item 26. This writer believes that the questions self-evidently belong together under this heading.

The fourth category, the feeling of freedom to express feelings, emphasizes the respondents perception of being permitted to show feelings regardless of what the particular feelings are. This category contains the largest number of .001 items, numbers 44, 27, 33, and 23. No less significant items have been added.

The fifth category has to do with complaints about not being understood. Here are placed items 20 and 8, both at the .001 level, and 35.

This writer believes that the kinship among these questions is clear enough to preclude further explanation.

The sixth category, clarity of messages as perceived by the respondent as listener, has only one item, 22. As Bienvenu says, lack of clarity or, as specifically asked about here, double messages are excellent indicators of poor or disturbed communication (See also Watzlawick et al., 1967).

The seventh category concerns attentive listening. The items are 45 and 31 at the .001 level, and item 10. Attentive listening is cited by Blood as one of the most constructive forms of communication for continuing marital interaction and, thereby, for maintaining the relationship (Blood, 1962, pp. 205-207).

Category Eight, on marital disengagement has two items. One is number 30, at the .001 level, and it concerns engaging in interests outside the home. This is mentioned by Blood as an excellent way, along with attentive listening, to maintain the marital relationship (Blood, 1962, pp. 209-214). Its absence is symptomatic of disengagement from the relationship (Blood, 1962, pp. 204-207). Item 37 has been placed here by the researcher. Although it is not about outside interests, it does share with item 30 reference to disengagement from the relationship by means of a decrease in conversation (Blood, 1962, pp. 204-207).

The ninth category refers to efforts to converse. Included here is one question at the .001 level, 46, and two others, 6 and 43, which the writer has added.

The final six categories do not describe the manner or means of communication so much as they do those variables supporting or enhancing

communication (Bienvenu, 1970, p. 29). This by no means signifies that these categories are less important. However, none of these categories contains any .001 level items. Also, although Bienvenu names the categories, he has not in any publication seen by this writer assigned any items specifically to any of these categories. The assignment of items has been done by this writer.

Category Ten refers to the communication of affection. Here are put questions 12, 14, 32, and 42. That these items belong together is self evident.

The next category, number eleven, refers to feelings and expressions of empathy. Included are items 13, 41, 28, and 18. Empathy is defined here as the perception of the needs and feelings of another person in much the same way as that person perceives them. Items 13 and 41 illustrate the presence or absence of empathy as a feeling. Questions 28 and 18 ask about overt expressions of empathy. In regard to this category, Blood emphasizes that emotional support in marriage cannot be overestimated (Blood, 1962, pp. 214-224). Each spouse needs support for role performance, and each needs to utilize the other during times of emotional stress. Blood says that the most helpful measures include sympathy and affection or advice and discussion about solving a problem (Blood, 1962, p. 222).

The twelfth category, support of individuality, has but one item, number 17. This asks the respondent about the frequency of support in pursuing his or her own interests.

Category Thirteen refers to conversational courtesies and includes items 15 and 36.

The fourteenth category, on handling money, has two self-explanatory

items, numbers 1 and 25.

The final category has the largest number of questions, items 2, 3, 16, 34, 38, 39, and 40. The subject here is uncommunicativeness. This term needs defining for purposes of this paper. "Uncommunicativeness" is failure to verbalize. In this way, one partner may perceive that the other is upset, but without the second person's verbalizing the upset, the feelings remain obscure. As was said in the section on systems theory, non-verbal communication is too ambiguous to convey information adequately. Moreover, a couple is being uncommunicative even if both know what the upset feeling is and what some of the reasons for it are if they do not talk about it. Although verbalizing can be good or destructive communication, the absence of verbalizing, it is assumed, inevitably cripples the good.

The MCI is scored by a numerical value being assigned to each of the four possible answers to each question. The values range from 0 to 3. The answer to each question that is most favourable to good communication is 3, always either "Usually" or "Never." The least favourable answer is 0, also always either "Usually" or "Never." The two intermediate answers, "Sometimes" and "Seldom," are 1 or 2. "Sometimes" is 1 if "Usually" is least favourable, 2 if "Usually" is most favourable. "Seldom" is 1 if "Never" is least favourable, 2 if "Never" is most favourable. Because scoring is completely objective, there is little chance of researcher bias.

Since the MCI can be analyzed into at least the fifteen categories discussed above, there is the possibility of a vast number of different composite pictures of marital relationships. Therefore, for purposes of

comparison, the mean of the total scores for client and spouse is the quantity used to represent the couple's level of communication. This, then, is the operational definition of "level of communication" for the research question and the hypothesis.

Drinking Involvement Questionnaire

The 10-item questionnaire on drinking involvement is an adaptation of a questionnaire devised by Gerald L. Smith (Smith, 1976, pp. 61-63) and used by his permission. Smith had eighteen items, which have been reduced here to ten (See Appendix C). Also, he administered his questionnaire three consecutive times to the same group in order to detect change in drinking involvement. This writer has used it once in order to establish the drinking involvement of the sample subjects relative to each other. Smith's original classification of responses has also been changed. Smith was not only concerned with the kind of drinking, but also with its regularity or irregularity. Thus, he had seven categories of drinking involvement. Here, regular or irregular drinking has been ignored and the categories of "abstinent," "normal," "controlled," and "uncontrolled" retained. Smith scored each question, except the one on abstinence, which was a "yes" or "no item, on a 5-point scale. For the sake of uniformity, the same 4-point scale as on the MCI is used here. Smith grouped each question in one of four categories, combined with "regular" or "irregular" to give the full seven, and then scored the questions. Whichever category had the highest score classified the respondent's drinking involvement. This writer has also grouped the ten items into four categories, but has decided to evaluate

them differently for reasons discussed below.

The categories, "abstinent," "normal," "controlled," and "uncontrolled" represent an ascending order of drinking involvement. The client, to be rated as "abstinent" will have had to answer "no" to question one and "never" to all the others (See Appendix C). From this point on, Smith and this writer differ in scoring. Instead of comparing the other three categories in terms of scores, this writer classified a respondent as "uncontrolled" who admitted to any uncontrolled drinking at all (items 4, 7, and 9). The rationale was that as one moves up the scale of drinking involvement, all the reasons for drinking in the less serious categories may still remain operative. For this reason, even a "Seldom" response to one of the questions about uncontrolled drinking classifies a respondent as "uncontrolled." For a person to be classified as "controlled" or "normal," there must be no self-reported evidence of uncontrolled drinking. The distinction between "normal" and "controlled" is, as in Smith's system, based on the comparison of scores of the items in these two categories (items 3, 5, and 8 for "normal;" items 2, 6, and 10 for "controlled"). Whichever group of questions has the higher score designated the classification of the respondent. In case of a tie, the respondent was classified in the more severe category, "controlled." Unlike the MCI, scoring high here indicates the less favourable condition.

Although any drinking is considered very risky for a recovering alcoholic, by the definition of alcoholism in Jellinek (Jellinek, 1960, p. 35), a "normal" drinker is not one who is having a problem with alcohol. "Controlled," however, still indicates a very problematic usage since alcohol is being used as a coping mechanism for problem-

solving or problem-avoidance, often described as hallmarks of alcoholism. Therefore, for purposes of this paper, those respondents classified as "controlled" or "uncontrolled" have been considered to have a high drinking involvement, and the other two categories make up those with a low drinking involvement. This, then, is the operational definition of "low degree of drinking involvement" in the hypothesis.

Questionnaire on Spouse's Drinking Frequency

This single item questionnaire (See Appendix D) asks the respondent to rate himself or herself in terms of how often he or she drinks. The effect of others' drinking on the recovering alcoholic does not appear to have been discussed very much in the literature, but seems to the writer to deserve being looked at in an investigation of the couple system.

The responses of the spouse indicate whether she or he is abstinent, drinks once a month or less, drinks two or three times a month, drinks once or twice a week or almost every day. There is no study known to this writer that has investigated a spouse's drinking so as to provide some idea of, first, whether there is any relationship to the alcoholic's drinking and, second, if there is, at what point the frequency becomes important. Therefore, the writer has decided to group those who say that they do not drink at all along with those saying they drink once a month as "those having a low frequency." Those responding "two or three times a week" or "almost every day" have been classified as "those having a high frequency." For Hypothesis Two and Three, these are operational definitions of the spouse's high or low drinking frequency.

The other parts of the instrument have already been discussed and

described.

