CHAPTER 2

REVIEW OF LITERATURE

2.1 Indian Studies
2.2 Western Studies
REVIEW OF LITERATURE

The treatment of alcoholism has changed during the past two decades. Notable developments have occurred in pharmacotherapy, psychotherapy and health care delivery. Family variables, family interaction patterns of alcoholic families, locus of control, motivational status and role of psychotherapy are highlighted in the present chapter. In short, the present chapter is focused on the related studies and the impact of non-pharmacological approaches. Such reviews of the studies are classified into Indian studies and Western studies.

2.1 Indian Studies

M. B. Ashok Malla (1988) conducted a study in which 15 matched pairs of alcoholics who had either refused or completed day treatment were reassessed 16 months after the initial assessment. The treated group had improved significantly more than the untreated group on measures related directly to alcohol abuse, in their utilisation of inpatient psychiatric services and the use of family decision’s services. The treated group had also used disulfiram for significantly longer periods of time. The treatment refuses had nonetheless achieved statistically significant, albeit modest, reduction in their consumption of
alcohol compared to their pre-assessment levels. Both groups showed equal amount of change on a number of psycho-social measures, such as employment, use of minor tranquillisers and non-prescription drugs, legal problems and symptoms of depression. These findings are discussed in the context of the effectiveness of a day programme, the use of disulfiram and certain pre-treatment characteristics of the patient.¹

Sunil Datta, B.J. Prasanthan and K. Kuruvilla, (1991) adopted a community-based approach for the treatment of alcoholism. The programme was held in a village of about 500 families, 21km away from the hospital. This village was reported in community surveys to have a very high prevalence of alcoholism among the males. The detoxification treatment was begun and the patients were discharged after one week and were put on Disulfiram. The discharged patients were required to come for daily group sessions lasting for 1½ hour for the next one week. After this the sessions were tapered to twice a week and finally to once a week. The after care programme consisted of weekly visits by the treatment team lasting for 1-2 hours every Friday evening. The patients had organised their own AA meeting even Sunday evening. The wives of these patients were encouraged to meet the female counsellor. This follow-up lasted for 1 yr. Result showed that all patients were followed up for 1 yr. At the end of 1 year, 13 were abstinent and were participating regularly in the AA meeting. 2 among these 13 had relapsed once during the year, on for 1 week and one patient
for one month. They then rejoined the programme. One patient dropped out of
the treatment programme after 4 months of abstinence. He came back again at 5
½ months and remained in the programme for 1½ months and relapsed again. He
rejoined again at 8 months and was abstinent for one month when he relapsed
again and did not come back to the group.²

understood a study to find out the degree of cognitive impairment in Indian
alcoholics (DSM III Criteria). A group of 30 alcoholic patients were taken from
out patient department of Psychiatry, Dayanand Medical College and Hospital,
Ludhiana. The patients were diagnosed to be suffering from alcohol abuse or
alcohol dependence on the basis of DSM III criteria. These patients were
matched with 30 healthy non-alcoholic controls on socio demographic variables.
The cognitive functions were assessed by P.G.I battery of brain dysfunction. This
battery consists of tests for intelligence, memory and percept motor acquity, there
was significant relationship between cognitive impairment and duration of
alcohol use. The cognitive impairment increases with the duration of alcohol use.
There was significant difference on cognitive functions in alcoholics as compared
to control.³

P. T. K. Kutty in Kerala in 1992 undertook a study on management of
alcoholism among railwaymen with special emphasis on behaviour therapy and
transactional analysis model. It has been documented that alcoholism causes
considerable absenteeism among railway staff. Forty-one male alcoholics were treated in railway hospitals in a period of 10 months. Thirty eight out of 41 were known alcoholics for the last 15 to 20 years. Three of them were addicts for the last 10 years only. All the 41 were in the age group 30-56 within average of 46 years. Qualifications varied from 3rd standard to intermediate. They were treated under medical supervision for 10 to 13 days in railway hospitals. Behaviour modification and Transactional Analysis were used at different levels of treatment. Presence of the client's wife was also insisted. Results indicated that 33 out of 41 were successfully abstaining from alcohol for a period of 3 to 9 months. Out of 8 relapses 3 were attended successfully. Out of 5 drop outs, 3 were living outside the headquarters without their families. Clients living away from the place of counselling centre and that too without families were more prone to relapse. Reasons for relapse given by the clients were the wives inability to accept them as non-alcoholics, loneliness, financial crisis and persuasions by friends/ supervisors. Twenty two patients out of 41 reported sexual dysfunctioning and 13 out of 41 wives also reported the same problem. So sex therapy was also conducted effectively.\(^4\)

Kishore Chandiramani and B.M. Tripathi (1993) used psycho educational group therapy for the treatment of alcoholism. Apart from achieving abstinence, the goal of this program was to enhance patients' quality of life by means of improved functioning in personal, social and professional spheres. The package
consisted of 8 sessions, each focusing on a specific issue or topic considered important in the process of recovery. The group comprised of 8 to 12 alcohol dependent individuals who had undergone detoxification. The group sessions were conducted thrice a week over a period of about 3 weeks. Each session was held for about 45 to 60 minute. Although no suggestion is made in the group for socialisation among members outside sessions, it has been observed that the group therapy package promotes socialisation among members and the opportunity has potential for constructive use.5

Teresa Neeliyara and S. V. Nagalakshmi (1994) developed a scale to assess the motivation for change in alcoholics. The study undertook to examine whether there would be any difference between the normative and the clinical group. Thirty male alcohol dependants as per ICD-9 Criteria between 25 and 50 years of age, with education ranging from 7 to 18 years were chosen and 30 normal male subjects of the same range of age and education were selected. Results indicated that alcohol dependents have scored low on all aspects of motivation except religious attitude. Low self-esteem, their locus of control is not internal, their attitude toward drinking related behaviour is also not internal. They have a tendency to blame external factors and the environment for their drinking behaviour, low on growth motivation, a low score on self criticality indicating that they have problems in objectively perceiving themselves.6
L. N. Suman and S.V. Nagalakshmi (1995) undertook a prospective study to examine the nature of family interaction patterns in alcoholic families. Forty alcoholic families and 10 non-alcoholic families, comparable in age and duration of marriage, were assessed using the Family Interaction Scales. Results revealed significant difference between alcoholic and non-alcoholic families. Alcoholic families were characterized by poor communication patterns, lack of mutual warmth and support, spouse abuse and poor role functioning. The spouses of alcoholics expressed greater dissatisfaction in all the areas of family functioning. Non-alcoholic families were characterised by free and open communication, mutual warmth and satisfaction and sharing of responsibilities. The study highlighted the importance of planning marital/or family therapy for alcoholics so that effectiveness of treatment programs is enhanced.7

Teresa Neeliyara and S.V. Nagalakshmi (1996) conducted a study, which focused on the development of a comprehensive multi-dimensional scale for assessing motivation for change in the alcohol dependent population. After establishing face validity, the items evolved were administered to a normal sample of 600 male subjects in whom psychiatric illness was ruled out. The data thus obtained were subjected to factor analysis. Six factors were obtained which accounted for 55.2% of variance. These together formed a 80 item five point scale 4 norms were established on a sample of 600 normal subjects. Further clinical validation was established on 30 alcohol dependent subjects and 30
normal. The status of motivation was found to be inadequate in alcohol dependent individuals as compared to the normal. Split-half reliability was carried out and the tool was found to be highly reliable.  

