1996

Spouse Enabling of Alcohol Abuse: Conception, Assessment, and Modification

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Journal of Substance Abuse, 8(1), 61–80 (1996)

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This article presents a conception of spouse enabling of partner alcohol abuse, a review of its dysfunctions, and an approach to assessment and modification to reduce spouse enabling behavior. Based on experience with its use in unilateral family therapy with many spouses of treatment-refusing alcohol abusers, procedural guidelines, treatment methods, two case examples from a crossover experimental dyad, and clinical results for the two cases in the dyad are described. Also presented are practice issues, characteristics of spouse enabling as they relate to disenabling intervention, and areas of possible application of the disenabling program.

Most spouses, as is widely recognized in alcohol and other substance abuse treatment, help in some way to foster the alcohol abuser's drinking. For example, it is not uncommon to find that the spouse purchases alcohol for the drinker, participates with the drinker in social activities where alcohol is served, and drinks with the drinker. Although spouse enabling is not viewed as necessarily causing excessive drinking, it may help sustain or increase the abuser's drinking, entail dysfunctions for the spouse, and, as such, it may be viewed as part of the drinking problem.

Because enabling is generally thought to be pervasive in families having members who abuse alcohol, treatment with family members of alcohol abusers frequently includes efforts to reduce the enabling. Al-Anon typically provides literature to help its members recognize and stop enabling and a self-help forum for discussion of this and related issues. Counselors of family members of alcoholics also commonly

The research reported here was supported in part by Grants 1 R01 AA04163-01 to 03 and 5 R01 0004163-04 to 07 of the National Institute of Alcohol Abuse and Alcoholism, Edwin J. Thomas, Principal Investigator. The authors wish to acknowledge the contributions of Cathleen Santa, Denise Bronson, and Joanne Yaffe in the pilot phase of the research and of Kathryn Betts Adams, Joyce Cunningham, and David Moxley in the evaluation phase. We also thank the editorial reviewers for their constructive comments on the manuscript.

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employ educational and self-help literature as aids to assist family members to give up enabling (e.g., see Johnson, 1986; *The Family Enablers*, 1987).

Several examples of specific treatment procedures applicable to enabling have been reported. These include a group treatment program for the wives of alcoholics containing some sessions on enabling that was found in a pre-post evaluation to reduce enabling (Dittrich & Trapold, 1984), a case study of a couple illustrating procedures to decrease spouse behaviors that could trigger or enable abusive drinking of a male alcoholic (McCrady, 1982), and confrontation of family members in an intensive substance abuse treatment program with specific instances of ways in which they had enabled the substance abuse of their adolescent children, as identified by the adolescents (Potter-Effron & Potter-Effron, 1986). In general, however, the means of assessing and modifying spouse enabling of alcohol abuse have been relatively undeveloped. Further work is needed on methods to make possible the systematic assessment and modification of spouse enabling.

This report presents a conception of enabling, the rationale for reducing enabling behavior, and a program intended to reduce spouse enabling. The disenabling program was developed as one of several components of a unilateral approach to alcohol abuse in which a cooperative spouse is assisted to influence an uncooperative alcohol-abusing partner to stop drinking, enter an alcohol treatment program, or both (Thomas, 1989; Thomas & Ager, 1993; Thomas & Santa, 1982; Thomas, Santa, Bronson, & Oyserman, 1987). This article describes the spouse disenabling program and related procedures of assessment; methods of planning, assigning, and monitoring the program; conditions under which to use it; illustrative case examples and outcomes drawn from a crossover experimental dyad; other clinical results and practice issues; and potential uses of the program.

SPOUSE ENABLING AND THE NEED FOR ITS MODIFICATION

Types and Functions of Enabling

Enabling of alcohol abuse involves those influences of an individual, family, organization, or institution that may serve to facilitate or sustain the alcohol use of one or more drinkers. Although stated more broadly, this conception is consistent with most viewpoints on spouse and/or family enabling of alcohol abuse offered in the literature (e.g., Doweiko, 1990; Johnson, 1973; Levinson & Ashenberg-Straussner, 1978; Mapes, Johnson, & Sandler, 1984). Excluded from this conception of enabling are efforts of the spouse or others to reduce the alcohol consumption of the drinker (e.g., nagging about the drinking or threatening divorce if the drinker does not stop drinking).[1]

In this conceptualization, enabling is made possible by two main factors: (a) potential influencers (e.g., interpersonal, social, physical, or environmental vari-

[1]Such efforts are more accurately regarded and measured as drinking control behaviors rather than as enabling (Thomas, Yoshioka, & Ager, 1994b). Like enabling, however, customary, pre-intervention drinking control behaviors of spouses can be dysfunctional for all involved (e.g., see Homila, 1985; Wiseman, 1980; Yoshioka, Thomas, & Ager, 1992) and merit assessment and intervention on their own terms (Yoshioka et al., 1992).

ables and/or conditions) that may increase or decrease the target behavior in question combined with (b) an action of one or more agents (e.g., spouses, family members, or events) that serves to accelerate or decelerate the potential influencers. Consider the example of a spouse who buys the beer for his or her alcohol-abusing marital partner. When specified in terms of the above components, the spouse is the agent whose purchase accelerates (i.e., makes available) a potential increaser—the beer, in the case of this drinker—of the abuser's drinking as the target behavior.

There are two basic classes of enabling, depending upon which aspect of the abuser's behavior is the principal target of the enabling influence. With *direct enabling*, the potential enabling influence acts primarily on some aspect of the abuser's drinking behavior or its consequences which, in turn, may serve to sustain or increase the drinking, whereas, with *indirect enabling*, the potential enabling influence acts mainly on some aspect of the abuser's nondrinking behavior which then may serve to sustain or elevate the drinking behavior. When these conceptual distinctions are applied to spouse enabling phenomena, it is possible to identify two types of enabling for each basic class, with each type being logically and behaviorally distinct.

Direct enabling is comprised of two types identified earlier in the context of measuring enabling behavior (Thomas, Yoshioka, & Ager, 1994a). Type I enabling pertains to those behaviors (or events) that serve to accelerate potential increasers of the abuser's drinking, such as indicating to the drinker that it is okay to drink, suggesting attending activities and social events where alcoholic beverages are served, and offering alcoholic beverages to the drinker. Type II enabling consists of those behaviors (or events) that decelerate potential decreases of abuser drinking. Examples of this type include cleaning up the abuser's alcohol-related messes, avoiding social contacts to cover up the abuser's drinking, making excuses to others for the abuser's drinking, and calling in sick for the abuser when he or she misses work because of the drinking. Enabling of the second type serves to cushion or protect the drinker from the adverse consequences of the drinking, thereby also promoting or sustaining the abuser's drinking. It is our impression that this second type is the aspect of enabling most often noted in the alcohol treatment community. Both types, however, are commonly encountered and would appear to be equally important.