Pre-testing and Administration of the Instrument

The first two parts of the instrument for the client was pretested with two clients, a male and female, enrolled in the three-week phase of the program at Connaught Clinic. The purpose was not to test for validity, but to find any unclear parts and to see how long it would take to complete the lengthiest part of the instrument. Also, a purpose was to give the researcher some practice in administering it.

Population and Sample

The population was defined as those clients at Connaught Clinic who had completed the three-week phase of the program by April, 1977, and who had stated at intake that they were living with their spouses, either legally married or common-law. The size of the population was 267. Out of this population, 32 were removed when the researcher decided, for practical reasons of making home visits in order to administer the instrument, to restrict the population to those living in Windsor and its environs.

From a resulting population of 235, the researcher, using a table of random numbers (Edwards, 1946, pp. 192-196), selected a sample of thirty and a second thirty to provide replacements.

The time terminus of April, 1977, was chosen to ensure that at least three months had passed between completion of the three-week phase and the filling out of the questionnaire. The three-month period was suggested as significant in the literature.

The researcher aimed at a sample of thirty couples, but only

twenty-one out of the sixty couples were able to be contacted and agreed to fill out the questionnaire. Of the twenty-one couples, one spouse was unable due to illness, to complete the MCI, but that person did answer the other parts. Only five of the sixty couples refused to participate. The rest either were no longer living in the Windsor area or were no longer living with anyone as a spouse.

There was no intention on the part of the researcher to generalize about the population of alcoholics. This sample was intended to represent treated married alcoholics who are living with their spouses. In view of the small size of the sample, however, the researcher will not attempt this generalization. Since, though, the sample does make up 8.9% of the entire defined population at Connaught Clinic, the results propably can be generalized to this population.

Assumptions

Besides those mentioned elsewhere, the researcher makes the following assumptions:

1. No members of the population have been overlooked in the files at Connaught Clinic.
2. All parts of the instrument are valid and reliable. Validity and reliability of the MCI have already been established.
3. The respondents will answer truthfully and understand the directions and questions.

Design Classification and Limitations

Classification

Of the three major categories of empirical research described by

Tripodi, Fellin, and Meyer (Tripodi et al., 1969, p. 21), experimental, quantitative-descriptive, and exploratory, this study falls in the category of quantitative-descriptive.

To be classified as a quantitative-descriptive study, certain criteria must be satisfied. First, it must be distinguished from an experimental study. Both kinds of studies are quantified descriptions of relationships between and among variables, but an experimental study requires an experimental and control group, with subjects assigned randomly to each. In addition, the independent variable is manipulated by the researcher in an experimental study. Neither of these things has been done in this study. As a second criterion, a quantitative-descriptive study must deal with measurable variables. The third criterion is that it have one or both of the following purposes, either to test hypotheses or to describe accurately the quantitative relations among variables (Tripodi et al., 1969, p. 38). This last criterion suggests that there may be no claim put forth for a cause-effect relationship among the variables. In this kind of study, though, which investigates the strength of association and correlation among the variables, the variables must be defined operationally in such a way that they can be measured.

Of the four subtypes of quantitative-descriptive studies, viz., 1) hypothesis-testing, 2) program evaluation, 3) population description, and 4) describing variable relationships, this study is primarily a population description of treated alcoholics who are living with their spouses. This study is also hypothesis-testing since the researcher is interested in determining whether certain characteristics in the description are significantly associated with one another. The hypotheses

are based on theory.

Limitations

One limitation is that the sample, though randomly selected, is still self-selected in that each subject had to agree to filling out the questionnaire. The same was true of the spouse.

A second limitation is that of reliance on self-report by the respondents.

A third limitation is the absence of a method to detect change in the population's characteristics over time.

Statistical Procedures

To decide on appropriate statistics, the types of scales are usually the determining factors. The scales for drinking involvement of the client and drinking frequency of the spouse are nominal. The MCI, although it is ordinal, does give a continuum of scores, and for purposes of this study, it will be treated as an interval scale. Hence, the F-test will be used to test for significance and eta for strength of assoication.

The writer refers readers who might be sceptical of this procedure of applying interval-nominal statistics to ordinal-nominal data to Labovitz' opinion that although there may be some small error in this kind of treatment, it is more than offset by the use of more powerful, sensitive, and developed statistics which are more clearly interpretable (Labovitz, 1970, pp. 515-524).

To describe single variables, the mean, a measure of central tendency, and the mode, a measure of frequency are used.

Summary

This chapter has presented the basic questions and their rationale and the research question and hypothesis derived therefrom. Also given were the formal operational definitions. This chapter discussed, too, the methodology of the project, which involved the measuring instrument and how its parts were developed and used. Then followed the definition of the population, the sampling procedure, assumptions, design classification, limitations, and a description of the statistical procedures used in this thesis.

CHAPTER IV

DATA ANALYSIS

The findings are presented in the following manner. The first section of this chapter describes the population in terms of the following characteristics:

1) Age of client and spouse
2) Education of client and spouse
3) Occupation of client and spouse
4) Length of cohabitation
5) Age when client's problem drinking began
6) Client's drinking involvement
7) Spouse's drinking frequency
8) Use of follow-up help by the client
9) Help sought by spouse related to the client's drinking
10) Level and patterns of communication between client and spouse

Presentation and examination of these variables will provide a description of the population.

The second section will examine the data related to the first hypothesis, contained in items 6 and 10 above. The third section will test the data for the second hypothesis, found in items 7 and 10 above. The fourth section will present the results of the data for the third hypothesis from items 6 and 7 above.

Description of the Population

Age

The sample consisted of 21 couples, a total of 42 persons. The range of these clients' ages was from 25 to 67, and of the spouses from 23 to 76.

TABLE 1

AGES OF CLIENTS AND SPOUSES

AGE	CLIENT	SPOUSE	TOTAL
65 and over	4.8% (1)	4.8% (1)	4.7% (2)
55-64	14.3 (3)	14.3 (3)	14.3 (6)
45-54	19.0 (4)	14.3 (3)	16.7 (7)
35-44	47.6 (10)	38.1 (8)	42.9 (18)
25-34	14.3 (3)	23.8 (5)	19.0 (8)
Under 25	0.0 (0)	4.8 (1)	2.4 (1)
TOTAL	100.0% (21)	100.1% (21)	100.0% (42)

NOTE: Numbers in parentheses represent frequencies.

The largest number of both clients and spouses are found in the 35-44 age bracket. The mean age for clients is 42.7, and for spouses it is 41.7.

Education

The last grade completed in school ranged from grade six to graduation from college for clients, as can be seen in Table 2. A slight majority of the clients, 52.4% and a larger majority of spouses, 71.4%, did not go beyond grade ten. The largest number of both clients

and spouses attained the grades 9-10 bracket.

TABLE 2

EDUCATION LEVELS OF CLIENTS AND SPOUSES

LAST YEAR COMPLETED	CLIENT	SPOUSE	TOTAL
Grades 6-8	19.0% (4)	23.8% (5)	21.4% (9)
Grades 9-10	33.3 (7)	47.6 (10)	40.5 (17)
Grades 11-12	19.0 (4)	19.0 (4)	19.0 (8)
Grade 13	9.5 (2)	9.5 (2)	9.5 (4)
Some university or college	4.8 (1)	0.0 (0)	2.4 (1)
Completed college	4.8 (1)	0.0 (0)	2.4 (1)
TOTAL	99.9% (21)	99.9% (21)	99.9% (42)

NOTE: Numbers in parentheses represent frequency.

Occupation

Both clients and spouses were asked to name their present occupations, which were classified by the researcher into one of the categories in Table 3. Of the 21 women involved, 14 were housewives. Of these 14, three are in the "Clients" column. The researcher has classified the largest number of clients as "skilled." Of some note here is, that no client in the sample could be rated as unemployed, defined as someone who does not have a job outside the home and is looking for one. Of the 18 women among the spouses, seven of them hold full-time jobs outside the home, four of them judged as skilled occupations. By and large, in terms of occupation, the clients present a better picture regarding both being employed and level of employment than the researcher expected.