John Abraham, R. Chandrasekaran and V. Chitralekha (1997) conducted a study in which a naturalistic, uncontrolled follow-up study was carried out on 60 cases of alcohol dependence syndrome diagnosed according to DSM-III R at JIPMER, Pondicherry. At the end of one year, 32.5% of patients could be classified under abstinent and non-problem drinker category. Thirty five percentage continued to drink but showed improvement in social and occupational functioning while 32.5% remained in the unimproved group. None of the pre-treatment variables differentiate patients with favourable outcome from those with unfavourable outcome. Duration of disulfiram use was strongly associated with a favourable outcome.  

Alcoholism is associated with impairment of information processing attention, memory and concept formation, which hamper the patients response to psychotherapy aimed at treating alcoholism. Grace Mathai, Shobini L Rao., P.S. Gopinath (1998) improved cognitive functioning in abstinent alcoholics through cognitive retraining. Eight detoxified male alcoholics, comparable on age, education, marital status, medication and years of alcohol consumption were assigned, four each to the treatment and control groups. Cognitive retraining given to the treatment group improved attention, information processing, memory
planning and reasoning. One-hour sessions were conducted daily for six weeks. Patients in the control groups were seen weekly once and counselled if necessary. In the treatment group, significant improvement of information processing, memory and reduction of neuropsychological deficits resulted from retraining. Control group showed no changes in cognitive function. Cognitive retraining did not influence family functioning and long-term abstinence. Neuropsychological rehabilitation is effective in improving cognitive deficits of abstinence alcoholics.\textsuperscript{10}

2.2 Western Studies

Hirschfeld, M.A. Robert, Todd Kosier, and Martin B. Belter (1989) undertook a study in which the clinical course of 289 patients with primary non-bipolar major depression without concurrent alcoholism was compared with that of 79 patients with non-bipolar major depression with concurrent alcoholism. Neither patient group suffered from dysthymia or current drug abuse. Contrary to expectations, the 2 groups did not differ on time to recovery from the major depression, time to relapse into a subsequent major depression or various cross-sectional clinical ratings at 2 years. The 2 groups did differ on psychosocial status. Although they were equally impaired at index, the alcoholism group maintained significantly lower levels of psycho-social functioning throughout the
2 years follow-up period. Inter personal relation with spouse was particularly worse among the alcoholic group\textsuperscript{11}.

Sandra A. Brown, Peter W. Vik, and John R. Mc Quaid (1990) examined the relationship between stressful life events and drinking outcome among 129 male alcoholics who had completed an alcohol treatment programme. Life events were assessed for the year prior to treatment and for the 3 months after treatment and were rated on the Psychiatric Epidemiology Research Interview and the Contextual Rating System. Approximately 40% of the pre-treatment stressors were found to be directly or indirectly related to alcohol use when stressor related to drinking were excluded from consideration, they found that men who returned to drinking after-treatment experienced more severe or highly threatening stress before their relapse than men who remained abstinent during the follow-up period. These data suggest that although less severe stress may not increase risk for relapse, acute severe stressors and highly threatening chronic difficulties may be associated with elevated relapse risk.\textsuperscript{12}

Debbie Carol Schachter, Juan C. Negrete and Essam Al Ansari (1990) examined the frequency of distribution of several alcohol dependence and police arrests for public drunkenness across samples of alcoholics with (n=77) and without (n=37) a family history of alcoholism. Both the percent of subjects presenting severe dependence and the history of police arrests were greater in the positive family history group, but these differences did not reach conventional
levels of statistical significance. However, results of logistic regression analysis demonstrate that male sex, younger age and above all, severity of alcohol dependence, are better correlates of the occurrence of police arrests than is the subject’s family history of alcoholism. The picture presented by this sample of out patient alcoholics appears to qualify some currently held assumptions of the influence of family history on the phenomenology of alcoholism.\textsuperscript{13}

J. Vilska, and A. Laminpaa. (1990) undertook a pioneering study in which 300 alcohol intoxications treated in hospital were examined. In 45% of the cases the family was broken, in 36% the family had visited child guidance clinics and in 31% of the families one parent was an alcoholic. The lower the mother’s social group was, higher the frequency of alcohol intoxication. Previous intoxications were reported in 9% of the cases. Most of the children’s intoxications were experimental (49%), suicidal cases amounted to 8% and cases in which the child had been forced to drink amounted to 6% and the rest of the patients belonged to the problem group and the mixed motives group.\textsuperscript{14}

Irving Maltzman and Avraham Schweiger (1991) examined the frequency of alcohol and drug use, abuse and severity of dependence, and personality and family characteristics in 280 female and male hospitalised adolescents in treatment for chemical dependence and 120 middle class adolescents. A MANOVA showed that parents’ drug and alcohol use was a main cause, increasing frequency of use and severity of dependence upon alcohol and drugs
in both groups of adolescents. Sexual and physical abuse studied in the patient
group also functioned as a main effect. Patients reported significantly less family
interests, and participation in intellectual, cultural and social activities, but more
control than the comparison group. It was concluded that adolescent alcohol and
other drug abuse is part of bio psycho-social syndrome of problem behaviour,
which includes the problem behaviour of parents and the interacting family
unit.\textsuperscript{15}

Barbara S Mc Crady, Robert Stout, Nora Noel, David Abrams and
Hilary Fisher Nelson (1991) undertook a research in which treatment was
provided to 45 alcoholics and their spouses in one of three out-patient
behavioural treatment conditions (1) minimal spouse involvement (n=14), (2)
alcohol-focused spouse involvement (n=12) or (3) alcohol-focused spouse
involvement plus behavioural marital therapy (n=9). Subjects were followed for
18 months after treatment. Subjects in all conditions reported significant decrease
in frequency of drinking and frequency of heavy drinking, and reported increased
life satisfaction. This information was corroborated by independent reports of the
spouses. Patterns of outcome varied across the three treatment conditions, with
alcohol focused spouse involvement plus behavioural marital therapy subjects
showing gradual improvement in proportions of abstinent days and abstinent plus
light drinking days over the last 9 months of follow-up. Subjects in the other two
treatment conditions showed gradual deterioration in proportion of abstinent days
and abstinent plus light drinking days. Subjects assigned to the alcohol-focused spouse involvement plus behavioural marital therapy condition were less likely to experience marital separations, and reported, greater improvement in marital satisfaction and subjective well-being than the other experimental groups.\textsuperscript{16}

