A COMPARISON OF TWO TECHNIQUES TO REACH RELATIVES OF ALCOHOLICS FOR INFORMATION OF AVAILABLE SUPPORT

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Abstract — Two different information techniques to reach spouses and relatives of inpatient alcoholics for information of available support, one standardized and one individualized, were compared. Each procedure was tested during 6 months in the same ward. In the standardized model 18% (20/112) and in the individualized model 20% (21/104) of spouses/relatives/friends attended the information session. In those living with a spouse, the rates were 46% and 41% respectively, and among those who were not cohabiting, but had relatives or sober friends, the figures were 11% and 17% respectively. There were no sex differences. Among preferred support, individual support, marital and family support and professional group support received the highest ratings. At the 1 year follow-up, more subjects in the individualized information group had received support compared with those in the standardized group. The low rates of informed subjects are in agreement with the literature and considerably lower than the rates in information programmes for relatives of schizophrenic patients.

INTRODUCTION

The importance of social network for successful outcome in alcoholism treatment has been acknowledged in recent years. One important therapeutic issue concerning spouses or close relatives of alcoholics is to reach them for information of available support and treatment. At present, only a few studies concerning different types of available support have been presented. Cheek et al. (1971) offered wives or parents of alcoholic patients an outpatient supportive programme. Among 158 spouses, 27 (17%) agreed to participate, but seven never attended a single meeting. This low rate was unexpected. Later research has mainly concerned couples in marital therapy. In controlled studies, different types of engagement concerning spouses have yielded various results (Kaufmann and Pattison, 1981; O'Farrell et al., 1985; O'Farrell, 1989). By and large more engagement improved prognosis for both the alcoholic and the spouse.

In order to study the implementation problem, i.e. to reach the spouse or relative for information on available support, we offered an information session to spouses and relatives of consecutively admitted inpatient alcoholics. The information was presented in a standardized way during a period of 6 months and in an individualized way during another 6 month period. The aim of the study was threefold: (1) to estimate the number of spouses and relatives who attended such an information session; (2) to study the efficiency of an individually adjusted information procedure in comparison with a standardized information procedure; (3) to study the long-term effects of the two different types of information procedures with respect to further seeking of support.

SAMPLE AND METHODS

General design

The present study has been performed at the Department of Alcohol Diseases, Malmö University Hospital, Malmö, Sweden. The intake ward at the department treats both female and male alcoholics after an initial detoxification at the emergency room for 1–4 days. The median treatment duration at the ward is 8 days. The study has been divided into two periods, one period with standardized information and one period with individualized information.
Phase 1. Standardized information technique; first half of 1990: the sample consisted of 112 patients, 76 men (67%) and 36 women (33%), with a mean age of 50 years (range 23–78). Eight women living with assaultive spouses were excluded from the study, because they were afraid of any contact between their relative and the hospital and such a contact was regarded as potentially harmful for the women.

Phase 2. Individualized information technique; first half of 1991: the sample consisted of 104 patients, 59 men (57%) and 45 women (43%), with a mean age of 49 years (range 25–85). Eighteen patients, seven men and 11 women, were excluded because they had been in treatment during the first phase.

In both groups, about 50% of the patients did not give consent to contact relatives and friends and about 15% of the relatives and friends did not want to attend the programme.

Method

The study was approved by the local Ethics Committee. The patient gave informed consent before the spouse or the closest relative/friend was contacted. The way of contacting and the information technique differed during the two phases. In order to standardize the information concerning different types of support, a video tape with a 10 min duration was produced. The senior psychiatrist at the ward (M.B.) was the speaker. The manuscript was written in collaboration with the available support groups, Al-Anon, the Link’s family program, the Social Services support and the professional support group at the Department. The final version of the video tape was approved by all these groups. In addition, it was mentioned in the video tape that some people preferred individual, marital or family support and that these types of support were available. After the video tape had been presented to the spouse/relative/friend, he/she was asked to rank the three most relevant alternatives presented on the video. The first alternative was given a score of three, the second alternative a score of two and the third alternative a score of one point. He/she also rated the different alternatives in a Likert-type scale (very positive, positive, uncertain or negative). If he/she wanted to take part in any of the available types of support the researcher (U.Z) offered help to establish such contact. During both phases, the interviews of the patients and the relatives have been made independently by two research assistants.

Phase 1. The standardized information technique. The patient was told by a researcher (U.Z.) about the information programme a few days after admission to the ward. It was a short information about the project and a formal inquiry which lasted for about 10 min. If the patient accepted to be included in the study, the researcher phoned the spouse/relative/friend and informed about the project. If the spouse/relative/friend accepted, the video tape was presented.