The other two are types of indirect enabling in which the enabling is initiated through reductions in particular nondrinking behavior of the abuser. Like drinking behavior, nondrinking behavior has its own increasers and decreasers such that when the nondrinking behavior is diminished, as was indicated, drinking behavior can be increased. In Type III enabling, the behaviors (or events) serve to decelerate potential increasers of the abuser's nondrinking behavior. For example, the spouse persuades the drinker not to attend his alcohol treatment session so that they can go to a movie together, or the spouse interferes with the pursuit of a hobby that the drinker engages in only when sober. Type IV enabling pertains to those behaviors (or events) that serve to accelerate potential decreasers of nondrinking behavior. For example, the spouse acts so as to heighten the level of stress, anxiety, frustration, or conflict of the drinker which thereby precipitates the marital partner's return to

drinking.[2] Although spouse enabling of any kind may trigger the drinker's relapse, some of the high-risk conditions for relapse identified by Marlatt (1985) could be potential decreasers of nondrinking behavior (e.g., negative emotional or physical-physiological states and interpersonal conflicts).[3] It is our impression that in contrast to the direct types, behavior reflecting the indirect types is less often thought of as being a form of enabling.

As social influence, enabling is seen as part of an "alcohol influence system" that takes place in the interaction of the spouse with the drinker and which is in operation prior to treatment for the spouse or other family member. Spouse enabling also may be thought of more generally as one aspect of how the spouse copes with the drinking (e.g., see Jackson, 1954; James & Goldman, 1971; Orford et al., 1975; Rychtarik, 1990) and as an accommodation that may help stabilize and maintain the equilibrium of the marital/family system (e.g., see Bowen, 1974; Kaufman, 1985; Steinglass, Bennett, Wolin, & Reiss, 1987; Steinglass, Weiner, & Mendelson, 1971).

Some Dysfunctions of Enabling

Spouse enabling no doubt has some adaptive functions, as already implied and as noted further in the discussion. However, the focus here is on the dysfunctions for the spouse and alcohol abuser. Among the dysfunctions of spouse enabling are that it can serve to (a) burden the spouse with household, family, and other responsibilities previously assumed by the alcohol abuser (e.g., see Bepko & Kerstan, 1985; Gacic, 1982; *The Family Enablers*, 1987); (b) relieve the drinker of taking responsibility for his or her drinking behavior (e.g., see Bepko & Kerstan, 1985; Johnson, 1986, 1990; Levinson & Ashenberg-Straussner, 1978); (c) deny the importance and severity of the drinking (e.g., see Cermak, 1986; Johnson, 1986, 1990; Mapes, Johnson, & Sandler, 1984); (d) keep the spouse overinvolved in the drinking and its effects (e.g., see Doweiko, 1990; Liepman, 1994; *The Family Enablers*, 1987); and (e) be an aspect of what some writers have called the codependency of the spouse with the drinker (e.g., see Pinkham, 1986; Schaef, 1986; Whitfield, 1989).

In addition, spouse enabling may negate, sabotage, or otherwise interfere with treatment-based interventions. By engaging in enabling, the spouse sends a mixed message to the drinker that runs counter to having the spouse function as a positive rehabilitative influence. A family milieu supportive of nondrinking has been described as one of the components necessary to maintain abstinence during the initial recovery phase (Cronkite, Finney, Neknich, & Moos, 1987; McCrady, 1989). Following recovery, the spouse's enabling may help precipitate the partner's return

[2]As these examples may suggest, enablers can have hostile motives (e.g., see Liepman, 1994), and such negative motivation may be more common in Types III and IV enabling than in the other types. However, although Types I and II enabling may arise more often from more benign motivation (e.g., to be caring, protective, or nurturant), enabling of these types may also grow out of fear of what the drinker might do if the enabling were reduced. Beyond clinical impressions, little is known here.

[3]However, some other high-risk situations identified by Marlatt (e.g., social pressures to drink) could be illustrative of Type I enabling.

to drinking, help sustain relapse, or otherwise help keep the partner from maintaining sobriety.

By discontinuing his or her enabling, the spouse may be helped to give up dysfunctional involvement, achieve emotional distance from the drinking and its impact, and possibly also increase his or her independence and empowerment (Burnett, 1984). Spouse enabling needs to be reduced sufficiently so that its ill-effects and dysfunctions are diminished and the spouse can be assisted to adopt more therapeutically beneficial behavior.

THE DISENABLING PROGRAM

The focus of the disenabling program was on reducing Types I and II enabling, because these were almost exclusively the types encountered in the pilot and evaluation phases of the research. As the direct and more readily observable kinds of enabling, Types I and II provide numerous, appropriate cases in point for developing an approach to the assessment and modification of spouse enabling. Although the program was based on these two types, the principles, procedures, and issues addressed presently appear to be applicable to all the types. The generalizability of the present work, of course, depends upon corroboration in further clinical research.

The disenabling program was developed, as indicated earlier, as part of the broader program of unilateral family therapy for alcohol abuse. In the unilateral approach, cooperative, non-alcohol-abusing spouses (or other family members) are assisted to influence their treatment-refusing alcohol-abusing partners to stop drinking, enter treatment, or both (Thomas, 1989; Thomas & Ager, 1993; Thomas & Santa, 1982; Thomas, Santa, Bronson, & Oyserman, 1987). In this treatment, abuser-directed interventions, such as a programmed confrontation or request (Thomas & Ager, 1993; Thomas & Yoshioka, 1989), are among the interventions carried out by the spouse after she or he has been assisted to assume a rehabilitative role. As part of helping the spouse to take on this new role, she or he is given the disenabling program and several other treatment modules (Thomas, 1989), including unilateral relationship enhancement (Thomas, Adams, Yoshioka, & Ager, 1990) and modification to reduce customary drinking control behavior (e.g., nagging about the drinking; Yoshioka et al., 1992).

Reduction of enabling is not intended nor expected to bring about a reduction in the drinking on its own, although such an outcome might occur in some instances. Rather, as indicated, the objective of disenabling is to help make way for the spouse to assume a more positive rehabilitative role. Although developed for use in the unilateral approach, the program presented here also is seen as capable of being employed as part of other treatment approaches in which a goal is to reduce the dysfunctional behavior of a family member.

A distinctive feature of the program is that an individualized change regimen is formulated for each participant in which specific enabling behaviors are identified, specified, and chosen for modification; and disenabling alternatives are targeted and their changes monitored. An important part of the individualization is that particular attention must be paid to the feasibility of change, recognizing that some

disenabling behaviors are potentially disruptive of marital/family relations, difficult to change, or dangerous.

Orientation and Identifying Enabling Behaviors

Clients were introduced to the disenabling program early in treatment by identifying particular instances of enabling that might be potential targets of change. To facilitate the process of identifying such potential targets, the Spouse Enabling Inventory (SEI) was employed, which makes it possible to assess the frequency of 47 enabling behaviors.[4] The therapist reviews the spouse's responses on this inventory, which should be completed prior to treatment. Each item for which the spouse reports having engaged in the behavior occasionally or more over the past 6 months (i.e., which was given a score of 3 or above, signifying occasionally or more) is flagged as a potential target of change and is listed by the therapist on a separate piece of paper.