Elizabeth M Hill, Janet, L. Nord, Frederic C. Blow (1992) assessed the effects of family history and family environment and alcohol misuse. From ongoing studies authors recruited parents who had children aged 18-30, 20 with a DSM-IIIR alcohol dependence diagnosis, 20 without. The child then completed a multidimensional assessment. The young adult participants included 20 men and 20 women (Mean age= 24.8). Differences of family history were restricted to substance abuse behaviours while a high level of alcohol problems occurred in both groups, those with an alcohol dependent parent were more likely to be heavy drinkers and showed more symptoms of alcohol dependence. Overall psychological adjustment did not differ between the groups, however. Alcohol misuse measures did correlate moderately with symptoms of poor emotional health. The most important correlates of alcohol misuse measures in this study were exposure to parental alcoholics, abusive punishment and psychological symptoms, with some separation at effects in the two subgroups. Psychological symptoms had a stronger relationship with misuse in subjects with social drinking parents, while abuse was more associated in the group with an alcohol-dependent parent. These results confirm the importance of environmental
interactions with familial risk. There appear to be strong protective effects of positive family relationships on the potential negative effects of a family history of alcoholism.\textsuperscript{17}

Oliver B. Williams and Patrick W. Corrigan (1992) undertook a study in which 139 undergraduate and graduate students completed measures of anxiety, depression, social avoidance, self-esteem and social support. Results showed that adult children of alcoholics, adult children of mentally ill and adult children of substance-abusing mentally ill had lower self-esteem and were more socially anxious than normal controls. Adult-children of mentally ill parents were more depressed and showed greater trait anxiety than adult children of alcoholics and controls. The impact of parental pathology is diminished when the adult child has a large and/or satisfactory social support.\textsuperscript{18}

Norman G Hoffman and Norman S. Miller (1993) reported that the one-year abstinence rate for alcohol-only abusers is 71\% (Out of 914 alcohol abusers). At the end of the 12-month interview, patients were asked about certain factors that may have contributed to their drinking or drug use or that may have made recovery difficult. The impediment to recovery cited most frequently by both relapsed and abstinent inpatients is emotional distress, such as boredom, anger, loneliness, or depression. Family stress and relationship problems were also among the commonly mentioned impediments to recovery. Emotional problems and family problems have been associated with relapse in other studies.
as well. The largest absolute differences between abstinent and relapsed patients were seen as craving alcohol and for not really wanting to quit; these differences were most striking even though relapsed patients dearly had more difficulties in all areas than abstinent patients. Another note worthy finding was that one of 4 relapsed patients and one of 10 abstinent patients had difficulties accepting that they were chemically dependent, which suggested that the treatment was unsuccessful in breaking through problem denial. The findings clearly showed that abstinent patients who reported difficulties in the 1st follow-up interval were much more likely to relapse than those who did not report such problems. Even patients who reported a relapse following treatment were very unlikely to report that using drugs/alcohol affects their job.19

Richard P. Mattick and Nick Heather (1993) found that a recent study (Heather N, Rollnick S, Bell A, Richmond R) on general hospital wards has shown that excessive drinkers who are not ready to cut down drinking, benefit more from motivated interviewing than from a skill-based counselling approach where as those who are ready to change appear to benefit equally from either type of counselling.

Three recent treatment-outcome studies have attested to the importance as relapse prevention approach for alcohol dependent people. The first study (O’Farrell TJ, Choquette KA, Cutter HSG, Brown ED) compared the effect of
behavioural marital therapy found that behavioural-marital therapy produced significant improvements that were enhanced by the use as relapse prevention.

In another study (O’Malley et al.) compared the impact on alcohol dependence as coping skills/relapse prevention therapy with supportive counselling when combined with medication. They reported that patients who received supportive therapy were most likely to maintain abstinence. In a study assessing the effects of combining cognitive behaviour therapy and pharmacotherapy, Annis and Peachey found evidence to support the use of relapse prevention. The study by Pfost et al. showed a disappointing effect for assertiveness training. Although assertiveness increased among a group of alcohol dependent inpatients trained in the procedures, there was no reduction of discomfort in negative situations, nor a change in patient’s perceptions of assertiveness in sober versus intoxicated states after tests or follow-up.

Despite much research, aversion therapy approaches have not been broadly accepted as useful procedures in the management of alcohol problems. These techniques were extensively used and studied in the past but have fallen into disfavour. However, Smith et al., Howard et al. in their studies revealed that patients treated with aversion therapy had significantly higher abstinence rates compared with the control group at 6 months follow-up.20

Terry E. Duncan, Susan C. Duncan and Hyman Hops (1994) demonstrated a latent grow with curve methodology for analysing longitudinal
data for adolescent alcohol use by combining information from different overlapping age cohorts to form a single development trajectory. Hypotheses concerning the form of growth in alcohol use, the extent of individual differences in the common trajectory over time, and covariates influencing both initial status and the form of growth were tested. Utilising five separate age cohorts each measured over the same 4-year period. Results suggested a common trajectory existed across the 8 years represented by the cohort-sequential analysis, with alcohol use increasing more rapidly during the adolescent transition to high school. Family cohesion and peer encouragement for alcohol use were hypothesized to influence both initial status and the trajectory of alcohol consumption during adolescence. While family cohesion served to suppress initial levels of consumption delaying the upward trajectory of alcohol use, peer encouragement was related not only to initial, and elevated, levels of use, but was predictive of those changes that occurred during adolescence.  