Phase 2. The individualized information technique. During this phase, the researcher cooperated closely with the patient’s key nurse at the ward. The family situation and the social network were evaluated according to the general clinical programme. The information to the patient about the support programme was given by the key nurse at a time considered appropriate from a psychological point of view. The key nurse met with the patient almost daily and could discuss the project and answer questions about the study on several occasions. The main problem was to motivate the patient to accept the relatives’ attendance in the study. The time taken for patient information was about 45 min. If the patient gave permission, the spouse/relative/friend was contacted by the key nurse in a flexible way depending on the family’s situation and the psychodynamic interactions. Contacts were taken either personally when the spouse/relative/friend visited the patient at the ward, or by telephone. Later, the key nurse and the researcher met with the relative/friend for further information. If the relative/friend agreed to participate, the video tape was presented.

In 10 cases, the spouse/relative/friend accepted the contact and asked for support, but did not want to attend the scientific part of the study, i.e. watch the video tape, neither rate their need of support nor answer several self-report questionnaires. The self-report questionnaires are not reported in the present study. The 10 cases were all given individualized information. Some of these relatives attended up to six support sessions. In the analysis, these subjects were included among relatives, who had attended the information session. However, they were not included in the follow-up study, because they had not given
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Table 1. Numbers of informed relatives by patients' living condition during the periods with standardized information and individualized information, respectively after permission from patients

<table>
<thead>
<tr>
<th></th>
<th>Standardized information</th>
<th>Individualized information</th>
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<tbody>
<tr>
<td></td>
<td>n = 20/112 (18%)</td>
<td>n = 21/104 (20%)</td>
</tr>
<tr>
<td></td>
<td>(informed/total)</td>
<td>(informed/total)</td>
</tr>
<tr>
<td>Female alcoholics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with spouse</td>
<td>4/9 (44%)</td>
<td>5/13 (38%)</td>
</tr>
<tr>
<td>Living with children</td>
<td>0/2 (0%)</td>
<td>0/7 (0%)</td>
</tr>
<tr>
<td>Contact with relatives/sober friends</td>
<td>2/17 (12%)</td>
<td>6/19 (32%)</td>
</tr>
<tr>
<td>No contact</td>
<td>0/8 (0%)</td>
<td>0/6 (0%)</td>
</tr>
<tr>
<td>Total</td>
<td>6/36 (16%)</td>
<td>11/45 (24%)</td>
</tr>
<tr>
<td>Male alcoholics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with spouse</td>
<td>8/17 (47%)</td>
<td>7/16 (44%)</td>
</tr>
<tr>
<td>Living with children</td>
<td>1/1 (100%)</td>
<td>0/0 (0%)</td>
</tr>
<tr>
<td>Contact with relatives/sober friends</td>
<td>5/45 (11%)</td>
<td>3/33 (9%)</td>
</tr>
<tr>
<td>No contact</td>
<td>0/13 (0%)</td>
<td>0/10 (0%)</td>
</tr>
<tr>
<td>Total</td>
<td>14/76 (18%)</td>
<td>10/59 (17%)</td>
</tr>
</tbody>
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Table 2. Mean rank points of preferred support in the relatives groups with standardized information and individualized information after permission from patients

<table>
<thead>
<tr>
<th></th>
<th>Standardized information</th>
<th>Individualized information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 20)</td>
<td>(n = 11)</td>
</tr>
<tr>
<td>Professional group support</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Individual support</td>
<td>1.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Marital/family support</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Al-Anon</td>
<td>0.7</td>
<td>1.0</td>
</tr>
<tr>
<td>The Link family programme</td>
<td>0.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Social service support</td>
<td>0.6</td>
<td>0.3</td>
</tr>
</tbody>
</table>

1st rank = 3 points; 2nd rank = 2 points; 3rd rank = 1 point.

Informed consent to the follow-up.

In the individualized information technique, the timing of the presentation could be adjusted to the general condition of the patient and thus be regarded as more effective, compared with the standardized technique. The patients' perception of the status of the information givers was not measured. However, the researcher (U.Z.) had previously been a social worker at the ward and was perceived as belonging to the staff of the ward. There were no formal assessments of the relationships between the patients and the relatives.

Follow up

Relatives, who had attended the information session, were contacted by telephone. This contact was made by a research assistant (K.A.-Ö.) who had not been involved in the first part of the study. The interview was performed 1 year after the first examination. The relatives were asked about type of support received after the initial examination and changes in the family situation as well as in the social situation, patient's drinking pattern, subject's own drinking pattern, use of drugs, role behaviour, living condition and physical and mental health according to a questionnaire developed by the researchers.

RESULTS

Early results

In Table 1, the numbers of subjects who attended the information sessions are presented. The rates were similar in the two types of intervention procedures, 20/112 (18%) in the standardized procedure and 21/104 (20%) in the individualized procedure. In those living with a spouse, the figures were 46% and 41%, respectively. Among those who were not cohabiting but had relatives or sober friends, the figures were 11% and 17%, respectively (Table 1). The rates of attendance in relatives/friends of female and male patients to the standardized information session were 12% and 11%, respectively. Corresponding rates for the individualized information session were 32% and 9%, respectively. The standardized information group (20 relatives) included eight
wives, four husbands, three mothers, three adult children and one sister. All of them accepted both the contact and the research part. The individualized information group (21 relatives) included seven wives, five husbands, three parents (mothers), four adult children, one sister and one sober friend. As mentioned earlier, 10 of these subjects did not attend the scientific part of the study.