TABLE 3

OCCUPATIONS OF CLIENTS AND SPOUSES

TYPE OF OCCUPATION	CLIENT	SPOUSE	TOTAL
Unemployed	0.0% (0)	4.8% (1)	2.4% (1)
Semi-skilled or unskilled	19.0 (4)	19.0 (4)	19.0 (8)
Skilled	42.9 (9)	19.9 (4)	31.0 (13)
White collar	14.3 (3)	0.0 (0)	7.1 (3)
Retired	9.5 (2)	4.8 (1)	7.1 (14)
Housewife	14.3 (3)	52.4 (11)	33.3 (14)
TOTAL	100.0% (21)	100.0% (21)	99.9% (21)

NOTE: Numbers in parentheses represent frequencies.

TABLE 4

LENGTH OF COHABITATION

YEARS	PERCENTAGE	(NUMBER)
40-49	4.8	(1)
30-39	23.8	(5)
20-29	0.0	(0)
10-19	57.1	(12)
Less than 10	14.3	(3)
TOTAL	100.0	(21)

Length of cohabitation

Most of the couples fall in the 10-19 years bracket for length of cohabitation. Completely lacking was any representation in the 20-29 years interval. This is certainly due to chance in sample selection. The range for length of cohabitation is 7 to 43, with a mean of 19.1.

Age when problem drinking began

The largest category on Table 5 is that of those clients who reported that they began to experience problems connected with their drinking in their teen years. The majority, 61.9%, reported their problem drinking as beginning before age 30. From the raw data it was found that almost a majority, 47.6%, placed the beginning at age 20 or younger. The range is from 14 to 46.

TABLE 5

AGE WHEN PROBLEM DRINKING BEGAN

AGE	PERCENTAGE	(NUMBER)
50 or older	4.8	(1)
40-49	9.5	(2)
30-39	23.8	(5)
20-29	23.8	(5)
Under 20	38.1	(8)
TOTAL	100.0	(21)

Drinking involvement of clients

Of special notice here is the comparatively high percentage of clients who have been abstinent over the past three months, the time referred to in the questionnaire. Those who have been abstinent make up 54.4% of the sample, and when "normal" drinkers are added, the proportion becomes 66.7%. This is high in view of the clinic's own records from follow-up questionnaires which indicate an abstinence rate of around 40%. Also to be noted is the low proportion of respondents in the middle ranges of "normal" and "controlled." The impression is that the great majority of the population either maintains abstinence or returns to uncontrolled drinking.

TABLE 6

DRINKING INVOLVEMENT OF CLIENTS

DRINKING INVOLVEMENT	PERCENTAGE	(NUMBER)
Abstinent	52.4	(11)
Normal	14.3	(3)
Controlled	9.5	(2)
Uncontrolled	23.8	(5)
TOTAL	100.0	(21)

Drinking frequency of spouses

As in the previous section, the majority are abstinent, 61.9%. When those classified as "seldom" or "occasional" drinkers are added, the proportion of low-frequency drinkers rises to 76.2%.

TABLE 7

DRINKING FREQUENCY OF SPOUSES

DRINKING FREQUENCY	PERCENTAGE	(NUMBER)
Abstinent	61.9	(13)
Seldom	9.5	(2)
Occasional	4.8	(1)
Weekly	19.0	(4)
Daily	4.8	(1)
TOTAL	100.0	(21)

Follow-up help

As was said in Chapter I, the clinic regards consistent and frequent use of follow-up help as essential for most clients in order to maintain their sobriety. In this area, the researcher was interested in identifying which sources were used and how frequently. There follows, therefore, a series of tables on the use of follow-up help by the clients and frequency of use.

TABLE 8

SOURCES OF FOLLOW-UP HELP USED BY CLIENTS

SOURCES	PERCENTAGE	(NUMBER)
Group follow-up	71.4	(15)
Alcoholics Anonymous	47.6	(10)
Individual counselling at Connaught Clinic	9.5	(2)
.001 at A.R.F.	9.5	(2)
Others	19.0	(4)

The above named sources are obviously not mutually exclusive, and some clients used more than one. Indeed, one client used all of the first four sources to the maximum that the instrument could measure. As can be seen on Table 7, 71.4% of the clients attended the clinic's own follow-up program at least once. Next in popularity was A.A. which 47.6% used at least once. Of somewhat less usage were individual follow-up and the .001 group at A.R.F. The other sources used will be named below.

The above table shows what follow-up help was used, but does not reveal the frequencies. These are shown below on Tables 9, 19, 11, and 12.

TABLE 9

FREQUENCY OF USE OF GROUP FOLLOW-UP

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	28.6	(6)
Once	14.3	(3)
Twice	4.8	(1)
Three times	23.8	(5)
Four or more	28.6	(6)
TOTAL	100.1	(21)

TABLE 10

FREQUENCY OF USE OF ALCOHOLICS ANONYMOUS

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	52.4	(11)
Once a month or less	28.6	(6)
Two or three times a month	4.8	(1)
Once a week or more	14.3	(3)
TOTAL	100.1	(21)

TABLE 11

FREQUENCY OF USE OF INDIVIDUAL COUNSELLING

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	90.5	(19)
One meeting	0.0	(0)
Two meetings	4.8	(1)
Three meetings	0.0	(0)
Four or more	4.8	(1)
TOTAL	100.1	(21)

TABLE 12

FREQUENCY OF USE OF .001 GROUP AT A.R.F.

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	90.5	(19)
One meeting	0.0	(0)
Two meetings	0.0	(0)
Three meetings	4.8	(1)
Four or more	4.8	(1)
TOTAL	100.1	(21)

TABLE 13

USE OF OTHER SOURCES

SOURCES	NUMBER
Brentwood	1
Open Door	2
Clergy	1

From Tables 9-13 the use of the clinic's group follow-up seems to dominate all the others. However, comparison with use of A.A. is not so clear. The reason is that A.A. is always available and can at any time be used as much or as little as a person with a drinking problem wishes. On the other hand, the clinic's group follow-up has a maximum

of five meetings, except for a few groups for whom there were eight. Nevertheless, Table 9 shows that a majority, 52.4% attended at least three times. Tables 10-12 show that possibly the other sources of follow-up help, even the well-known A.A., are under utilized. Perhaps the Connaught Clinic needs to emphasize more strongly the use of help by clients after the three-week phase that is of an ongoing nature.

Among the "other" sources, Brentwood is itself a residential treatment center, but has a follow-up program of its own, which meets frequently and is open to all alumni of Brentwood. It is the follow-up part of treatment at Brentwood that the respondent had in mind here and so expressed it to the researcher.

All in all, these tables reveal all the sources of help used by the client subjects in this sample. Probably there are other important sources for the population, but these seem to be the principle sources.

Help sought by the spouse related to the client's drinking

As with the clients, the spouses were asked to give the frequency of use of help. It was expected that from this part of the questionnaire would be revealed their principle sources and the rate of utilization.

TABLE 14

HELP SOUGHT BY SPOUSE

SOURCES	PERCENTAGE	(NUMBER)
Alanon	19.0	(4)
Couple counselling at Connaught Clinic	47.6	(10)
Significant Others meetings	66.7	(14)
Others	23.8	(5)

As in the case of the clients, the clinic's own program and service were utilized by the largest number of spouses. Two-thirds attended at least one Significant Other meeting, and almost half, 47.6%, had at least one session of couple counselling at the clinic. In contrast, the ongoing program of Alanon, designed especially with family members of alcoholics in mind, was used by only 19.0%.

TABLE 15

FREQUENCY OF USE OF ALANON

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	81.0	(17)
Once a month or less	9.5	(2)
Two or three times a month	4.8	(1)
Once a week or more	4.8	(1)
TOTAL	100.0	(21)

From Table 15 can be seen more clearly how little Alanon was used. Of the four who attended at all, two reported averaging one meeting a month or less.

Although two-thirds of the spouses, 66.7%, used couple counselling only once or not at all, there was a sizable minority, 28.5%, who utilized it three or more times.

TABLE 16

FREQUENCY OF USE OF COUPLE COUNSELLING

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	52.4	(11)
Once	14.3	(3)
Twice	4.8	(1)
Three times	9.5	(2)
Four or more	19.0	(4)
TOTAL	100.0	(21)

TABLE 17

FREQUENCY OF ATTENDANCE AT SIGNIFICANT OTHERS MEETINGS

FREQUENCY	PERCENTAGE	(NUMBER)
Not at all	33.3	(7)
Once	9.5	(2)
Twice	14.3	(3)
Three times	42.9	(9)
TOTAL	100.0	(21)

This program at Connaught Clinic consists of only three meetings. Possibly the very fact that there is a limited number encourages attendance both because the chance to use this source will not always be there and its scope is more easily comprehended by the users.