If the SEI is not used, however, the therapist must decide how best to obtain information from the spouse about his or her enabling, realizing that this may be a sensitive topic for some spouses. Ranging roughly from the more to the less direct, some alternatives include: (a) explaining the concept and asking for examples of the spouse's past or present behavior that may have made it easier for the abuser to drink; (b) posing such questions as "Have you ever found yourself making excuses for the drinker's alcohol-related behavior?" or "Have you taken over any of your partner's responsibilities because of the drinking?"; (c) supplying common examples of enabling and/or assigning reading material (e.g., *The Family Enablers*, 1987) as aids to help trigger the spouse's recognition of his or her enabling behaviors; or (d) continuing with other treatment issues until the spouse happens to mention an instance of his or her enabling (a common occurrence) and to use that instance as the point of entry to explain the concept and obtain other instances. All spouse mentions of enabling behaviors are listed, as before, on a separate piece of paper.

The therapist and spouse then review each of the behaviors on the list to obtain specific examples of the enabling behavior and characteristic abuser reactions.[5]

[4]The items of the SEI were inductively derived from instances of spouse enabling that occurred in the pilot phase of the project and from related reading (e.g., Orford et al., 1975). The inventory is intended as a clinical and research tool. For each item, the spouse is asked to indicate how often he or she has engaged in that behavior over the past 6 months. Response options are *never* (5), *rarely* (4), *occasionally* (3), *frequently* (2), and *always* (1), and are reversed in direction for scoring. In addition to a total enabling score, the instrument provides scores for Types I and II enabling. The inventory, its subscales, and preliminary psychometric results are described in Thomas, Yoshioka, and Ager (1994a). Additional psychometric properties of the SEI are to be reported elsewhere.

[5]If the SEI is used, the list prepared from the inventory is presented to the spouse without indicating that these were the items the spouse responded to earlier with moderate to high endorsement. The list is described as some examples of the behaviors many spouses living with the problem drinker have employed in trying to cope with the problem drinking. Reviewing the actual SEI responses of the spouse could have biased his or her subsequent item endorsement in the later research assessments. Interestingly, as it turned out, none of the spouses seemed to connect the list with their earlier SEI responses, yet they could readily acknowledge that they engaged in the enabling behaviors in question when presented with the items on the list.

With these instances now before them, the therapist provides further orientation to the concept of enabling. The spouse is told that most spouses commonly engage in some form of enabling—usually unintentionally—and that they should not feel to blame for having acted in these ways. The spouse is told that the aim of this aspect of the treatment is to reduce the enabling to make way for introducing new ways of responding that can support abstinence and an alcohol-free lifestyle.

Determining Feasibility of Change

The therapist should review the enabling behaviors on the list to determine their feasibility for change. In so doing, the therapist needs to consider with the spouse the extent to which the spouse has the ability and willingness to change and the possible consequences of change with regard to such matters as marital distress, the abuser's employment, and the safety of the abuser and others.

What often appears at first to be a minor and easy item to change can turn out to be much more. For example, one spouse reported that she always bought the lemons and tonic water for her husband's cocktails in her weekly shopping. It turned out that this was part of a long-standing arrangement with the couple, the woman had never taken a firm stance against the drinking throughout the marriage, and she strongly opposed the idea of discontinuing the purchase of these items. It appeared that her not buying these items would have constituted a substantial intervention on its own at a time when she and the therapist were planning to conduct a major abuser-directed intervention. The therapist consequently passed over this item in favor of other disenabling changes that were judged to be less potentially disruptive.

Disenabling behaviors that could produce more serious consequences (e.g., threaten the abuser's ability to keep a job because the spouse will no longer make excuses for the drinker to the employer) generally call for introducing disenabling alternatives that could be less disruptive. In this example, these might include having the spouse refer all employer inquiries about the drinker to the drinker for response.

In regard to safety, the spouse must be informed that his or her disenabling efforts should at no time endanger the safety of the spouse, the abuser, or others. If the spouse identifies a disenabling response that might lead to harm for him or her, that response should be passed over. Thus, responses that risk domestic violence for either partner should be foregone. Spouses should not hesitate to drive for the abuser, obtain another sober driver, or otherwise be of assistance when the abuser is too inebriated to function safely in that situation.

Selecting Targets

In addition to feasibility, there are other questions of target suitability. Some enabling behaviors may be particularly problematic or "serious" and thus merit high priority for change. Examples include buying the alcohol for the drinker, mixing, preparing, or getting the drinks for the drinker, drinking with the drinker, suggesting going to bars, and arranging drinking parties that the drinker would

attend.[6] Furthermore, high-frequency enabling behaviors should generally have greater enabling potential than low-occurrence enabling and thus also merit early attention.

Selecting Disenabling Alternatives

The spouse's willingness to reduce the enabling for the behaviors surviving the screening is then sought. If the spouse is willing, the behaviors are specified, if not done so earlier. The list is then reviewed with the spouse to choose those behaviors easiest to change in the first step of intervention, with more difficult items introduced in subsequent steps. Initially, the spouse is generally assigned three enabling behaviors to change, and, as progress is made in changing them, the others are added in subsequent sessions, usually also in groups of up to three.

A disenabling alternative is identified for each behavior in the target set, beginning with those selected for the first step. As indicated, there are generally several disenabling responses available as substitutes for any given enabling behavior, with some alternatives typically being more suitable than others, given the spouse's situation. *Complete discontinuance* of enabling is of course to be preferred (e.g., no longer going to bars with the drinker or drinking with him or her). Sometimes, however, stopping completely may not be feasible or appropriate because, as mentioned, complete discontinuance could result in risks of harm for the spouse or abuser and other adverse effects.

In such instances, responses involving something less than complete discontinuance may be suitable. *Modified discontinuance* can be achieved in several ways. For example, the spouse (a) may not enable as often (e.g., making excuses for the drinker to the employer only some of the time) or (b) may not enable as much (e.g., retaining a small bottle of spirits in the home for selected guests in contrast to keeping a fully supplied liquor cabinet). When the risk of potential harm from disenabling varies from high to low, the spouse may use (c) discretionary disenabling (e.g., influencing the abuser to go to restaurants that do not serve alcohol only when the spouse judges that it would be unlikely to result in an argument or other marital disruption, but not otherwise). Still another is (d) experimental discontinuance, suitable when there are reasons to proceed provisionally and with caution. Here, the spouse could be asked to carry out given disenabling responses on a trial basis for a short period, say a week, with him or her reporting back to the therapist to re-evaluate such matters as potential for conflict, disruption, or danger.

In all cases, the spouse and therapist work collaboratively in identifying, selecting, and determining the feasibility and suitability of the disenabling alternatives so that the disenabling plan is carefully individualized and acceptable to the spouse and therapist, given available information.