L.M. Najavits and R.D. Weiss (1994) undertook a research in which psychotherapies for substance-use disorders were reviewed, with particular attention to modifications of standard treatments necessary to make them effective for patients with disorders. Treatments reviewed included cognitive-behavioural therapies (Relapse Prevention, Cognitive Therapy, Contingency Contracting, Behavioural Treatment, Cue Exposure, Net work Therapy and Aversion therapy) and psycho-dynamic/interpersonal methods (Supportive-
Expressive Therapy, Interpersonal Therapy, Motivational Interviewing and Modified Psycho-analytic Therapy). The psychotherapies selected were individual, verbally based treatments for substance-use disorders; except for modified psychoanalytic therapy, all have been presented in treatment manuals and empirically studied. Research showed that these forms of psychotherapy can be effective, with some treatments providing more benefit than others for specific sub-populations, but no one treatment is consistently more effective than any other.22

W. Fals-Stewart, G. R. Birchler and T.J. O’Farrell (1996) undertook a study in which married or cohabitating substance-abusing patients (n=80) who were entering individual out patient treatment, most of whom were referred by the criminal justice system (n=68; 85%), were randomly assigned to a no-couples-treatment control group (n=40) or to 12 weekly sessions of adjunctive behavioural couples therapy (n=40). Drug use and relationship adjustment measures were collected at pre-treatment, post treatment, and at 3-, 6-, 9- and 12-month follow-ups. Couples who received behavioural couples therapy as part of individual-based treatment had better relationship outcomes, in terms of more positive dyadic adjustment and less time separated, than couples in which husbands received individual-based treatment only. Husbands in the behavioural couples therapy condition also reported fewer days of drug use, longer periods of abstinence, fewer drug-related arrests, and fewer drug-related hospitalisations
through the 12-month follow-up period than husbands receiving individual-based treatment only. However, some of the drug use and relationship adjustment differences between these groups dissipated over the course of the follow-up period.\textsuperscript{23}

A. J. Jaffe, B. Rounsaville, G. Chang, R.S. Schottenfeld, R.E. Meyer and S.S. O’Malley (1996) undertook a study in which alcohol-dependent patients (n=97) were randomly assigned to receive either naltrexone or placebo and either relapse prevention therapy or supportive therapy. The present report explored the hypothesis that patients could be matched to the above treatments on the basis of specific pre-treatment characteristics. Treatment matching variables explored included craving, alcohol dependence severity, and cognitive measures of learning and memory. Results of linear regression analyses tentatively suggested that patients experiencing higher levels of craving and poorer cognitive functioning might derive the greatest benefit from naltrexone versus placebo. For psychotherapy, lower levels of verbal learning were associated with poorer drinking outcomes for relapse prevention therapy but not for supportive therapy. Conversely, higher levels of verbal learning were associated with better outcomes for relapse prevention therapy but not for supportive therapy.\textsuperscript{24}

D. J. Kavanagh, T. Sitharthan and G.P. Sayer (1996) investigated predictors of response to correspondence interventions for alcohol abuse and examined both subject retention and alcohol intake over a 12-month period. The
primary focus was on the predictive utility of self-efficacy, stages of change and alcohol dependence. Self-efficacy performed relatively well in the study, predicting both retention and later consumption. When predicting 12-month consumption from pre-test assessments or examining subject retention over the last 6 months, self-efficacy offered a significant contribution to multi-variant analyses. However, in some other predictions a significant effect of self-efficacy was eliminated after the entry of other variables. Stages of change significantly predicted mid-way through treatment, but did not provide an independent prediction of overall retention or treatment response. Neither the degree of alcohol dependence nor level of alcohol problems figured in any of the predictions. Older subjects stayed longer in the study, and those with lower intake and higher pre-test self-efficacy had the lowest consumption at 12 months.25

G.A. Marlatt (1996) reviewed a paper to provide historical overview of the development of the taxonomy of high-risk situations for relapse in patients receiving abstinence-based treatment for alcoholism. Research conducted during the 1970s on determinants of relapse is briefly reviewed, beginning with a preliminary analysis of relapse patterns in alcoholics treated with aversion therapy. Theoretical foundations underlying the development of the taxonomy were then discussed with an emphasis on social-learning theory and its implications for cognitive-behavioural interventions for relapse prevention.
Findings supported the efficacy of coping-skills training for high-risk relapse situations, based on a prospective treatment outcome study for inpatient alcoholics, were also presented in support of the clinical validity of the relapse model. The paper concluded with a description of the refined and extended taxonomy of high-risk situations and the associated cognitive-behavioural model of relapse described in the Marlatt and Gordon (1985) text on relapse prevention.²⁶

V. Murgraff, D. White and K. Phillips (1996) designed a brief planning intervention and its effectiveness compared to an information-based health promotion programme (control). All participants were given information about the safe limit per drinking occasion and the adverse consequences of binge drinking and were asked to drink within the safe limits in order to avoid those consequences. In addiction, participants in the planning group received an option menu of possible responses for refusing a drink, asked to choose one strategy and specify a time and place in which the chosen strategy would be implemented. The planning intervention group did not differ from the control group on reported likelihood of future binge drinking, nor on levels of past drinking, age and gender. At a 2-week follow-up, members of the planning intervention group reported lower drinking frequency than controls.²⁷

S. Allsop, B. Saunders, M. Phillips and A. Carr (1997) studied the outcome of a controlled trial of a relapse prevention programme with male
problem drinkers (n=60) attending an alcohol treatment unit. Subjects who met
the inclusion criteria were allocated to a relapse prevention (n=20) procedure or a
discussion (n=20) or no-additional treatment (n=20) control procedure. Subjects
were followed up at 6 and 12 months by the first author. The relapse prevention
programme was associated with significantly greater probability of total
abstinence than all controls over the first 6-month follow-up. In addition, the
relapse prevention programme was associated with significantly longer survival
time to an initial lapse and relapse than the controls. At 12-month follow-up,
treatment effects had been eroded. It was concluded that the relapse prevention
programme was an effective treatment in the short term and that longer-term
impact may require greater focus on maintenance factors, such as the individual’s
environment.28

F.C. Breslin, M.B. Sobell, L. C. Sobell, G.Buchan and J. A.
Cunningham (1997) identified individuals at risk for continued problem
drinking; predictors of post treatment drinking were examined for 212 problem
drinkers who presented for treatment in an outpatient treatment clinic. All
participants completed a brief cognitive behavioural motivational intervention. At
the pre-treatment assessment demographic, drinking pattern, severity of
dependence and other cognitive variables (eg: self efficacy, goal choice) were
collected. Within-treatment, drinking pattern and cognitive variables such as self-
efficacy and goal choice were again measured. Regression analyses showed that
therapist prognosis ratings contributed significantly to the prediction of outcome even when pre-treatment variables were controlled. However, when within-treatment variables were included in the prediction, variables such as within treatment drinking eliminated the predictive utility of therapist prognosis ratings. This pattern held for both percentage of days abstinent and drinks per drinking day at a 6-month follow-up.