TABLE 18

USE OF OTHER SOURCES BY SPOUSES

SOURCES	NUMBER
A.A. open meetings and A.A. persons	3
Church	1
Brentwood meetings for wives	1
TOTAL	5

The other sources of help used by spouses related to their partner's drinking appear above on Table 18. Regarding both clients and spouses, it is of interest to note how few are the sources outside of those generally recognized as providing service for alcoholism. No respondent used any family service agency, industrial or union service, physician or psychiatrist.

To conclude this section on client's use of follow-up and spouse's seeking help, there were four clients and six spouses who used no sources of help at all.

Level and patterns of communication

A major aspect of the description of the population of clients having completed the three-week phase of the program at Connaught Clinic and who are living with their spouses is the level and patterns of communication between them and their spouses.

In what follows, the data from the MCI are presented to describe the levels of communication and to identify patterns, both those that are conducive to good communication and those conducive to poor.

TABLE 19

FREQUENCY OF SCORES ON THE MCI

SCORE INTERVALS	CLIENTS (NO.)	SPOUSES (NO.)	COUPLES (NO.)
120 or more	9.5% (2)	0.0% (0)	4.8% (1)
100-119	19.0 (4)	35.0 (7)	23.8 (5)
80-99	28.6 (6)	20.0 (4)	23.8 (5)
60-79	23.8 (5)	20.0 (4)	28.6 (6)
40-59	14.3 (3)	20.0 (4)	14.3 (3)
20-39	4.8 (1)	5.0 (1)	4.8 (1)
TOTAL	100.0 (21)	100.0 (20)	100.1 (21)

Note: Mean for clients is 84.67 sd is 27.05
Mean for spouses is 80.45 sd is 29.59.
Mean for couples is 82.48 sd is 25.74
One observation is missing for spouses.

The possible range on the MCI is from 0 to 138. The clients' range is from 24 to 136. The range of the spouses is from 23 to 119, and that of the couples is from 23.5 to 127.5. The means of the clients and spouses do not differ significantly as is shown on the following table.

TABLE 20

CLIENTS' SCORES ON MCI
BY SPOUSES SCORES ON MCI

SCORES	CLIENTS	SPOUSES	TOTAL
Above mean	12	8	20
Below mean	9	12	21
TOTAL	21	20	41

X^2 (1) = 1.20 p = n.s.

TABLE 21

MEAN SCORES ACCORDING TO CATEGORIES

CATEGORIES	CLIENTS	SPOUSES	COUPLES
1-9	46.71	43.40	45.05
10-15	38.29	36.40	37.36
19 items at .001 level of confidence	30.29	28.90	29.60
1 (12)	5.52	5.65	5.57
2 (3)	1.14	1.20	1.16
3 (15)	7.81	7.71	7.79
4 (12)	7.09	6.40	6.69
5 (9)	6.19	5.49	5.90
6 (3)	1.29	0.90	1.05
7 (9)	5.62	5.60	5.62
8 (6)	4.33	3.55	6.57
9 (9)	6.62	6.40	6.57
10 (12)	7.90	7.90	7.90
11 (12)	7.33	7.45	7.40
12 (3)	2.57	2.60	2.59
13 (6)	3.52	3.70	3.62
14 (6)	4.48	3.55	4.10
15 (21)	12.19	11.40	11.79
	n= 21	n= 20	n= 21

Note: Numbers in parentheses are the maximum scores possible on the individual categories.

The .001 level of confidence has been found by Bienvenue for 19 items, all within Categories 1-9.

Analyzing the overall scores for clients, spouses, and couples yields the results shown on Table 21.

Upon persuing Table 21, one can intuitively identify certain individual categories as indicating probable areas of weakness or strength in marital communication for the clients and spouses as groups. Categories 5, 8, 9, 10, 12 and 14 seem to be those that present the least problem to clients and spouses as individuals or as couples. In each of these categories, either the clients or the spouses or both averaged at least two-thirds of the maximum score. On the other hand, only Categories 1, 2, and 6 seem especially troublesome, in which one or both groups averaged less than one half the possible maximum. These proportions are hard to interpret because this is an ordinal, not an interval or ratio scale. The scores give relative, not absolute strength. Clearly, too, in no category did either the clients or spouses average the maximum possible, indicating that there is some problematic communication in all areas tested. Nor did either group average zero in any category, which indicates there is some strength in every area. Selecting two-thirds of maximum and less than one half of maximum possible averages to distinguish strengths and weaknesses, respectively, is arbitrary and, to reiterate, intuitive.

To pursue this intuitive interpretation further, the "strong" categories tested for "complaints about not being understood (Cat. 5)," "marital disengagement (Cat. 8)," "attempts to converse (Cat. 9)," "giving and receiving affection (Cat. 10)," "freedom to pursue one's own interests (Cat. 12)," and "discussion of finances (Cat. 14)."

The "weak" categories tested for "destructive and damaging communication (Cat. 1)," "irritating tone of voice (Cat. 2)," and

"clarity of communication (Cat. 6)." The reader is referred to Appendix B for the register of categories which will give their titles and show what items are included in them.

Apparently, as a group, the clients and their spouses have fewer problems about understanding one another, doing and talking about things together, making attempts to converse, giving and receiving affection, feeling free to pursue their own interests, and discussing finances. They have more problems in the area of disagreeing with one another in that, when they argue, they tend to insult one another. Also, they tend to say things better left unsaid, and they nag one another. In addition, they consistently find their partner's tone of voice irritating. Finally, they complain that their partners do not say what they really mean more often than not. The instrument did not permit defining these areas more finely. The rest of the categories fall between these two groups of items.

Hypothesis One

Those couples that have a low degree of drinking involvement by the client have a higher level of communication than those couples in which the client has a high degree of drinking involvement.

The data for the first hypothesis have been presented in Tables 6 and 19. What will be done here is to compare the data from these tables in order to see whether there is a significant relation between drinking involvement and level of marital communication. Moreover, there will be subanalyses of the overall scores on the MCI to test for significance of areas and patterns of communication with drinking involvement of the

clients. As was stated in Chapter III, since the MCI is being treated for purposes of analysis as an interval scale, the F-test, which compares interval and nominal data, has been used to test for significance. For the same reasons, the correlation ratio, eta, has been used to find the strength of association between the variables.

TABLE 22

COUPLE SCORES ON MCI BY DRINKING INVOLVEMENT OF CLIENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	2950.10	1	2950.10
WITHIN	10301.64	19	542.19
TOTAL	13251.74	20	F = 5.44

$p < .05$, $eta^2 = 0.22$

The results show that couples in which the client has a low drinking involvement do have a significantly higher level of marital communication than couples in which the client has a high drinking involvement. The value of eta, 0.22, shows that drinking involvement accounts for 22% of the variance of the scores on the MCI.

Of interest to the researcher was whether the married partners' individual scores were also significantly related to the clients' drinking involvement. The results of this subanalysis are shown on Tables 23 and 24.

TABLE 23

CLIENT SCORES ON MCI BY DRINKING INVOLVEMENT OF CLIENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	2438.09	1	2438.09
WITHIN	11626.58	19	611.93
TOTAL	14064.67	20	F = 3.98

p = n.s., eta^2 = 0.16

TABLE 24

SPOUSES' SCORES ON MCI BY DRINKING INVOLVEMENT OF CLIENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	3665.87	1	1060.02
WITHIN	12973.08	18	175.25
TOTAL	16638.95	19	F = 5.09

$p < .05$, eta^2 = 0.22

The results are not significant for the clients, but they are for the spouses, who are the ones, it seems, who bring the scores of the couples to a significant level of relationship to clients' drinking involvement.

The researcher decided to subanalyze Categories 1-9 in relation to client drinking involvement because those categories contain the 19 items Bienvenu found to discriminate between the top and bottom quartiles at the .001 level of confidence. The researcher also decided to test the

significance of couples' scores on those 19 items as a group in relation to client drinking involvement. The results appear on the following two tables.