Spouses are requested to refrain from drinking alcoholic beverages during the period of treatment. It is explained that by not drinking, the spouse reduces his or

[6]To reduce potential respondent defensiveness and questionnaire bias, the items of the SEI were ordered to range generally from less to more problematic, as determined by the research team following careful evaluation of the items.

her involvement in the drinking pattern, sets a good example, and conveys the seriousness of the spouse's intentions and commitment to changing the abusive drinking.

The spouse is cautioned not to expect that the disenabling program, by itself, will bring about any reduction in the drinking. In the unilateral approach, the program is described as one of many changes to be introduced as part of preparation of the spouse to carry out an abuser-directed intervention. The spouse is generally asked not to reveal the goals of the program to the drinker, to carry out the program without explanation, and otherwise to keep the program in low profile. However, if the abuser should inquire about why an enabling behavior has changed, the spouse might find it useful to say "I don't feel comfortable doing this anymore," "I don't feel comfortable doing this because it is enabling your drinking," or "I think drinking has become a problem in our lives, and I'm changing my drinking [or other enabling behavior] in light of this."

Monitoring

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

The therapist may wish to monitor the spouse's progress from week to week by reviewing how things are going with each item on the targeted list or by inquiring in general whether there were any instances of enabling since the last session. If closer monitoring is desired, the spouse may be asked to record the enabling and disenabling behaviors that were observed on a recording form prepared for that purpose.

The disenabling program, once worked out, should remain more or less in place throughout the treatment period. However, as a result of the monitoring, it may be necessary to make some adjustments, depending on such factors as the spouse's progress, program adherence, and abuser reactions to the spouse's new responses.

Handling Difficulties and Special Problems

Occasionally a spouse will object to a proposed change of enabling. If not known already by other means, the therapist should look into the basis for the spouse's resistance and respond accordingly. One basis for resistance is spouse misunderstanding. For example, some spouses may be reluctant to alter their enabling on grounds that they do not believe that these behaviors have any influence on the abuser's drinking. After reiterating that the program, by itself, is not intended to change the drinking problem, the therapist can indicate that enabling is largely dysfunctional and counterproductive in light of the treatment goal to help the

drinker progress toward recovery, and, that by reducing the enabling, any spouse support of, or unwitting collusion in, the drinking is thereby reduced.

When lifestyles are affected by the disenabling, their change can sometimes occasion opposition. For example, one spouse and her mate enjoyed frequent entertaining in their home which was highly appropriate given their social and professional standing. However, at these parties, the abuser drank large amounts of alcohol and the spouse also liked to drink, although she drank considerably less. When she was asked if she would agree to refrain from holding cocktail or dinner parties in their home for at least the duration of treatment, she resisted it, stating that she felt she was being punished for her husband's drinking problem. After pointing out how she was also deeply involved in the drinking lifestyle and how it could interfere with the spouse treatment program, she agreed to reduce the frequency of such entertaining and make other changes in her social activities to support the objectives of the treatment.

The spouse also may resist changing because the enabling behaviors are linked by the spouse with his or her way of carrying out the marital role. For example, enabling may represent nurturing (e.g., making hangover remedies for the drinker), being comforting (e.g., excusing the drinking excesses of the alcohol abuser), or caring (e.g., buying the alcoholic beverages or cleaning up alcohol-related messes). The situation was so extreme with one spouse that she thought of her enabling as her only way of expressing affection in the marriage. This type of overinvolvement in the enabling can be reduced by helping the spouse to separate the enabling and its dysfunctions from the marital role and, if appropriate, to assist the spouse to find other ways to enhance the marital role.

METHODS

The disenabling component was used with a total of 68 spouses of treatment-refusing alcohol abusers in the course of developing and evaluating the unilateral treatment program. The spouses had been screened according to eligibility criteria, including an absence of domestic violence, no other drug abuse on the part of either partner, no history of severe emotional disorder, and no immediate plans for marital dissolution.

Each of the two cases presented here is a single-case experimental study linked together as a crossover experimental dyad. The dyad was taken from the set of dyads used in the experimental evaluation phase of the research. In composing the dyads, the first case of each successive pair of eligible spouses enrolling in the unilateral treatment program was randomly assigned to receive either 6 months of immediate treatment or 6 months of treatment delayed for 6 months.[7] Both spouses in each dyad were assigned to the same therapist. Thus, each crossover experimental dyad is in effect a replicated single-case experiment inasmuch as the intervention is essentially repeated, first with the spouse who received immediate treatment and then with the spouse who received delayed treatment.

[7]In the pilot phase, treatment lasted 4 to 6 months.

In the following case examples, Case A received immediate treatment and Case B received delayed treatment. Although not necessarily exemplary, the cases were chosen because they illustrate many aspects of the disenabling assessment and treatment procedures and the relatively favorable treatment outcomes that a disenabling program can achieve. In addition, the cases were chosen to illustrate the two alternative ways to identify enabling behaviors described earlier. That is, the first case illustrates development of a spouse's program by use of the interview, whereas the second case is an example of the assessment of enabling with the aid of the SEI. The efficacy of the treatment was determined for both cases by changes in SEI scores of targeted and nontargeted enabling behaviors measured at enrollment and at three successive 6-month intervals.[8]

Case A

Mr. and Mrs. A were both in their 40s and professionally employed outside the home. Mrs. A described their marriage as generally rewarding, although she was angry about a DUI charge that Mr. A had recently received. Mr. A's score on a spouse-rated version of the MAST was 17, which is considerably higher than the cutoff of 5 considered to be indicative of alcoholism (Selzer, 1971).[9]

During the second session, the therapist introduced the concept of enabling, a concept with which Mrs. A said she was familiar. She indicated matter of factly that she did not enable the drinking. Even so, she was willing to take some reading material that the therapist provided on the topic of enabling "to see if it might apply in any way to your situation" (she was provided with *The Family Enablers*, 1987, of the Johnson Institute).[10]

In the following session, Mrs. A reported having read the pamphlet and maintained that she did not enable the drinking. The therapist then reviewed a list of illustrative enabling behaviors with her in an attempt to jog her memory. This resulted in the identification of the following three enabling behaviors: buying the alcohol for the home, drinking with her husband, and going with him to restaurants that served alcohol and where he invariably drank. The therapist indicated that engaging in at least some enabling was very common in marriages having an alcohol abuser and that she was not to assume that she was thereby responsible for Mr. A's alcohol problem. She was reminded, however, of what some of the dysfunctions of enabling were and was briefed on the possible benefits of discontinuing the ena-

[8]Although the SEI was given to all spouses in the evaluation phase of the research, its use for the clinical assessment of enabling had not yet been solidified when Case A (the first in this series to receive unilateral treatment) entered the project. By the time Case B started (the second such case in this series), the procedure for the clinical use of the SEI was in place, thus fortuitously making possible this comparison of the two methods of identifying enabling behaviors. The other procedures were otherwise the same for both cases, particularly the intervention, which was the critical factor being evaluated in the dyad.