R.A. Brown, D.M. Evans, I.W. Miller, E.S. Burgess and T. I. Mueller (1997) conducted a study which focused on alcoholics with depressive symptoms score > or =10 on the Beck Depression Inventory who received 8 individual sessions of cognitive-behavioural treatment for depression (n=19) or a relaxation training control (n=16) plus standard alcohol treatment. Cognitive behavioural treatment patients had greater reductions in somatic depressive symptoms and depressed and anxious mood than relaxation training control patients during treatment. Patients receiving cognitive behavioural treatment had a greater percentage of days abstinent but not greater overall abstinence or fewer drinks per day during the first 3-month follow-up. However, between the 3 and 6-month follow-ups, cognitive behavioural treatment patients had significantly better alcohol use outcomes on total abstinence (47% Vs 13%), percent days abstinent (0.5% Vs 68.3%), and drinks per day (0.46 Vs 5.71).

G.J. Connors, K.M. Carroll, C.C. Di Clemente, R. Longabaugh and D.M. Donovan (1997) evaluated the relationship between the therapeutic alliance
and treatment participation and drinking outcomes during and after treatment among alcoholic out patient and after care clients. In the out patient sample, ratings of the working alliance, whether provided by the client or therapist, were significant predictors of treatment participation and drinking behaviour during the treatment and 12-month post treatment periods, after a variety of other sources of variance were controlled. Ratings of the alliance by the after care clients did not predict treatment participation or drinking outcomes. Therapist’s ratings of the alliance in the after care sample predicted only percentage of days abstinent during treatment and follow-up. The results documented the independent contribution of the therapeutic alliance to treatment participation and outcomes among alcoholic out patients.\(^{31}\)

G. De Leon, G. Melnick and D. Kressel (1997) used CMRS scales to assess motivation and readiness for treatment of a large sample of primary alcohol, marijuana, heroin, cocaine and crack cocaine abusers admitted to a long term residential therapeutic community. Findings showed few significant differences in overall retention or initial motivation and readiness. Initial motivation and readiness scores persisted as significant predictors of short-term retention in treatment across most groups. Findings supported the therapeutic community perspective that the substance abuse problem was the person, not the drug of choice, and were consistent with prior research emphasising the importance of dynamic rather than fixed variables as determinants of retention.\(^{32}\)
E.E. Epstein, B. S. Mc Crady and L.S. Hirsch (1997) conducted a research, which designed to study marital functioning of alcoholics in light of current alcohol typologies. Subjects were part of a larger study on conjoint treatment of alcoholic males and their female partners. Four typologies— including Type ½, In-Home/Out-of-home, Steady/Episodic, and Early/Late Onset were tested for replicability and discriminant validity before linking them to marital functioning. Discriminant validity was found only for the Early (59%)- versus Late (41%)- Onset typology; thus further analyses linked only this typology with marital functioning. At baseline, Early-Onset couples reported more marital instability, and the females in these couples were more distressed. During treatment, Early-Onset couples reported higher daily marital satisfaction than Late-Onset couples. Regardless of age of onset, males reported higher marital satisfaction than their spouses during treatment, but their satisfaction did not increase during treatment. Female partners’ marital satisfaction increased during treatment. Female partners of Late-Onset males reported particularly low marital satisfaction during treatment. Parsing the sample according to the early/late onset typology yielded different predictors of marital satisfaction for males and females within each subtype. For female partners of Early-Onset alcoholics, psychological distress unrelated to her partners drinking severity was most associated with her own marital satisfaction, where as marital adjustment of female partners of Late-Onset alcoholics was most associated with the male’s
level of perceptual accuracy regarding her needs. This pattern was reversed for the males; marital adjustment of Early Onset alcoholics was associated with his partner’s perceptual accuracy of his needs, where as marital functioning of Late-Onset alcoholics was best accounted for by his own psychological distress.\(^{33}\)

R. Ermalinski, P.G. Hanson, B. Lubin, J. I. Thornby and P.A. Nahormek (1997) evaluated a group of alcoholic patients who were treated with a physical fitness program as an adjunct to the usual program, which showed significantly less craving for alcohol than members in the standard treatment group. The group treated with physical fitness as well as therapy saw themselves as having more internal locus of control and being less controlled by powerful others. Nurses were the hospital professionals most likely to be involved with important roles in exercise programs with alcoholic patients.\(^{34}\)

M.M. Fichter, S.M. Glynn, S. Weyerer, R. P.: Liberman and U. Frick (1997) undertook a study in which family-based predictors of relapse were examined in 100 alcoholics who participated in a 12-week treatment program with 6-month and 18 month follow-ups. “Expressed Emotion” (EE) or attitudes of relatives toward the alcoholic as measured by the Camberwell Family Interview, scales measuring rejection of the alcoholic by relatives and self-reports of partner interaction were evaluated as possible predictors of abstinence. During therapy, partnership interactions showed a transient deterioration with increased temporary friction. Based on conservative criteria, the abstinence rate was 40% at
6-month follow-up and 30% at 18-month follow-up. An association with the relapse at follow-up could be obtained for the Patient Rejection Scale (PRS) and, using empirically derived classification rules, for the main three variables of the Camberwell Family Interview (CFI) conducted on admission; “Critical Comments”, “Emotional Over involvement”, and “Warmth”. A low number of Critical Comments and a high score in Warmth were associated with a lower risk of relapse; however, contrary to expectations, Emotional Over involvement of the significant other was associated with more abstinence. In addition, the number of Critical Comments made by relatives about the alcoholic, a major component of high EE as measured by the CFI, had a statistically significant impact on the “survival function” of abstinence, and thus contributed to the prediction of the course of alcoholism in the expected direction.35

L.S. Hirsch, B. S. Mc Crady and E.E. Epstein (1997) undertook a study in which the Drinking Related Locus of Control (DRLC) scale was administered to 93 treatment-seeking male alcoholics meeting DSM- IIR criteria for alcohol abuse or dependence who attended a clinical screen and baseline assessment for a larger study designed to examine the efficacy of conjoint marital therapy in the treatment of alcoholism. Subjects were recruited through newspaper, radio and television announcements, letters to physicians employee assistance programs, outpatient treatment programs and detoxification centres. Subjects were either married or in a cohabitating relationship with a non-alcoholic, female pattern.
Results indicated that a factor analysis with a procrustes rotation failed to replicate the three-factor structure identified by previous researches and consequently the reliability coefficients of the corresponding subscales were found to be low. Several items were endorsed as internal by more than 95% of the sample, showing little or no variability among subjects. An independent factor analysis, which excluded the items endorsed predominantly as internal, identified a single factor structure comprised of first person statements about helplessness and an inability to abstain from drinking.  