TABLE 25

COUPLES' SCORES ON CATEGORIES 1-9
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	1060.02	1	1060.02
WITHIN	3329.68	19	175.25
TOTAL	4389.60	20	F = 6.04

$p < .05$, $eta^2 = 0.24$

TABLE 26

COUPLES' SCORES ON BIENVENU'S 19 ITEMS
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	265.00	1	265.00
WITHIN	1205.81	19	49.52
TOTAL	1470.81	20	F = 5.35

$p < .05$, $eta^2 = 0.13$

Under both conditions the results are significant, although the strength of association in Table 26 is much less than in Table 25.

As before with the overall scores, the researcher wished to see whether clients' and spouses' scores were each significantly related to

client drinking involvement. The results for Categories 1-9 for clients and spouses are given in Tables 27 and 28. For the items at the .001 level of confidence the results appear in Table 29.

TABLE 27

CLIENT SCORES ON CATEGORIES 1-9 OF MCI
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	850.50	1	850.50
WITHIN	2838.70	19	149.40
TOTAL	3689.20	20	F = 5.69

$p < .05$, $eta^2 = 0.17$

TABLE 28

SPOUSES' SCORES ON CATEGORIES 1-9 OF MCI
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	1330.29	1	1330.29
WITHIN	4146.51	18	230.36
TOTAL	5476.80	19	F = 5.77

$p < .05$, $eta^2 = 0.24$

TABLE 29

SPOUSES' SCORES ON BIENVENU'S 19 ITEMS
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	556.00	1	556.00
WITHIN	2064.74	18	114.71
TOTAL	2620.74	19	F = 4.85

$p < .05$, $eta^2 = 0.24$

Both clients'and spouses' scores on Categories 1-9 were significantly related to client drinking involvement. In the case of the 19 items at the .001 level of confidence, only the spouses' scores were significantly related to drinking inovlvement.

Further subanalysis was done on couples', clients', and spouses' scores on Categories 10-15. The results that were significant are given in Table 30.

TABLE 30

COUPLES' SCORES ON CATEGORIES 10-15 OF MCI
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	546.48	1	546.48
WITHIN	2071.09	19	109.00
TOTAL	2617.57	20	F = 5.01

$p < .05$, $eta^2 = 0.24$

From the preceding tables, the first hypothesis must be accepted. Marital communication as revealed by the spouse seems much more related to client drinking than marital communication as described by the client. In the subanalysis of Categories 1-9, scores for clients and spouses, as well as for both together as couples, agree that marital communication is related to client drinking involvement. For Categories 10-15, however, neither the clients nor the spouses show any significant relationship between communication and drinking involvement, whereas as couples they do.

Up to this point, reference has been made only to overall marital communication or large fractions of it without regard to patterns of communication. Attention now will be given to the patterns tested for on the MCI and referred to in the categories. In what follows, only those categories will be discussed that had at least one of the groups, clients, spouses or couples, that showed scores significantly related to drinking involvement. Going through the categories consecutively, the first to be taken up is Category 3, problems in dealing with anger and differences between partners.

TABLE 31

COUPLES' SCORES ON CATEGORY 3
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIANCE	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	33.49	1	33.49
WITHIN	110.80	19	5.83
TOTAL	144.29	20	F = 5.74

$p < .05$, $eta^2 = 0.23$

TABLE 32

SPOUSES' SCORES ON CATEGORY 3
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	51.12	1	51.12
WITHIN	43.63	18	2.42
TOTAL	94.75	19	F = 21.12

$p < .01$, $eta^2 = 0.23$

From these two tables can be seen that spouses of clients with a high drinking involvement see the dealing with anger and differences as much more of a problem than their partners do. However, since the combined scores as couples are still significant, it can be said that those couples with a partner who has a high drinking involvement have more of a pattern than the other couples of finding anger and differences hard to handle.

The next is Category 8, marital disengagement.

TABLE 33

COUPLES' SCORES ON CATEGORY 8
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	28.34	1	28.34
WITHIN	23.80	19	1.25
TOTAL	52.14	20	F = 22.67

$p < .01$, $eta^2 = 0.54$

TABLE 34

CLIENT SCORES ON CATEGORY 8
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	18.67	1	18.67
WITHIN	36.00	19	1.89
TOTAL	54.67	20	F = 9.88

$p < .01$, $eta^2 = 0.34$

TABLE 35

SPOUSES' SCORES ON CATEGORY 8
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	42.16	1	42.16
WITHIN	44.79	18	2.49
TOTAL	86.95	20	F = 16.93

$p < .01$, $eta^2 = 0.49$

Both as individuals and together as a couple, the pattern of disengagement is much stronger among couples with a client who has a high drinking involvement. Moreover, the kind of drinking involvement explains 54% of the variance for the couples, 49% for the spouses, both very high correlation ratios, and 34% for the clients. A pattern of marital disengagement here means specifically, doing very little together outside the home and seldom talking about subjects of interest to both parties.

Also very significant were the results for Category 9, attempts to converse with one another.

TABLE 36

COUPLES' SCORES ON CATEGORY 9
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	30.01	1	30.01
WITHIN	58.23	19	3.06
TOTAL	88.24	20	F = 9.81

$p < .01$, $eta^2 = 0.33$

TABLE 37

CLIENT SCORES ON CATEGORY 9
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	32.59	1	32.59
WITHIN	64.36	19	3.39
TOTAL	96.95	20	F = 9.61

$p < .01$, $eta^2 = 0.34$

TABLE 38

SPOUSES' SCORES ON CATEGORY 9
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	41.86	1	41.86
WITHIN	70.94	18	3.94
TOTAL	112.80	19	F = 10.62

$p < .01$, $eta^2 = 0.37$

Clients, spouses, and both as couples show a highly significant relationship between problems in the area of trying to converse and the presence of a client who has a high drinking involvement. Also, the strength of association is high, with 33% of the couples' variance, 34% of the clients', and 37% of the spouses' accounted for by the drinking involvement.

Category 14 has significant results for the couples. This category refers to discussion of money matters.

TABLE 39

COUPLES' SCORES ON CATEGORY 14
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	8.15	1	8.15
WITHIN	27.16	19	1.43
TOTAL	25.31	20	F = 5.70

$p < .05$, $eta^2 = 0.23$

These results show that couples in which the client has a high drinking involvement has more trouble discussing money. According to the items, they either discuss money less frequently or they argue more frequently or both.

The fifteenth and final category also showed for the couple a significant relationship. This category has to do with uncommunicativeness. This is the largest category, comprising seven items. In general, each refers to failure on the part of the respondent or the respondent's partner to verbalize feelings, opinions, interests or experiences. From

the table below can be seen that those couples with a client who has a high drinking involvement are significantly more uncommunicative than the other couples.

TABLE 40

COUPLES' SCORES ON CATEGORY 15
BY CLIENT DRINKING INVOLVEMENT

SOURCE OF VARIATION	SUM OF SQUARES	df	VARIANCE ESTIMATE
BETWEEN	61.93	1	61.93
WITHIN	238.36	19	12.55
TOTAL	300.29	20	F = 4.93

$p < .05$, $eta^2 = 0.21$

Hypothesis Two

Those couples that have a lower drinking frequency by the spouse have a higher level of communication than couples with a spouse who has a higher drinking frequency.

The results of the data related to Hypothesis Two are non-significant ($F = 0.33$; $eta^2 = 0.08$). Therefore, the null hypothsis must be accepted that there is no correlation between drinking frequency of the spouse and marital communication.

Hypothesis Three

More spouses who have a high drinking frequency have marital partners who have a high drinking involvement.

Since both scales are nominal, Chi Square is the only proper

statistic for comparing the variables. The results were nonsignificant ($\chi^2 = 1.67$, 1 df). In fact out of the five spouses with a high drinking frequency, four were married to clients with a low drinking involvement. In addition, of the seven clients with a high drinking involvement, six were married to spouses with a low drinking frequency.

Summary

This chapter presented the data analysis for the research question and three hypotheses described in Chapter III. Also, there were sub-analyses of the data for Hypothesis One.

CHAPTER V

SUMMARY AND CONCLUSIONS

There were two purposes of the research project. The first was to describe the population of clients at Connaught Clinic who had completed the three-week phase of the program and who were married and living with their spouses. The description of the population consisted of the level and patterns of communication between the clients and their spouses, demographic data, current drinking involvement, and use of follow-up help. The same information was gathered about the spouses, except for drinking frequency instead of drinking involvement and the use of help related to the client's drinking. The second purpose was to measure the relationship between marital communication and drinking involvement and drinking frequency.