[9]Research has shown that there is generally a high degree of correspondence between collateral reports of abuser drinking behavior and the self-reports of abusers (e.g., see Leonard, Dunn, & Jacob, 1983; McCrady, Paolino, & Longabaugh, 1978; Midanik, 1982; Morse & Swenson, 1975; O'Farrell, Cutler, Bayog, Dentch, & Fortgang, 1984).

[10]The therapist was not aware of the SEI scores of Case A.

bling at this point when they were attempting to set up conditions favorable for conducting subsequent abuser-directed interventions. Mrs. A then volunteered that she thought she could change the enabling behaviors successfully. The two agreed that all three behaviors would be targeted simultaneously, and she was asked to begin to refrain from behaving in these ways.

Over the weeks of treatment, the therapist continued to inquire periodically about how Mrs. A's disenabling efforts were progressing, and, by all reports, she appeared to successfully eliminate the targeted enabling.

Concurrent with the disenabling program, the therapist and Mrs. A worked together to formulate an abuser-directed intervention which was subsequently delivered by her to Mr. A. In response, Mr. A. agreed to see an alcohol therapist, but later he canceled an appointment that had been arranged for him. However, after the disenabling program was introduced, Mr. A reduced his drinking substantially.

Case B

In their late 40s, Mr. and Mrs. B were both self-employed with two adult children still living at home. Other than Mr. B's heavy drinking and Mrs. B's distress and anger about it, the marriage was stable and reasonably satisfactory for the couple. Mrs. B had noted that over the past 6 years it took increasingly smaller amounts of alcohol for Mr. B to become intoxicated and that he was experiencing increasing difficulties with his memory. His spouse-rated MAST score was 16.

In the sixth session, the therapist introduced the concept of enabling after Mrs. B had mentioned in another context a recent occasion when she and Mr. B had gone out for cocktails. Mrs. B's drinking with her husband was then used as an example of spouse behavior that could be enabling by helping to support the abusive drinking. After the therapist added that refraining from drinking with the abuser was a way to model abstinence and self-control, Mrs. B agreed to stop having drinks with Mr. B for the period of the program.

Based on her responses on the SEI taken before entering treatment, the therapist prepared a list of the items endorsed at the level of occasionally or more and, without indicating its source, presented it to Mrs. B with the explanation that these were some examples of the ways some spouses enable drinking. She was then asked if any applied to her situation. The therapist learned that of the behaviors for the nine items thus endorsed, Mrs. B said she had discontinued four, leaving five as potential candidates for change (Items 7, 12, 27, 33, and 35). The behaviors in question were then specified further and examined for their feasibility for inclusion in the change program.

Mrs. B was reluctant to forego all social events at which alcohol might be served (Item 7). The accommodation that seemed most appropriate was that she forego only those social activities that involved the conspicuous serving of alcohol and that did not require her attendance.

In reference to helping her husband find things lost while drunk (Item 12), Mrs. B reported that her husband often misplaced his car keys when drunk and then required her and her children (who were adults) to find them for him. The therapist pointed out that finding her husband's keys for him was most probably

cushioning some of the ill effects of his drinking and was another form of enabling. In light of the risks of Mr. B driving while drunk, the therapist firmly recommended that Mrs. B and her children not help Mr. B locate his car keys after he had been drinking. Mrs. B indicated that this would be a big change for them and Mr. B would not like it, but that she did not anticipate any serious consequences.

In connection with preparing dinner for her husband to reduce the effects of the drinking (Item 33), Mrs. B wondered whether she should stop making dinner every night. The therapist clarified that preparing a routine family meal should be distinguished from the enabling involved in especially preparing food for an inebriated abuser to help him sober up.

After the remaining items had also been discussed, Mrs. B indicated her willingness to reduce the enabling and to do so for all five behaviors at the same time. During the following weeks, the therapist's monitoring indicated that, in the main, Mrs. B was successful in stopping these behaviors, although she periodically mentioned difficulties. For example, she reported that although she and her children no longer helped her husband look for his car keys if lost when he was drunk, her children still had reservations about this change. Suggestions were made to her about how she might further justify the change to them, and she again agreed to solicit their continued help in refraining from this behavior. The therapist praised Mrs. B's progress here in disenabling as he did in the other instances throughout the program.

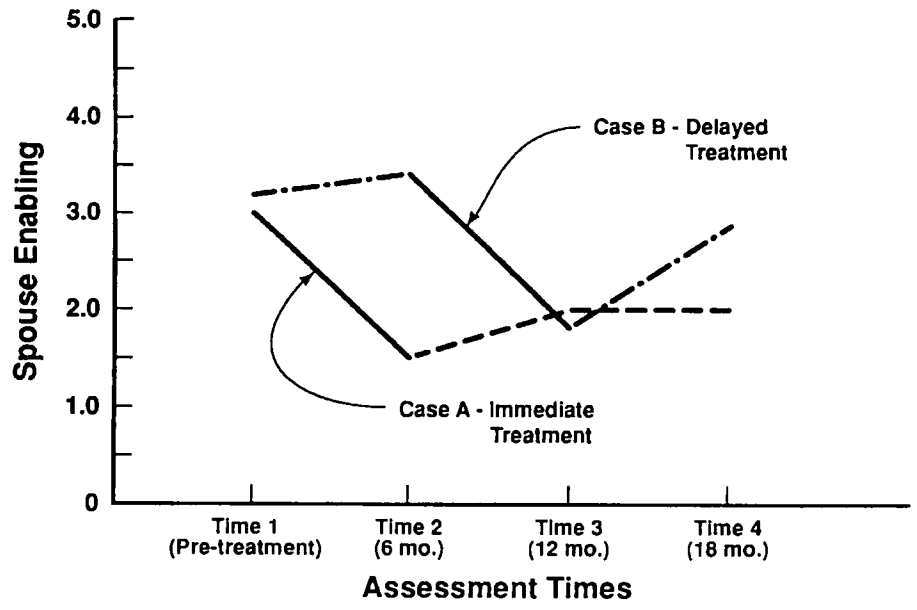
Concurrent with the disenabling program, the therapist and Mrs. B planned two abuser-directed interventions, the first was enlisting the assistance of the family physician and the second was a programmed request by the spouse deemed appropriate in her situation. In response to carrying out the interventions, Mr. B attended an evaluation at a community agency and later entered treatment.[11] Earlier, after introduction of the disenabling program, Mr. B also reduced his drinking substantially.