D.C. Hodgins, G. Leigh, R. Milne and R. Gerrish (1997) examined the relationship between individuals’ choice of abstinence or moderate drinking during out patient behavioural management treatment and outcome over 12 months post treatment. At the initial assessment, 46% of 106 chronic alcoholic subjects chose abstinence, 44% chose moderate drinking and 9% were unsure. Over the course of treatment, subjects were more likely to move from moderation to abstinence goals, and after the first 4 weeks of treatment, two-thirds chose abstinence. These subjects were older, had more severe alcohol problems (i.e. higher MAST scores), and were more likely to maintain their weekly alcohol consumption goals during the 16-week treatment period. Moreover, these subjects reported less alcohol use in the 12-month follow-up period and a greater proportion were judged as having successful outcomes.
S. Maynard (1997) undertook a pioneering research in which adults from alcoholic families of origin were compared to persons from non-alcoholic families on differentiation of self and state and trait anxiety. Data were collected from community college students, clients in a private psychotherapy practice and individuals attending several community-based Al-anon/Adult children of alcoholics meetings. A total of 112 volunteers met the criteria for participation in the study. Offspring from alcoholic families experienced higher levels of state and trait anxiety and lower levels of differentiation of self than offspring from non-alcoholic families.\textsuperscript{38}

C.M. Murphy and T. J. O’Farrell (1997) undertook a study to examine the associations between communication problems and marital violence in couples with a male alcoholic and to determine whether the communication correlates of marital violence found in non alcoholic community samples also characterize male alcoholics relationships. Ninety newly abstinent treatment seeking male alcoholics and their wives completed a 10-minute problem discussion while both partners were sober. Their communication behaviours were coded with the Marital Interaction Coding system. Couples were separated into maritally aggressive (n=60 couples) and non-aggressive (n=30 couples) groups on the basis of any husband-to-wife physical aggression in the previous 12 months. Results indicated that the base-rate percentage of aversive-defensive communication was significantly higher for couples with a physically aggressive
husband than for couples with a non-aggressive husband. The base-rate percentage of facilitative enhancing communication did not differ significantly between groups. In sequential analyses, physically aggressive husbands, but not their wives, displayed more negative reciprocity than their non-aggressive counterparts. Alcoholic husbands in general displayed lower rates of facilitative enhancing communication than did their wives. 39

J. L. Obert, R. A. Rawson and K. Miotto (1997) designed a study in which a six-session cognitive behavioural protocol has been developed for substance abusers that met the description “hazardous users”. This category included individuals evidencing mild to moderate use of alcohol or other drugs, whose lifestyles were minimally disrupted, or who were displaying signs of problems use or abuse, but were unwilling to enter intensive treatment. The treatment model was non-confrontational and was designed to motivate the individual to recognise the problems associated with his or her substance use and initiate treatment-seeking behaviour. A positive outcome was indicated by the client taking action which was consistent with an increased awareness of the problem as conceptualised by Prochaska and Di Clemente(1982). This model was as alternative to the traditional confrontational models of “breaking through denial”. 40

T. J. O' Farrell, K. A. Choquette, H. S. Cutter and G. R. Birchler (1997) examined the contribution of alcoholism and marital conflict to male
alcoholics’ sexual problems. Married couples with an alcoholic husband (n=26) were compared with 26 maritally conflicted and 26 non-conflicted couples without alcohol related problems on both sexual dysfunction and sexual satisfaction. The male alcoholics and their wives experienced less sexual satisfaction across a range of variables and more sexual dysfunction specifically husbands’ diminished sexual interest, impotence and premature ejaculation and wives’ painful intercourse than non-conflicted couples. However, impotence was the only aspect on which alcoholics reported more difficulties than did maritally conflicted couples. When husbands’ age was considered, more frequent retarded ejaculation with older age was unique to the alcoholics since it did not occur in conflicted or non-conflicted husbands and there was greater decline in frequency of intercourse with older age among the alcoholic than among the conflicted couples.

A. Ojeehagen, M. Berglund and L. Hansson (1997) conducted a study where alcoholics were randomised to two out patient treatment programmes; multi-modal behavioural therapy and psychiatric treatment based on a psychodynamic approach. As part of the study, analyses were performed concerning differences in alliance between the two treatment models, and concerning the relationship between alliance and treatment outcome. A Swedish version of the Helping Alliance Questionnaire was used to measure alliance. All therapy sessions were tape-recorded. An independent researcher rated the
patient’s and therapist’s contribution to the alliance at the third session. Early patient and therapist alliances were not related to socio-demographic data or initial measures of alcohol severity, psychiatric symptoms or personality structure in either therapy. Early therapist alliance was better in multi-modal behavioural therapy in comparison with psychiatric treatment based on a psychodynamic approach. For multi-model behavioural therapy patients, a significant positive correlation was found between early patient alliance and mood dimensions at 6 months. There were no significant positive correlations between early alliance and drinking outcome during the course of treatment and in the third year after start of treatment. Mood and drinking outcome also showed low correlations.\textsuperscript{42}

B. M. Pechter and N. S. Miller (1997) reviewed that proper diagnosis of co morbid disorders is crucial in treatment planning for the dually diagnosed. Since psychoactive substance use can obfuscate the diagnosis, special case must be taken to exclude organically based syndromes. Adequate periods of abstinence should first be achieved and subsequently the patient re-examined for residual symptoms compatible with a non-addictive, non-substance induced psychiatric disorder. The integration of concurrent treatment of both the mental and the addictive disorders appears to be the best approach for treatment of co morbid psychiatric and addictive disorders. An abstinence-based model that typically utilizes a 12-step group therapy is often employed for the addictive illness. Other forms of psychosocial therapies such as case managers are being used as well.\textsuperscript{43}
C. Sharp, D. P. Hurford, J. Allison, R. Sparks and B. P. Cameron (1997) undertook a study to determine if autogenic relaxation training facilitated through biofeedback promotes an increase in internal levels of locus of control. The participants were residents of two southwest Missouri alcohol treatment centres and ranged in age from 18 to 21 years. Treatment and control groups were compared on their responses on the Drinking Related Locus of Control and fingertip temperature pre- and post training. The training was effective in teaching autogenic relaxation as demonstrated by increased fingertip temperature for the treatment group post-training while no differences were observed for the control group. Most importantly, the treatment group was not only significantly more internal in their locus of control after training but were also significantly more internal than the control group post-training. Given that alcoholics are significantly more external in their locus of control than non-alcoholics, and that an internal locus of control implies an individual’s belief that he or she has control and is responsible for his or her behaviour, autogenic relaxation facilitated through biofeedback may be very important component in therapeutic intervention for adolescent alcoholics. 44