The rationale for the investigation was derived from communication systems theory which asserts that behaviour of persons within a system is reciprocal. It seemed, then, legitimate to predict hypothetically that couples in which clients have a low drinking involvement will have a higher level of communication than couples in which clients have a high drinking involvement.

Besides the above mentioned concerns, it was felt that the results of the study might give indications of how the Connaught Clinic or any similar facility might focus or change their efforts to serve this population better. The project had the support of the clinic and Windsor Western Hospital.

Summary of Findings

The findings are presented under four headings: the description of the sample, the relationship between client drinking involvement and marital communication, the relationship between the spouses' drinking frequency and marital communication, and the relationship between the spouse's drinking frequency and the client's drinking involvement.

Description of the sample

The clinic sample was made up of 21 persons, 18 men and 3 women. Their ages ranged from 25 to 67 with a mean of 41.7. The largest number, 10, fell in the 35-44 age bracket.

In terms of education, the majority, 52.3%, did not go beyond grade 10, although the range is from grade 6 through completion of college. On the whole, the clients seem better educated regarding years of schooling than thier spouses.

In regard to occupation, not one sample subject was unemployed, although two were retired. Of the latter, one had retired early due to health reasons connected with drinking. The largest number of subjects were employed in skilled occupations. All three women were housewives.

Regarding length of cohabitation, the largest number of subjects, also on absolute majority of 57.9%, belong to the 10-19 years bracket.

For the age when problem drinking began, the largest percentage reported their teen years, 38.1%; none said a younger age. When those who stated the age of 20 are included, the percentage rises to 47.6%. A picture emerges of almost half as beginning to have problems due to

drinking very early in life.

A majority of clients, 52.4%, reported being abstinent during the three months preceding filling out the questionnaire, which seems a high proportion. When those respondents rated as "normal" drinkers are included, the proportion rises to 66.7%. Since, however, the sample was self-selected in the sense that their consent was necessary to be included, what appears to be an outstanding success rate must not be generalized to the population of clients.

Regarding the use of follow-up help, 71.4% of the subjects attended the clinic's group follow-up at least once. A.A. meetings were attended at least once by 47.6%. Individual counselling at the clinic and the .001 group at A.R.F. were little used. As far as frequency of use is concerned, 52.4% attended at least three of the five group meetings, but only 19.1% averaged two or more A.A. meetings per month. There seems to be an under utilization of A.A.'s program of ongoing help.

Up to this point, little mention has been made of the spouses because they are not members of the population. However, as marital partners, data on them are pertinent. Their age reange is from 23 to 76, with a mean of 41.7. Like the clients, the largest number are in the 35-44 age bracket. In school, 71.4% did not go beyond grade 10, and none ever attended college or university.

Eighteen of the spouses were woman, and eleven of the 18 were housewives. Of the seven remaining none was unemployed, 3 were employed in skilled professions, and 4 in semi-skilled or unskilled. Of the three male spouses one was unemployed, one retired, and one held a skilled job.

In terms of drinking frequency, 61.9% are abstinent. Adding to these those rated "seldom" or "occasional" drinkers, the proportion of infrequent drinkers rises to 76.2%. All three male spouses were high frequency drinkers, rated either "weekly" or "daily."

Looking at the sources of help sought by the spouse related to the clients' drinking, one finds that 66.7% attended at least one Significant Others meeting, and that 42.9% went to all three meetings. Adding those who attended two, the proportion becomes 57.2%. Yet, 33.3% attended none. The next most used source was couple counselling which 47.6% used at least once, but only 28.5% of the spouses went to more than two sessions. Alanon, the ongoing program designed for spouses, was used by 19.1%, and only by 9.6% more than once a month on the average.

For both clients and spouses, the list of other sources was not extensive, and, except for the church, did not include any source not already recognized as specialized for alcoholism. It seems in the areas of follow-up help and hlp for spouses, there is much room for more community involvement.

Concerning level and patterns of communication, the clients ranged in overall scores from 24 to 136 and describe about a normal curve with the highest percentage, 28.6%, in the 80-99 bracket. The spouses range from 23 to 119, but have the largest percentage at the top with 35.0% in the 100-119 bracket. When client scores are averaged with their spouses' to give the couples' scores, the couples range from 23.5 to 127.5, with the largest percentage, 28.6%, in the 60-79 bracket. There were some couples in which the scores for the partners

differed greatly, but the means for the groups of clients and spouses were not significantly different. The means were for clients, spouses, and couples, respectively, 84.67, 80.45, and 82.48.

Since for purposes of description the scales based on the MCI can be treated only as ordinal, no secure conclusions may be drawn as to which scores represent good or poor communication. One can only say that the couples with the higher scores probably have better relationships than those with lower scores. One can not say how much better. However, when the overall scores are analyzed into patterns, represented by the fifteen categories, the researcher has made some intuitive and tentative identifications of good and poor patterns. In this way, he has indicated that as a group the clients show poor patterns of communication in regard to 1) destructive and damaging communication (Category 1), 2) finding the partner's voice irritating (Category 2), and 3) lack of clarity in that they experience their spouse as, more frequently than not, saying one thing but meaning another (Category 6). The spouses also score low in these same categories. The area of good communication for both partners seem to be 1) the feeling of being understood (Category 5), 2) marital engagement (Category 8), 3) attempts to converse (Category 9), 4) the giving and receiving of affection (Category 10), 5) freedom to pursue interests that are different from their partner's (Category 12), and 6) discussing family finances (Category 14). The remaining six categories, 3, 4, 7, 11, 13, and 15, the researcher did not classify as either strong or weak.

As a group, then, both clients and spouses have patterns of nagging, insulting, saying things that would better be left unsaid, and using an

irritating tone of voice. Moreover, each tends to feel that the other means something else than what is said. On the other hand, they feel understood and understanding about each other's feelings and attitudes. They also often do things outside the house together and talk about things interesting to both, which activities indicate a high degree of engagement in the marital relationship. Too, they have a pattern of frequently making attempts to converse, using mealtimes as an opportunity and pleasant occurances as subject matter. Both feel they often give and receive affection, both verbally and nonverbally. Both feel free to pursue his or her own interests, although the researcher suspects that this may often be the result of mutual indifference, rather than of caring. Finally, money matters pose little problem for either partner as both participate and do so co-operatively.

Relationship between client drinking involvement and marital communication

For the overall scores on the MCI of couples and spouses, the results showed that couples in which the client has a low drinking involvement, and spouses married to those clients, have a significantly higher level of marital communication than the other couples and spouses at better than a .05 level of confidence. For purposes of accepting or rejecting the null hypothesis, only a test of the overall scores for couples was necessary. Thus, the null hypothesis may be rejected and the research hypothesis accepted. The researcher has pointed out that no linear cause-effect relationship is intended here, and has said only that these two variables would be significantly related. These findings correspond to the conclusions found by Orford and his co-workers (Orford et al., 1976) and by Esser

(Esser, 1970), that family or marital functioning has much to do with an alcoholic's recovery.

The researcher further subanalyzed the scores. First, he took Categories 1-9 because they contained those 19 items Bienvenu found to be the most powerfully discriminating between the top and bottom quartiles of scores. The couples' scores did discriminate between couples with or without a client with a high drinking involvement at better than a .05 level of confidence. Similar results were obtained for couples' scores on the 19 items, i.e., a confidence level of better than .05. Moreover, both clients' and spouses' scores discriminated high involvement from low at better than a .05 level of confidence for Categories 1-9. For the 19 items, the spouses' scores discriminated at better than a .05 level.

Subanalysis was also done on Categories 10-15 because Bienvenu described the items, which the researcher distributed among these categories, as seeming to enhance or to block good communication. In this way, Bienvenu seemed to regard them as being of a different nature than those in Categoires 1-9. Here again, couples' scores discriminated according to drinking involvement at better than a .05 level of confidence.

All the several analyses of overall scores and large fractions of them showed significance for the couples at better than a .05 level of confidence. Overall scores for spouses, scores on Categories 1-9 for clients and spouses, and spouses' scores on the 19 items were also significant at better than a .05 level of confidence.

In order both to refine the findings related to the first hypothesis and to focus more sharply the description of the population, the researcher analyzed the scores on each of the categories. The expectation was that

the scores would identify those patterns most troublesome for the couples according to the drinking involvement of the client. Categories 3,8, 9, 14, and 15 showed significant results.