RESULTS

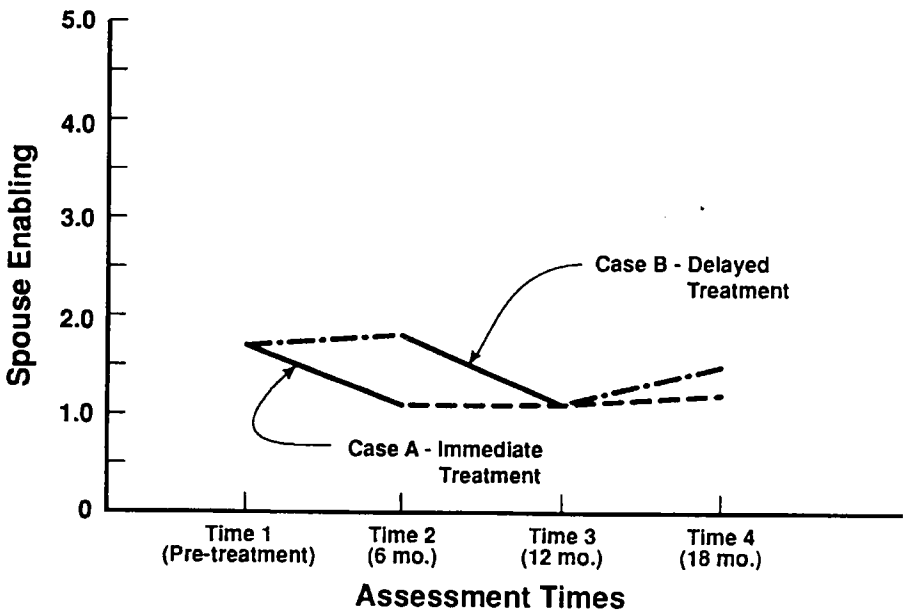
The disenabling program was successful in reducing the targeted enabling behaviors (see Figure 1a). Compared to baseline, for both cases, the targeted enabling scores of the SEI fell during and in the intervals immediately after treatment (treatment segments are indicated by solid lines in the figures).[12] For Case A (immediate treatment), there were large score reductions for Interval 1–2, whereas, for Case B (delayed treatment), there were analogous reductions in Interval 2–3. Similar results were obtained for both cases for enabling behaviors that were not targeted, as reflected in the total SEI scores (see Figure 1b). The reductions largely remained diminished for Case A for Intervals 2–3 and 3–4, whereas there was some

[11]Given that the research was funded to evaluate the spouse treatment program, alcohol treatment for the abusers, when they were ready to enter treatment, had to be provided outside the project.

[12]Because the SEI was not used in the development of Mrs. A's disenabling program, it was necessary to use SEI items that corresponded with the enabling behaviors targeted in that program. This could be done for two of the three targeted behaviors—buying alcohol (Item 10) and drinking with the drinker (Item 45).



a. Targeted Enabling Behaviors



b. Total Enabling Behaviors

Figure 1. Mean Spouse Enabling Scores of targeted and total behaviors of Cases A and B of the same crossover experimental dyad, by assessment times.

rebound for Case B for the posttreatment Interval 3–4, but not to the pretreatment levels.

Considering the 68 cases enrolled in the larger studies, the number of items targeted in disenabling interventions ranged from 2 to as many as 10 or more, with the typical number falling between 2 and 5. Occasionally, all the items endorsed by the spouse survived the screening to become targets for intervention, but in most cases, some items were screened out. When a large number of items were identified as targets of change, a few spouses attempted to reduce them all concurrently, when that seemed feasible, but typically behaviors were targeted three at a time, as indicated.

In the main, the spouses agreed to try to reduce the enabling, the program was readily introduced and implemented, and the spouses stayed with it without alteration or removal of target items. Although the large majority of programs called for complete discontinuance of targeted enabling behaviors, with modified discontinuance used only rarely, there was variation in program stringency and spouse compliance. Most of these differences reflected the individualized and flexible application of the program, given considerations of feasibility and spouse motivation to change. And, of course, there was also variation in the success of the disenabling programs, with not all cases necessarily displaying as much reduction in enabling as there was for those reported here.[13]

No adverse effects of the disenabling changes were observed for the spouses or their drinking marital partners during and after the disenabling intervention or at the follow-ups.[14] This is in accordance with the intent of the program which, as indicated, placed emphasis on the careful, stepwise preparation and engagement of the spouse and on introducing disenabling alternatives selectively and individually after having determined that making the proposed changes was feasible. However, if therapist efforts to reduce enabling are made without giving attention to the potential risks of disenabling noted earlier and to disenabling program procedures, such as those described here, the therapist could increase potential harm for the spouse and/or the others involved.

DISCUSSION

There are three relatively distinctive aspects of spouse enabling that merit emphasis because of their particular relevance to any effort to reduce enabling. The

[13]In the aggregate, however, enabling scores also were significantly reduced for the 42 spouses who received unilateral treatment in the evaluation phase of the research, as tested by repeated measures ANOVAS. The reductions in SEI scores could not be attributed to reductions in abuser drinking associated with the unilateral treatment programs, as indicated by an ANCOVA with reductions in abuser drinking as the covariate. These and other outcomes of the experiment to evaluate the unilateral approach go beyond the focus here and will be reported elsewhere.

[14]Beneficial outcomes without accompanying adverse effects were also found for the other components of the unilateral family therapy approach in the pilot phase (Thomas et al., 1987) and in the experimental evaluation (for a preliminary report, see Thomas, Yoshioka, Ager, & Adams, 1990, June). Likewise, no adverse effects have been reported in studies of confrontation interventions with alcohol abusers patterned after those employed by the Johnston Institute (e.g., see Liepman, 1993; Liepman, Nirenberg, & Begin, 1989; Logan, 1983).

first is that spouse enabling is largely an externally defined problem that carries some negative evaluation and stigma. It would be the rare spouse who complained of his or her enabling and sought help for it. Yet, in our experience, all spouses living with an alcohol abuser enable their partner's alcohol use one way or another. Most spouses do not like to think of themselves as enablers, and some become defensive if the idea of their possible enabling is not carefully introduced. Even if they know the word, however, most spouses have diverse notions of what enabling means, have some trouble at first in connecting the concept to their own behavior, and, in some cases, will simply deny that they engage in any enabling.

Unaided by proper assessment, then, the many ways in which a spouse can engage in enabling remain largely unknown. Recall that initially Mrs. A denied that she enabled Mr. A's drinking. However, following assessment of her enabling by interview, three enabling behaviors were finally identified. And all the while, her pretreatment SEI total enabling scores were as high as those for Case B (see Figure 1). Although the interview made possible the identification of enabling behaviors for Case A and for the spouses in the earlier pilot phase, the SEI is superior in that it can be completed rapidly and yields a quantitative profile of enabling behaviors that can be used by the therapist to pinpoint potential intervention targets and to monitor and evaluate program change.

A second noteworthy characteristic of spouse enabling is that it is highly "nested" with many other aspects of the spouse's and abuser's lives. Spouse enabling relates behaviorally, psychosocially, and systemically to the partner's roles and responsibilities in the marriage and family, the couple's marital relationship, social relations, lifestyle, safety, and employment. Enabling also relates to spouse motivation in relationship to the abuser and, along with the drinking behavior, to repetitive patterns of interaction sequences with the drinker, such as family behavior loops (Liepman, Silvia, & Nirenberg, 1989). Nested connections with enabling can implicate many dysfunctions, as outlined earlier. However, the nesting can also involve positive and/or adaptive functions in the alcoholic marriage and/or family, as some systems theorists have noted (e.g., see Steinglass, Bennett, Wolin, & Reiss, 1987; Steinglass et al., 1971). For example, as was documented earlier, spouse enabling may have the more general functions of helping to facilitate and/or maintain spouse coping with the drinking and, along with the drinking, of stabilizing and maintaining the equilibrium of the marital/family system. Other potentially adaptive functions are that spouse enabling may help foster fulfillment of the spouse's marital role in providing care, support, and nurturance for the partner and protection of the spouse and abuser's safety, social standing, and financial security.