J. W. Smith, P. J. Frawley and N. L. Polissar (1997) undertook a research in which 249 patients who were treated for alcoholism in an inpatient multimodal treatment program that included aversion therapy were matched post hoc on 17 baseline variables with patients from a national treatment outcome
registry. The latter patients received in patient treatment that emphasised individual and group counselling as the primary therapeutic elements but did not include aversion therapy for alcohol. Six and 12-month abstinence rated from alcohol and all mood-altering chemicals are reported. The patients treated with aversion therapy for alcohol had higher alcohol abstinence rates at 6 and 12 months. The abstinence rates from all mood-altering chemicals were higher in the aversion groups at 6 months but not at 12 months. These comparisons pooled faradic aversion and chemical aversion results. In order to determine whether or not the faradic aversion gave comparable results to the chemical aversion, the two groups were separately analysed. No significant differences in outcome were found. In fact, the faradic aversion group showed a slight increase in abstinence rate.\textsuperscript{45}

M. L. Steinberg, E. E. Epstein, B. S. Mc Crady and L. S. Hirsch (1997) examined sources of motivation to seek treatment. Participants were 105 male alcoholics and their non-alcoholic female partners who participated in a study of three different approaches to the conjoint treatment of alcoholism. Participants' sources of motivation were coded from responses to questions at the initial clinical screening interview. Sources of motivation were classified as "internal" or "external". More participants had internal sources of motivation (74\%) than external sources. Participants with internal sources of motivation scored higher on the Michigan Alcoholism Screening Test (MAST) than participants with
external sources of motivation but did not differ on other measures of pre-treatment severity of alcohol problems. About half of the participants (53%) cited their partner as a primary source of motivation to seek treatment. Other sources of motivation cited were: increasing problems with alcohol, mental health problems and physical health problems. There was greater variability among internal sources of motivation. Participants’ partners but not the male participants themselves experienced an increase in marital satisfaction from pre-to-treatment when the participant was motivated to come to treatment by his partner.46

K. M. Carroll, C. Nich, S.A. Ball, E. Mc Cance and B. J. Rounsavile (1998) evaluated disulfiram and three forms of manual guided psychotherapy for individuals with cocaine dependence and concurrent alcohol abuse or dependence. One hundred and twenty two cocaine/alcohol abusers were the participants. One of five treatments delivered over 12 weeks: Cognitive behavioural treatment plus disulfiram; Twelve Step Facilitation (TSF) plus disulifiram; clinical management plus disulfiram; cognitive behavioural treatment plus no medication; Twelve Step Facilitation plus no medication. Duration of continuous abstinence from cocaine or alcohol; frequency and quantity of cocaine and alcohol use by week, verified by urine toxicology and breathalyser screens. Findings showed that Disulfiram treatment was associated with significantly better retention in treatment, as well as longer duration of abstinence from alcohol and cocaine use. The two active psychotherapies (Cognitive behavioural
treatment and Twelve Step Facilitation) were associated with reduced cocaine use over time compared with supportive psychotherapy (clinical management). Cocaine and alcohol use were strongly related throughout treatment, particularly for subjects treated with disulfiram. This study underlines the importance of combining psychotherapy and pharmacotherapy in the treatment of drug use disorders. 47

R. Cisler, H. D. Holder, R. Longabaugh, R. I. Stout and A. Zweben (1998) conducted a study to examine the relative costs of three manual guided, individually delivered treatments and the costs of replicating them in non-research settings. Costs of delivering a 12-session Cognitive Behavioural Therapy (CBT), a 4-session Motivational Enhancement Therapy (MET) and a 12 session Twelve Step Facilitation treatment over 12 weeks were assessed for three treatment sites at two of the nine project MATCH locations. Results showed that Motivational Enhancement Therapy cost twice as much or more per patient contact hour than cognitive behavioural therapy and twelve step facilitation but was less costly per research participant than both Cognitive Behavioural Therapy and Twelve Step Facilitation. 48

retention in a sample of 164 alcohol and/or cocaine-dependent out patients. Results indicated that level of family attendance at a multifamily group strongly predicted completion of short term and long-term outpatient treatment. Effects were greater for cocaine dependent than for alcohol dependent subjects in analyses of short-term treatment retention. Multifamily therapy may be a powerful method to engage patient’s families in treatment and promote treatment retention, especially in the early, intensive phases of treatment for alcohol and chemical dependency.\textsuperscript{49}

S. Gabel, M.C. Stallings, S.E. Young, S. Schmitz S, T. J. Crowley and D.W. Fulker (1998) undertook a study in which the families of 50 male youths in a residential centre for alcohol and substance misuse were compared with the families of a community control group. Within-subject group comparisons also were made. Family structure, interactive processes, maternal and paternal alcohol and substance use and criminality were assessed through direct interview and/or self-report. The families of alcohol and substance misusing boys were markedly disadvantaged or impaired on numerous family structure, process and substance misusing behavioural variables in comparison with community controls. Within the alcohol and substance-misusing group itself, family process variables, maternal alcohol symptoms and maternal criminality differentiated boys with more verses less severe drug dependence symptoms. Maternal alcohol problems and criminality were more important than family process variables. Paternal
alcohol or substance misuse or criminality did not differentiate proband symptom severity.  

A. P. Greeff and W.S. Conradie (1998) undertook a study to assess the effect of progressive relaxation training on insomnia in institutionalised chronic alcoholic men, 22 subjects between the ages of 20 and 60 years, were randomly allocated to treatment and control groups. The treatment group received 10 sessions of progressive relaxation training over a 2-week period after which both groups completed a post experimental questionnaire. Analysis showed a significant improvement in the sleeping patterns of the treated group, but no changes in the sleeping patterns of the control group. In addition, a distribution-free two-sample permutation test to compare mean differences of the groups confirmed that a significantly greater change occurred in the quality of the sleeping patterns of the treated group.  

S. Hsieh, N. G. Hoffmann and C.D. Hollister (1998) examined the relationship between pre-, during-, post treatment variables, and treatment outcome by using a secondary data analysis of the 6- and 12- months post treatment follow-up data from 2,317 adolescent subjects. Pre-treatment variables included in this study are psychosocial, family-related, substance abuse and special event variables. During treatment variables are length of stay and parental participation in treatment. Post-treatment variables cover the attendance of subsequent treatment/continuing care, such as AA/NA and CD after care, and parental
attendance of subsequent treatment. Results from discriminant function analyses indicated that during- and post treatment variables could differentiate the abstinence status at 6- and 12-month follow-ups. It was also shown that the post-treatment variable group exhibited the best classification accuracy among the three variable groups across both follow-up periods.  

Y. Kaminer, C. Blitz, J.A. Burleson, M. Rounsaville, and B. J. Rounsaville (1998) undertook a pioneering work in which the group sessions rating scale, a group-therapy process measure, was studied to determine its appropriateness for assessing group treatment of adolescents with (a) substance use disorders, (b) inter-rater reliability, (c) internal consistency and (d) ability to discriminate the active ingredients of cognitive behavioural therapy from interactional therapy. Inter-rater reliabilities were moderate to high, with those for cognitive behavioural therapy generally higher than those for interactional therapy. Internal consistency of cognitive behavioural therapy item was moderate, where as those of interactional therapy were moderately high. Discriminability between the two treatment modalities was high. The frequency of active ingredients was generally therapy-specific: high for the relevant and low for the non-relevant therapeutic modality items.  