On Category 3 couples' scores discriminated at better than a .05 level of confidence and clients' scores at better than a .01 level. Apparently, a pattern of finding it hard to deal with anger, both one's own and one's partner's, and with disagreements is much more pronounced if the client has a high drinking involvement.

Category 8, identified by the researcher as a strong area for the whole sample, showed results for couples, clients, and spouses that discriminated drinking levels at better than a .01 level of confidence. It seems that couples with a client of high drinking involvement are much more disengaged from their marital relationship.

Category 9, also identified as a strong area for the whole sample, had scores for couples, clients, and spouses that discriminated at better that a .01 level of confidence. Couples with a client who has a high drinking involvement seem to find it much harder to make or take advantage of opportunities to converse.

Category 14, again called a strong area by the researcher, had scores for couples that discriminated at better than a .05 level of confidence. Couples with a client with a high drinking involvement less often discussed finances and, when they did, more often argued about them.

Finally, scores for couples on Category 15 discriminated the two kinds of drinkers at better than a .05 level of confidence. Couples with a client who has a high drinking involvement are significantly more uncommunicative.

From the above, one can conclude that couples in which the client has a low drinking involvement do have a significantly higher level of marital communication, do more to enhance and less to block good communication, and do not exhibit patterns that are conducive to poor communication. These are in comparison to couples with a client with a high drinking involvement. One can not say that the former couples have good communication, but their communication seems to be better than that of the other couples.

The strength of association as revealed by the correlation ratio will be discussed later in this chapter.

Relationship between spouses' drinking frequency and marital communication

The results showed no relationship between the spouse's drinking frequency and level of marital communication. This raises the question of whether the behaviour of spouse's drinking carries very much importance in the couple's system. Possibly, more refinement is needed of the instrument to measure drinking frequency. Also, the amount of drinking, even if it is not very frequent, may be relevant. In any case, from the instrument used here, the relationship between spouse's drinking frequency and marital communication is extremely small.

Relationship between spouse's drinking frequency and client's drinking involvement

Again the results were nonsignificant. A limitation here was not ascertaining a change in the spouse's drinking frequency. For the clients a baseline of some degree of uncontrolled drinking may be assumed for each although that was not necessary for this thesis. For the spouse, who has had no known pattern of drinking, what was reported on the questionnaire

might have represented a considerable change. Also, the raw data gives the impression that the relationship might be in the opposite direction from the one the researcher predicted in that spouses' drinking may be complementary to rather than symmetrical with that of the clients. This area of the marital relationship merits further consideration.

Implications

From the analyses of the data related to the first hypothesis, one notes that, except for the results for Categories 8 and 9, the values of eta, the correlation ratio, were not very high. They ranged for the significant results from 0.13 to 0.24 (except for the Categories 8 and 9). This is interpreted as meaning that the drinking involvement of the client accounts for 13% to 24% of the variance in the scores on the MCI and the different parts of its. That the strength of association does not exceed 24%, except for those results at the .01 level of confidence, is to be expected. As was stated in Chapter II, only one system out of several has been selected for study. The couple system is only one within the family system, children, family of origin, and extended family, all were ignored here. In addition, the work system, though present in this study as part of the population description, was not weighed, and job security was mentioned in the literature as a significant factor related to recovery from alcoholism (Rae, 1972, p. 613). Also, the support systems mentioned in the questionnaire were not evaluated. Systems of friendships, socializing, and church were not considered. In view of the many systems that a client and spouse participate in, that there was an association between drinking and marital communication as high as 24%, and

as high as 54% for Category 8, is impressive. One can not say for certain for this population that the couple system is the one most strongly associated with drinking, but it certainly is one of the most important. Beyond doubt it deserves much attention in a program of rehabilitation for alcoholics.

Another implication from the values of the correlation ration is that they tend to confirm some of the findings of Kogan and Jackson (Kogan and Jackson, 1964, pp. 555-557), who say that even when drinking has stopped the marital problems continue. Stopping drinking, as Esser says (Esser, 1970, p. 280), is only a negative gain, and does not in itself heal a damaged relationship. Nevertheless, to stop drinking is a major step toward that goal.

From what has been said above, this study implies that communication between spouses is a significant and relatively weighty factor related to a client's recovery. Not implied, however, is that one depends on the other for change in either. Rather, they go together as functions of the same system.

There are two implications in regard to use of help. One is that those sources named in the questionnaire are under utilized by both clients and spouses, except possibly Significant Others meetings by the spouses. The other is that the variety is very limited and more attention needs to be given to other sources.

Limitations of the Study

The chief limitation was reliance on self-report data that could not be confirmed objectively. The researcher could not observe sufficiently

communication between husband and wife nor the drinking behaviour of either. Another limitation in regard to rating marital communication was the lack of an absolute standard in order to compare sample subjects with one another and with the general population of North America, no small order in any case. This limitation could have been partly overcome by the use of a control group of couples without an alcoholic member.

Another limitation for a fuller understanding of the relationship between marital communication and drinking is the researcher's not being able, for reasons of time, to consider changes in both over time. Obviously, those clients who are abstinent have changed their drinking behaviour, but assumption of change or no change can not be made so surely for the others. Likewise for marital communication, a low score for a couple relative to the others might be a high score relative to themselves at the time of the client's treatment.

Also a limitation is the manner in which the sample was selected. Although the two lists of thirty couples was randomly drawn, only those who agreed to participate did so. In view of the proportion of clients with a low drinking involvement, 66.7%, there may have been a bias in that direction due to this self-selection.

Finally, generalizability must be limited to the population at the Connaught Clinic and to similar treatment facilities, largely due to the small size of the sample.

Recommendations

In this section are included recommendations for the program at Connaught Clinic and for further research.

Regarding the clinic's program, the researcher does not recommend any qualitative changes. He does recommend that attention to the marital relationship be increased throughout all three phases of the program. He does not go so far as to say that spouse participation be made a condition for treatment. Ideally, the researcher recommends that married clients have their own follow-up groups with spouses invited to attend.

Strongly recommended is more emphasis on follow-up, in particular ongoing follow-up at A.A. or elsewhere, and the exploration of broader community involvement in follow-up of treatment for alcoholism. A similar recommendation is made for spouses that the clinic try to involve them in seeking help related to the clients' drinking. It is the understanding of the researcher that the Connaught Clinic along with the A.R.F. is already making moves to enlist other sources of support in the Windosr community to provide long-term follow-up, and in particular agencies with a recognized competence in working with persons who are having marital problems. The researcher heartily endorses this movement.

In regard to further research, projects which do not have the previously mentioned limitations are recommended. A project is needed that measures marital communication, before or during the client's treatment as well as after. Also, clients who have a relationship analogous to a marital relationship ought to beincluded or surveyed separately. This would include boyfriend-girlfriend and homosexual relationships.

A study that uses a control group is strongly recommended. This would provide a means of comparison. The control group could be couples without an alcoholic member or couples with an untreated alcoholic. The

former control group would probably be easier to recruit.

A study on a larger scale that describes the population in terms of several systems and weighs these systems with each other in relation to drinking is the most strongly recommended direction of research. Such a study also needs, ideally, to consider changes in all the systems over time.

Summary

This chapter presented a summary of the findings of the study. It also discussed the implications of the findings and the limitations of the study. Recommendations for future programming and for further research were made.

APPENDICES

APPENDIX A

MARITAL COMMUNICATION INVENTORY

The MCI to be filled out by the husband is presented here. The one for the wife is identical except for the gender of the pronouns and references to the husband.

Directions

1. Please answer each question as quickly as you can according to the way you feel at the moment (not the way you usually feel or the way you felt last week).
2. Please do not consult with your partner while completing this questionnaire nor change any answers.
3. Honest answers are very necessary. Please be as frank as possible. Your answers are confidential. Your name is not required.
4. Use the following examples for practice. Put a mark (x) in one of the four blanks on the right to show how the question applies to your relationship.

	USUALLY	SOME-TIMES	SELDOM	NEVER
Does your partner like to talk about himself/herself?	____	____	____	____
Does he/she let you know when he/she is displeased?	____	____	____	____

Read each question carefully. If you cannot give the exact answer to a question, answer the best you can, but be sure to answer each one. There are no right or wrong answers. Answer according to the way you feel at the present time.