In Table 2, the results of the ratings of preferred alternatives after the presentation of the video tape are presented. Professional group support, individual support, marital and family support received high ratings in both information sessions, whereas Al-Anon, the Link's family support and social service support were rated low.

Results of a 1 year follow-up

Among the 20 subjects in the standardized information group, information was available for 15 subjects (one male spouse was deceased at the follow-up and was excluded). For four relatives, contact could not be established (new addresses and/or unlisted telephone numbers). All 11 subjects in the individualized information group were interviewed. Four out of 15 (27%) in the standardized information group had received support, compared with 10 of the 11 (91%) in the individualized information group ($\chi^2 = 8.11, P < 0.01$). In the standardized information group, one out of four subjects had obtained the chosen support (first ranked alternative), compared with four out of 10 subjects in the individualized information group. Nine out of 15 (60%) in the standardized information group reported that they were in good health mentally and physically, compared to 10 out of 11 (91%) receiving individualized information (difference not significant). Two individuals, one in each group, who had received support, reported bad health mentally or physically.

The three following case vignettes illustrate the follow-up results:

'My son has tried sobriety since the in-patient treatment period. There have only been one or two short relapses. He seems to be in good shape. I am both physically and mentally in good condition, but I am worried about my son, because he is out of work. We talk daily by phone.' (Mother, standardized information.)

'My mother has been sober since the in-patient treatment period. There has been a positive change in our relationship, even if it takes time to build it up again. I am very proud of my mother, because she has managed to stay sober. She is physically and mentally well, but sometimes a bit restless. I am also in good shape both physically and mentally. We do things together now in our spare time, like short travels, go dancing and listen to music.' (Daughter, individualized information.)

'After the treatment at the ward, my wife has got additional treatment according to the 12-step programme. She has been sober since discharge. I, myself have been in a family programme for one week. There has been a positive change in our family life and my wife takes better care of our son now. We have also improved our relationship with our friends. We are all physically and mentally well. I have reduced my drinking to 4–5 beers/week.' (Husband, individualized information.)

DISCUSSION

The main finding in the present study was that the percentage of spouses/relatives/friends who attended the information session was low and similar in both types of information sessions, 18% and 20% for all patients, respectively and 46% and 41%, respectively for those who were living with spouses. The second finding was that the individualized procedure yielded a higher rate of subjects receiving support during the follow-up period, 10/11 (91%) compared to 4/15 (27%) in the standardized procedure.

The first finding is in good agreement with previous reports by Cheek et al. (1971) and Pattison et al. (1965). In Cheek's study, 17% attended the treatment programme. In the present study, 18% and 20%, respectively attended the information sessions. In the study by Pattison et al. (1965) 80 women were seen, constituting 40% of wives with husbands in treatment. The majority (57%) did not return after the first visit.

The selection of subjects in our study differs somewhat from those cited above. In the present study, not only partners were included, but also other primary and secondary relatives and close friends. The initial selection of participants in the study of Cheek et al. (1971) was done by a search of record among previous inpatients and their spouses. The initial contact was taken directly with patients and relatives by mail or telephone. In
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the study by Pattison et al. (1965) wives of alcoholics treated in an alcoholism outpatient clinic were contacted. This approach is similar to ours, although our subjects also included other relatives and friends.

One of the main problems in our study was to receive the patients' consent to contact the relatives. This kind of problem was also discussed in the study by Pattison et al. (1965), who considered the problem as a very important one, since the patient often forgot or neglected to inform his wife. Our study differed in that it was based on a staff approach to relatives and friends after getting consent from the patient.

Other studies on relatives of alcoholics addressing resistance to joint treatment have emphasized the importance of the high stress situation in the alcoholic family (Pattison et al., 1979). Ruined or altered role patterns and the frequent subordinate role of the alcoholic are other factors emphasized in the research literature. Orford et al. (1992) have reported that some of the most usual coping behaviours used by relatives of problem drug-takers are avoidance and inaction, probably promoting non-participation.

The results of the present study differ from those obtained in similar approaches in other disorders, for example schizophrenics living with their families. Stirling et al. (1991) reported a study of 45 cohabiting schizophrenic patients, where 42 agreed for their families to be contacted and 38 (83%) of the families agreed to participate in the study. In a study by Haas et al. (1988) concerning 297 patients with schizophrenic disorder, 186 patients with relatives agreed to enter the study (63%). Obviously relatives of patients with schizophrenic disorder more frequently attend information programmes compared with relatives of alcoholics. These differences can possibly be explained in terms of more interaction problems in families of alcoholics with higher degree of hostility, threats and violence, more social and economical instability and acting out behaviour. Differences in age between the generally older alcoholic patients and generally younger patients with schizophrenic disorder may also be of importance.

Could the results have been improved by further measures, for example more education of the ward staff about families of alcoholics, or could the results have been improved if we had engaged just one or a few special key nurses in the information programmes? These questions have to be addressed in future studies.

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REFERENCES