An important consequence of this nesting is that changes of enabling behavior can readily upset customary relations and patterns for all parties involved. To address these factors, as was emphasized before, accommodations to avoid risks of harm to the spouse and others were incorporated into the disenabling procedure (e.g., determining the consequences and feasibility of disenabling) and were applied in the spouse disenabling plans (e.g., targeting some enabling behaviors with modified discontinuance, on occasion, as well as the more customary and preferable complete discontinuance of enabling). Even so, however, when procedures such as these are followed, the practitioner nonetheless should continue to be alert to

possible adverse effects of the disenabling and, if noted, to make program adjustments accordingly.

A related consequence of the nesting is that the enabling behaviors can be difficult to dislodge from their nested context and/or system, thereby contributing to their persistence. Enabling can continue to persist in at least two forms with a disenabling program. The first consists of any enabling allowed in a program having modified discontinuance (in effect, enabling which is residual to the program). In general, the greater the accommodation of the program to try to avoid potential harm, the greater the possible residual enabling.[15] The second form of continued enabling is that which can be attributed to any noncompliance with disenabling interventions. Both forms of continued enabling can serve to sustain and be supported by the personal relations and social systems in which the enabling is embedded.

Another implication of the nesting is how it may affect the changeability of any given enabling behavior. Can some enabling behaviors be thought of as being more nested than others? Probably. For example, possible indicators of the degree and/or manner of nesting are the frequency of an enabling behavior, its motivation and the needs it meets, its relevance to one's marital/family or social role, the interactional connectedness of the enabling with the behaviors of others in the marital/family system, and its contribution to maintaining the equilibrium and homeostasis of the marital/family system.[16] More generally, is it the case that enabling behaviors nested in ways such as these are more difficult to change? At this point, little is known about what enabling behaviors are most amenable to change, including what role the different types of enabling may play in all this. These are questions for further inquiry.

The third feature of spouse enabling is that generally it is a secondary target of change, with the primary target being another behavior and/or condition to which it is presumably related, in this instance recovery of the alcohol abuser. To the extent that spouse enabling contributes to an alcohol abuser's excessive drinking or is otherwise dysfunctional for the spouse or the abuser, spouse enabling can be justified as a target of intervention. However, although most practitioners in such areas as family therapy and substance abuse treatment would judge that disenabling intervention is justified, one should recognize that assumptions are being made about the dysfunctions of enabling and/or the benefits of reduced enabling for which there is presently little empirical backing beyond clinical observation. These issues merit further examination in their own right and entail empirical questions the answers to which could have important implications for approaches to treatment in substance abuse and related areas.

Returning now to the clinical results, the disenabling program was shown to reduce targeted and nontargeted enabling behavior for the two cases in the cross-

[15]The residual enabling attending any modified discontinuance of enabling is judged to be small in comparison with the general disenabling gains that the program can achieve and to be a relatively small price to pay for averting the potential harm that might occur otherwise.

[16]Instruments, such as the SEI, may be used to measure the frequencies of Types I and II enabling, and Family Behavior Loop Mapping may be helpful in discerning loops and other sequential interaction patterns (Liepman et al., 1989).

over experimental dyad. More generally, we judge that the program could be employed to achieve more or less change than reported here, depending upon the intervention objectives and how loosely or stringently the program was applied. In any case, modification of spouse enabling should help reduce its dysfunctions and assist the spouse to become more detached from the abuser's drinking. It also could be used to help pave the way, as was intended here, for introducing other spouse interventions directed toward facilitating the abuser's sobriety.

Disenabling should be applicable with spouses or other family members before, during, and after alcohol treatment of the alcohol abuser, either as the main treatment component or as part of a broader treatment program. With suitable modifications of this program, it also may be applied to problems other than abusive drinking, such as enabling with overeating, child misbehavior, or mental disorder.

REFERENCES

Bepko, C., & Kerstan, J.A. (1985). *The responsibility trap: A blueprint for treating the alcoholic family.* New York: The Free Press.

Bowen, M. (1974). Alcoholism as viewed through family systems theory and family psychotherapy. *New York Academy of Sciences, 233,* 115–145.

Burnett, M.M. (1984). Toward a model for counseling the wives of alcoholics: A feminist approach. *Alcoholism Treatment Quarterly, 1,* 51–60.

Cermak, T.L. (1986). *Diagnosing and treatment codependence: A guide for professionals who work with chemical dependents, their spouses and children.* Minneapolis, MN: Johnson Institute Books.

Cronkite, R.C., Finney, J.W., Neknich, J., & Moos, R.H. (1987). Remission among alcoholic patients and family adaptation to alcoholism: A stress and coping perspective. In R.L. Collins, K.E. Leonard, & J.S. Searles (Eds.), *Alcohol and the family.* New York: The Guilford Press.

Dittrich, J.E., & Trapold, M.A. (1984). A treatment program for wives of alcoholics: An evaluation. *Bulletin of the Society of Psychologists in Addictive Behaviors, 3,* 91–102.

Doweiko, H.E. (1990). *Concepts of chemical dependency* (2nd ed). Pacific Grove, CA: Brooks/Cole.

Gacic, B. (1982). Basic principles of family therapy of alcoholism. In P. Golding (Ed.), *Alcoholism: A modern perspective.* Lancaster, England: MTP Press Limited.

Homila, M. (1985). *Wives, husbands and alcohol: A study of informal drinking control within the family.* Helsinki: Finnish Foundation of Alcohol Studies.

Jackson, J.K. (1954). The adjustment of the family to the crisis of alcoholism. *Quarterly Journal of Studies on Alcohol, 4,* 562–586.

James, J.E., & Goldman, M. (1971). Behavioral trends of wives of alcoholics. *Quarterly Journal of Studies on Alcohol, 32,* 373–381.

Johnson, V. (1973). *I'll quit tomorrow.* New York: Harper.

Johnson, V.E. (1986). *Intervention: How to help someone who doesn't want help.* Minneapolis, MN: Johnson Institute Books.

Johnson, V. (1990). *Everything you need to know about chemical dependency.* Minneapolis, MN: The Johnson Institute.

Kaufman, E. (1985). Family systems and family therapy of substance abuse: An overview of two decades of research and clinical experience. *The International Journal of the Addictions, 20,* 897–916.

Leonard, K., Dunn, N.J., & Jacob, T. (1983). Drinking problems of the alcoholic: Correspondence between self and spouse reports. *Addictive Behaviors, 8,* 369–373.