Y. Kaminer, J. A. Burleson, C. Blitz, J. Sussman and B. J. Rounsaville (1998) undertook a study which tested the hypothesis that dually diagnosed adolescent substance abusers could be matched to effective treatments on the
basis of their co-morbid psychopathology. Specifically, patients with externalising disorders would have better outcomes when treated with cognitive-behavioural group treatment, and subjects with internalising disorders without comorbid externalising disorders would fare better in interactional group treatment. Thirty-two dually diagnosed adolescent substance abusers were randomised into two 12-week manual guided outpatient group psychotherapies: cognitive behavioural group treatment and interactional group therapy. At 3-month follow-up, no patient-treatment matching effects were identified. Adolescents assigned to cognitive behavioural group therapy demonstrated a significant reduction in severity of substance use compared with those assigned to interactional group therapy. Improvement in severity of family function showed a trend in favour of cognitive behavioural group therapy. School function, peer-social relationships, legal problems, and psychiatric severity all showed a consistent-non-significant direction in favour of cognitive behavioural group therapy over interactional group treatment. Cognitive behavioural group treatment appears to be a promising short-term psychosocial intervention for adolescents.54

S.A. Maisto, J. R. Mc Kay and T. J. O’Farrell (1998) undertook a study to investigate the relationship between abstinence from alcohol during the first year following group Behavioural Marital Therapy (BMT) for alcohol problems and drinking and marital functioning through 30 months post group Behavioural
Marital Therapy (BMT). The subjects were 73 white male veterans with severe alcohol problems who participated in a clinical trial of group behavioural marital therapy and individual behavioural marital therapy after care. All subjects who entered the clinical trial were classified as either abstinent from alcohol for the full first 12 months following completion of group behavioural martial therapy or not. Following completion of group behavioural marital therapy, subjects were re-evaluated on drinking, marital functioning and related behaviours at 3, 6, 12, 18, 24 and 30 months later. Results showed that the outcome analyses, taking in to account baseline differences between drinker groups on age, marital functioning and number of days light drinking showed better alcohol use (18, 24 and 30 months) and marital functioning (6, 12, 18, 24 and 30 months) for the first year abstainers. Further more, fewer first-year abstainers than drinkers reported they were hospitalised for alcohol-related reasons at the 18, 24 and 30-month follow-ups, and the abstainers showed a greater degree of self-efficacy not to drink heavily at each of the 6, 18 and 30 months follow-ups.\footnote{55}

T. J. O’Farrell, K. A. Choquette and H.S. Cutter (1998) studied a complete report of outcome data from a study of behavioural marital therapy with and without additional couples relapse prevention sessions. Fifty-nine couples with an alcoholic husband, after receiving weekly behavioural marital therapy couples sessions for 5-6 months, were assigned randomly to get or not get 15 additional couples relapse prevention sessions over the next 12 months. Out
come measures were collected before and after behavioural marital therapy and at quarterly intervals for the 30 months after behavioural marital therapy. Results indicated behavioural marital therapy plus relapse prevention produced more day’s abstinence and greater use of the Antabuse contract than behavioural marital therapy only; and those superior drinking outcomes for behavioural marital therapy plus relapse prevention lasted through 18-month follow-up (i.e., 6 months after the end of relapse prevention). Behavioural marital therapy plus relapse prevention had better wives’ marital adjustment than behavioural marital therapy only throughout the 30 months of follow-up, with the superiority of behavioural marital therapy plus relapse prevention over behavioural marital therapy only being greatest for wives with poorer pre-treatment marital adjustment during the later months of follow-up. Behavioural marital therapy plus relapse prevention also maintained their improved marriages longer (through 24-month follow-up) than behavioural marital therapy only (through 12-month follow-up). Irrespective of treatment condition, more use of behavioural marital therapy targeted marital behaviours was associated with better marital and drinking outcomes throughout the 30-month follow-up period whereas more use of the Antabuse contract was associated with better marital and drinking outcomes through 12-month follow-up. Alcoholics with more severe marital problems had more abstinent days and maintained relatively stable levels of abstinence if they received behavioural marital therapy plus relapse prevention,
while their counter parts who received behavioural marital therapy only had fewer abstinent days and showed a steep decline in abstinent days during the 30 months of follow-up.\textsuperscript{56}

C. A. Patten, J.E. Martin, M.G. Myers, K. J. Calfas and C.D. Williams (1998) examined the efficacy of a mood management intervention for smoking cessation in abstinent alcoholics with a history of major depression. Participants were 29 heavy smokers, with an average of 6.8 years of continuous abstinence from alcohol and drugs, randomised to behavioural counselling or behavioural counselling plus cognitive behavioural management (CBT). A 2x5 repeated measures design was used to evaluate the effectiveness of the interventions on smoking outcome at baseline, post treatment and at 1, 3 and 12-month follow-up. Verified self-report indicated that significantly more smokers in cognitive behavioural therapy quit by post treatment than in behavioural counselling. These abstinence rates remained unchanged at 1-month follow-up. At 3-month follow-up, differences in smoking abstinence rates were non-significant between cognitive behaviour therapy and behavioural counselling conditions. However, at 12-month follow-up, significantly more participants in cognitive behaviour therapy were abstinent from smoking than in behavioural counselling.\textsuperscript{57}

J. C. Van. de Velde, G.E. Schaap and H. Land (1998) undertook a study which reported on inpatient treatment of addicts. Attention was paid to the Therapeutic Community (TC) model employed with alcoholics. A sample of 881
patients was assessed at intake and was followed up. The results demonstrated that the patients improved on a variety of outcome measures. Some associations were found between patient variables and improvement. Treatment variables predicting a positive outcome were sustained treatment in a therapeutic community and attending AA meetings. The relative efficacy of therapeutic communities, originally created by drug users, holds for alcoholics as well. It is concluded that an important precondition to a positive treatment outcome is the continuity of the treatment process. Pursuing that continuity seems to be an excellent mediate goal for both addicts and treatment personnel.$^5$

The relevant studies carried out in India and abroad concluded that better outcome is found when the alcoholics received nonpharmacological treatment along with pharmacological treatment. Most of the related studies are limited to selected psychotherapy and the impact of comprehensive family intervention therapy is not evaluated. However, reviews of the studies have provided an overview of the major psycho-social approaches used in more intensive speciality treatment of patients with substance use disorders.

References


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