	USUALLY	SOME-TIMES	SELDOM	NEVER
1. Do you and your wife discuss the manner in which the family income should be spent?				
2. Does she discuss her work and interests with you?				
3. Do you have a tendency to keep your feelings to yourself?				
4. Is your wife's tone of voice irritating?				
5. Does she have a tendency to say things which would be better left unsaid?				
6. Are your mealtime conversations easy and pleasant?				
7. Do you find it necessary to keep after her about her faults?				
8. Does she seem to understand your feelings?				
9. Does your wife nag you?				
10. Does she listen to what you have to say?				
11. Does it upset you to a great extent when your wife is angry with you?				
12. Does she pay you compliments and say nice things to you?				
13. Is it hard to understand your wife's feelings and attitudes?				
14. Is she affectionate toward you?				
15. Does she let you finish talking before responding to what you are saying?				
16. Do you and your wife remain silent for long periods when you are angry with one another?				
17. Does she allow you to pursue your own interests and activities even if they are different from hers?				
18. Does she try to lift your spirits when you are depressed or discouraged?				
19. Do you fail to express disagreement with her because you are afraid she will get angry?				
20. Does your wife complain that you don't understand her?				
21. Do you let your wife know when you are displeased with her?				
22. Do you feel she says one thing but really means another?				
23. Do you help her understand you by saying how you think, feel, and believe?				
24. Do you and your wife find it hard to disagree with one another without losing your tempers?				
25. Do the two of you argue a lot over money?				
26. When a problem arises that needs to be solved are you and your wife able to discuss it together (in a calm manner)?				
27. Do you find it difficult to express your true feelings to her?				
28. Does she offer you cooperation, encouragement and emotional support in your role (duties) as a husband?				
29. Does your wife insult you when angry with you?				
30. Do you and your wife engage in outside interests and activities together?				
31. Does your wife accuse you of not listening to what she says?				
32. Does she let you know that you are important to her?				
33. Is it easier to confide in a friend rather than your wife?				
34. Does she confide in others rather than in you?				
35. Do you feel that in most matters your wife knows what you are trying to say?				
36. Does she monopolize the conversation very much?				
37. Do you and your wife talk about things which are of interest to both of you?				
38. Does your wife sulk or pout very much?				
39. Do you discuss intimate matters with her?				
40. Do you and your wife discuss your personal problems with each other?				
41. Can your wife tell what kind of day you have had without asking?				
42. Does she fail to express feelings of respect and admiration for you?				
43. Do you and your wife talk over pleasant things that happen during the day?				
44. Do you hesitate to discuss certain things with your wife because you are afraid she might hurt your feelings?				
45. Do you pretend you are listening to her when actually you are not really listening?				
46. Do the two of you ever sit down just to talk things over?				

APPENDIX B

REGISTER OF THE CATEGORIES (BIENVENU'S 19 ITEMS ARE UNDERLINED)

1. Using destructive and damaging communication

   Items 5, 9, 29, 7

2. Finding spouse's tone of voice irritating

   Item 4

3. Finding it difficult to deal with anger and disagreements

   Items 11, 19, 24, 21, 26

4. Feeling free to express feelings to spouse

   Items 44, 27, 33, 23, 27

5. Complaints about not being understood

   Items 20, 8, 35

6. Perceptions of spouse's messages as clear

   Item 22

7. Listening attentively

   Items 45, 31, 10

8. Engagement in marital relationship

   Items 30, 37

9. Making deliberate and frequent attempts to converse

   Items 46, 6, 43

10. Communicating affection

    Items 12, 14, 32, 42

11. Feeling and expressing empathy

    Items 13, 41, 28, 18

12. Supporting individuality

    Item 17

13. Showing conversational courtesies

    Items 15, 36

14. Discussing the handling of money

    Items 1, 25

15. Being uncommunicative

    Items 2, 3, 16, 34, 38, 39, 40

APPENDIX C

DEMOGRAPHIC DATA, DRINKING INVOLVEMENT QUESTIONNAIRE, AND QUESTIONNAIRE ON THE USE OF FOLLOW-UP HELP BY THE CLIENT

These three parts complete the instrument for the client. The Drinking Involvement Questionnaire, copyrighted in 1976 by Gerald L. Smith, was used by his permission and adapted for the purposes of this thesis.

PART TWO

THE FOLLOWING WILL HELP THE RESEARCHER BETTER UNDERSTAND THE INFORMATION YOU HAVE GIVEN HIM:

Age ____

How long have the two of you been living together? ____

Education

Grade 0-8 ____

Grade 9-10 ____

Grade 11-12 ____

Grade 13 ____

Technical training other than school system ____

Community College Some ____ Completed ____

University Some ____ Completed ____

Present occupation _____

Age at which problem drinking began ____

PART THREE

PLEASE ANSWER THE FOLLOWING QUESTIONS ACCORDING TO HOW THEY APPLY TO YOU OVER THE PAST THREE MONTHS.

		YES			NO
		USUALLY	SOME-TIMES	SELDOM	NEVER
1.	Did you drink any alcohol at all?				
2.	When you drank, was it to solve problems which you had?	____	____	____	____
3.	When you drank, did you get drunk?	____	____	____	____
4.	When you drank, once you started, could you stop yourself?	____	____	____	____
5.	When you drank, was it your intention to get drunk?	____	____	____	____
6.	Did you drink only when you had problems?	____	____	____	____
7.	If you stated drinking, did you continue until you became unconscious?	____	____	____	____
8.	Did you drink because drinking is a social custom?	____	____	____	____
9.	Was your purpose when you drank to make yourself unconscious?	____	____	____	____
10.	When you drank, was your purpose to avoid problems which you have?	____	____	____	____

PART FOUR

PLEASE ANSWER THE FOLLOWING QUESTIONS ON HELP YOU MAY HAVE USED SINCE COMPLETING THE THREE-WEEK PROGRAM AT CONNAUGHT CLINIC.

1. How many of the weekly follow-up meetings did you attend?

   None ___ One ___ Two ___ Three ___ Four or more ___

2. About how often have you attended A.A.?
   Not at all ___ About once a month or less ___
   About twice a month ___ At least once a week ___

3. How many individual follow-up counselling meetings did you attend at Connaught Clinic?

   None ___ One ___ Two ___ Three ___ Four or more ___

4. How many meetings of .001 did you attend at the Addiction Research Foundation?

   None ___ One ___ Two ___ Three ___ Four or more ___

5. Please name any other sources of help for drinking you have used since the three-week program.

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APPENDIX D

DEMOGRAPHIC DATA, DRINKING FREQUENCY QUESTIONNAIRE, AND QUESTIONNAIRE ON THE HELP SOUGHT BY THE SPOUSE RELATED TO THE CLIENT'S DRINKING

These three parts complete the instrument for the spouses.

PART TWO

THE FOLLOWING WILL HELP THE RESEARCHER BETTER UNDERSTAND THE INFORMATION YOU HAVE GIVEN HIM:

Age ____

How long have the two of you been living together? ____

Education

Grade 0-8 ____

Grade 9-10 ____

Grade 11-12 ____

Grade 13 ____

Technical training other than school system ____

Community College Some ____ Completed ____

University Some ____ Completed ____

Present occupation _____

PART THREE

How would you describe your own drinking, on the average, in terms of frequency, over the last three months?

a) No alcohol at all

b) Once a month or less

c) Two or three times a month

d) Once or twice a week

e) Almost every day

PART FOUR

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT HELP YOU MAY HAVE SOUGHT RELATED TO YOUR PARTNER'S DRINKING.

1. How often have you attended meetings of Alanon?

   Not at all ___ Less than once a month on the average ___
   Once or twice a month ___ Once a week or more ___

2. How many couple counselling meetings at Connaught Clinic have you had? ___

3. How many Significant Other meetings at Connaught Clinic did you attend? ___

4. If you have sought help from other sources, what are they? How many times did you use each source?

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Abbreviations:

Quart. J. Stud. Alcohol: Quarterly Journal of Studies of Alcohol

J. Stud. Alcohol: Journal of Studies of Alcohol

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VITA

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In 1975, Mr. Shriver entered the School of Social Work at the University of Windsor, earning the B.S.W. in 1976. His practicum that academic year was at the Catholic Social Services of Wayne County in Detroit. He continued the following year in the M.S.W. program at the same university. Since he had developed an interest in alcoholism, he was placed at the Connaught Clinic of Windsor Western Hospital. His experience there along with previous experience in working with families at the Catholic Social Services led to his doing this thesis.

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