Levinson, V.R., & Ashenberg-Straussner, S.L. (1978). Social workers as "enablers" in the treatment of alcoholics. *Social Casework, 59,* 14–20.

Liepman, M.R. (1993). Using family influence to motivate alcoholics to enter treatment: The Johnson Institute Intervention approach. In T.J. O'Farrell (Ed.), *Marital and family therapy in alcoholism treatment.* New York: Guilford Press.

Liepman, M.R. (1994). The family in addiction. In N.S. Miller & M.C. Doot (Eds.), *Principles of addiction medicine.* Chevy Chase, MD: American Society of Addictive Medicine.

Liepman, M.R., Nirenberg, T.D., & Begin, A.M. (1989). Evaluation of a program designed to help family and significant others to motivate resistant alcoholics into recovery. *American Journal of Drug and Alcohol Abuse, 15,* 209–221.

Liepman, M.R., Silvia, L.Y., & Nirenberg, T.D. (1989). The use of Family Behavior Loop Mapping for substance abuse. *Family Relations, 38,* 282–287.

Logan, D.G. (1983). Getting alcoholics to treatment by social network intervention. *Hospital and Community Psychiatry, 34,* 360–361.

Mapes, B.E., Johnson, R.A., & Sandler, K.R. (1984, Winter). The alcoholic family: Diagnosis and treatment. *Alcoholism Treatment Quarterly, 1,* 67–83.

Marlatt, G.A. (1985). Situational determinants of relapse and skill-training interventions. In G.A. Marlatt & J.R. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford Press.

McCrady, B.S. (1982). Conjoint behavioral treatment of an alcoholic and his spouse. In W.M. Hay & P.E. Nathan (Eds.), *Clinical case studies in the behavioral treatment of alcoholism.* New York: Plenum.

McCrady, B.S. (1989). Extending relapse prevention models to couples. *Addictive Behaviors, 14,* 69–74.

McCrady, B.S., Paolino, T.J., Jr., & Longabaugh, R. (1978). Correspondence between reports of problem drinkers and spouses on drinking behavior and impairment. *Journal of Studies on Alcohol, 39,* 1252–1257.

Midanik, L. (1982). The validity of self-reported alcohol consumption and alcohol problems: A literature review. *British Journal of Addiction, 77,* 357–382.

Morse, R.M., & Swenson, W.M. (1975). Spouse response to a self-administered alcoholism screening test. *Journal of Studies on Alcohol, 36,* 400–405.

O'Farrell, T.J., Cutter, H.S.G., Bayog, R.D., Dentch, G., & Fortgang, J. (1984). Correspondence between one-year retrospective reports of pre-treatment drinking by alcoholics and their wives. *Behavioral Assessment, 6,* 263–274.

Orford, J., Guthrie, S., Nicholls, P., Oppenheimer, E., Egert, S., & Hensman, C. (1975). Self-reporting coping behavior of wives of alcoholics and association with drinking outcome. *Journal of Studies on Alcohol, 36,* 1254–1267.

Pinkham, M.E. (1986). *How to stop the one you love from drinking.* New York: G.P. Putnam's Sons.

Potter-Effron, B.A., & Potter-Effron, R.T. (1986). Treating the family of the chemically dependent adolescent: The enabling inventory and other techniques for responsibility. *Alcoholism Treatment Quarterly, 3,* 59–72.

Rychtarik, R.G. (1990). Alcohol-related coping skills in spouses of alcoholics: Assessment and implications for treatment. In R.L. Collins, K.E. Leonard, & J.S. Searles (Eds.), *Alcohol and the family.* New York: The Guilford Press.

Schaef, A.W. (1986). *Co-dependence: Misunderstood-mistreated.* San Francisco: Harper & Row.

Selzer, M.L. (1971). The Michigan Alcoholism Screening Test (MAST): The quest for a new diagnostic instrument. *American Journal of Psychiatry, 3,* 176–181.

Steinglass, P., Bennett, L., Wolin, S.J., & Reiss, D. (1987). *The alcoholic family.* New York: Basic Books.

Steinglass, P., Weiner, S., & Mendelson, J.H. (1971). A systems approach to alcoholism: A model and its clinical application. *Archives of General Psychiatry, 24,* 401–408.

The family enablers. (1987). Minneapolis, MN: The Johnson Institute.

Thomas, E.J. (1989). Unilateral family therapy to reach the uncooperative alcohol abuser. In B.A. Thyer (Ed.), *Behavioral family therapy.* Springfield, IL: Charles C. Thomas.

Thomas, E.J., Adams, K.B., Yoshioka, M.R., & Ager, R.A. (1990). Unilateral relationship enhancement in the treatment of spouses of uncooperative alcohol abusers. *American Journal of Family Therapy, 18,* 334–344.

Thomas, E.J., & Ager, R.D. (1993). Unilateral family therapy with spouses of uncooperative alcohol abusers. In T.J. O'Farrell (Ed.), *Treating alcohol problems: Marital and family interventions.* New York: Guilford Press.

Thomas, E.J., & Santa, C.A. (1982). Unilateral family therapy for alcohol abuse: A working conception. *American Journal of Family Therapy, 10,* 49–60.

Thomas, E.J., Santa, C.A., Bronson, D., & Oyserman, D. (1987). Unilateral family therapy with spouses of alcoholics. *Journal of Social Service Research, 10,* 149–162.

Thomas, E.J., & Yoshioka, M.R. (1989). Spouse interventive confrontations in unilateral family therapy for alcohol abuse. *Social Casework, 70,* 340–347.

Thomas, E.J., Yoshioka, M.R., & Ager, R.D. (1994a). Spouse Enabling Inventory (SEI). In J. Fischer & K. Corcoran (Eds.), *Measures for clinical practice: A Sourcebook, Vol. 1 Couples, families, and children* (2nd ed.). New York: The Free Press.

Thomas, E.J., Yoshioka, M.R., & Ager, R.D. (1994b). Spouse Sobriety Influence Inventory (SSII). In J. Fischer & K. Corcoran (Eds.), *Measures for clinical practice: A sourcebook, Vol. 1 Couples, families, and children* (2nd ed.). New York: The Free Press.

Thomas, E.J., Yoshioka, M.R., Ager, R.D., & Adams, K.B. (1990, June). *Reaching the uncooperative alcohol abuser through a cooperative spouse.* Paper presented at the Fifth Congress of the International Society for Bio-Medical Research on Alcoholism, Toronto, Canada.

Whitfield, C.L. (1989). Codependence: Our most common addiction—Some physical, mental, emotional, and spiritual perspectives. *Alcoholism Treatment Quarterly, 6,* 19–36.

Wiseman, J.P. (1980). The "home treatment": The first steps in trying to cope with an alcoholic husband. *Family Relations, 29,* 541–549.

Yoshioka, M.R., Thomas, E.J., & Ager, R.D. (1992). Nagging and other drinking control efforts of spouses of uncooperative alcohol abusers: Assessment and modification. *Journal of Substance Abuse, 4,* 309–318.