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Abstract

The aim was to describe discrepancies between patients' and spouses' dyadic adjustment scores, spouse strain and patients' temptation to drink during abstinence. Patients overestimated the dyadic adjustment scores of their partner and spouses underestimated patients' scores. Spouses overestimated patients' temptation to drink. Correlations between patients' and spouses' scores were generally high (.61 to .78) except for five measures of spouse strain which were lower (.31 to .50). Results show discrepancies concerning marital function and the temptation to drink which could be important when planning treatment and prevention of relapse.

COMPETING INTERESTS: None declared.

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Keywords

- *alcohol problem*
- *caregiver*
- *couple*
- *illness perception*
- *strain*
- *temptation*

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Introduction

THERE IS substantial evidence for the negative effects of alcohol misuse not only for the drinkers themselves, but also for their families (Copello, Velleman, & Templeton, 2005; Rotunda & Doman, 2001; Rotunda & O'Farrell, 1998). Adjustment to an alcohol problem may result in an increase in the family's emotional and physical illness (Bloom, 1985) and altered familial function. The situation may be especially bad if the spouse is always 'on-call' to cope with the partner's consumption and to deal with the daily crises of alcohol dependence, such as violence, drunk driving or the partner's disappearance for days at a time (Copello et al., 2005). The spouses of drinkers report psychological and somatic complaints as well as low levels of marital satisfaction (Halford, Bouma, Kelly, & Young, 1999). Moreover, this link is often reciprocal (Bamford, Barrowclough, & Booth, 2007), as drinking has the potential to both affect and be affected by marital events (Magura & Shapiro, 1988; Roberts & Leonard, 1998).

Members of a family are often the first to attempt to manage a person's use of alcohol (Raitasalo & Holmila, 2005; Wiseman, 1991). Tolerant-inactive coping may be bad for relatives (Orford et al., 2001) and certain spouses engage in an attempt to 'home treat' their partners' alcoholism. The partners of people who drink heavily typically try to influence their partner to reduce her/his use of alcohol with a variety of coping strategies, such as pouring out drinks, persuasion, emotional pleading to change, ignoring her/him when she/he is drunk, nagging, threats to leave, drinking along with her/him, indirect and manipulative approaches, and turning to clinicians for help (for a review, see Rotunda & Doman, 2001). The frequency of use of these strategies increases with the severity of the alcohol problem, yet these attempts may sometimes be counterproductive as increased drinking is associated with a higher frequency of confrontation (O'Farrell, Hooley, & Fals-Stewart, 1998).

Alcohol treatment programs that include spouses in the therapy process have been introduced, especially in the United Kingdom and in the United States (for a review of treatments, see Copello et al., 2005). These programs employ the three major areas of intervention for couples, which are based on the idea that the spouse can influence the partner by helping them to decide to accept help, that positive dyadic adjustment is related to positive therapy outcomes and that there is a need for reducing strain on family members.

Among potentially relevant topics in the family functioning and treatment process would be the evaluation of dyadic adjustment, drinkers' behaviors and associated strain on the spouse. One can presume that divergent perceptions between the patient and spouse are important both in day-to-day life and during treatment. This may be dependent upon the extent to which the patient and their spouse hold similar perceptions about problems and therapy (Bamford et al., 2007). Other studies about the topic of somatic illness demonstrate the importance of congruent evaluation for marital adjustment (Heijmans, DeRidder, & Bensing, 1999) and psychological distress in couples (Richards et al., 2004). According to Raitasalo and Holmila (2005), the links between the drinker's own concerns and the pressure exerted by the spouse can be particularly troublesome when the individual's own evaluation is not supported by the partner. Notably, this is the case when a person thinks that her/his drinking is not a problem, but the partner thinks differently and tries to manage her/his behavior in various ways.

Research has classically been conducted on the accuracy of drinkers' self-reporting of alcohol consumption. Reports by the spouse were often seen as the standard of how accurate the patient's report was. Several reviews have collected results showing that the correlations between the drinker and spouse were positive and statistically significant. Discrepancy analyses showed no consistent tendency for the drinker to over-report or under-report alcohol consumption (e.g. Connors & Maisto, 2003). This type of research is essentially concerned with objective measures such as the number of abstinent days or total amount of alcohol consumed. Surprisingly little research has been directed at the subjective approach. Moreover, most of the earlier studies have not looked into how the drinker's perception corresponds with the spouse's own feeling of strain. There are no studies to date that have compared crossed evaluations of alcohol problems and the emotional health of the couple in problem drinkers and their spouses.

This study aimed to examine and compare crossed evaluations of strain, dyadic adjustment and alcohol problems in patients and their spouses. Alcohol problem evaluations of both partners were independently measured using subjective (i.e. temptation) and objective perspectives.

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Method

Participants

The study sample consisted of 66 problem drinkers and 66 spouses recruited as part of a wider study examining family functioning during chronic illness. Inclusion criteria were: (1) couples with just one partner who had an alcohol problem; (2) relationship lasting longer than two years; and (3) participants between 18 and 65 years of age. Exclusion criteria were: (1) patients with major psychiatric disorders; (2) violent relationships; and (3) relationships where the spouse also had a drinking or drug problem or any major psychiatric disorder.

Procedure

All patients were recruited following inpatient treatments for alcohol problems and were approached by research assistants who had an undergraduate degree in psychology. Patients were being followed either by an alcoholics' support group ($N = 27$; 41%) or by a medical team ($N = 39$; 59%). The topic and procedure of this research were presented in writing and only patients and partners who both gave their consent were included. The couples were instructed to complete the survey in private and not to discuss the survey with each other until both had completed and mailed them back.

Measurements

Drinking frequency and quantity We computed indices of drinking level from couples' responses to questions about the quantity and frequency of consumption in the week before treatment. A standard measure of consumption, the average weekly volume, was computed.

Alcohol abuse screening The Short Michigan Alcohol Screening Test (SMAST; Seltzer, Vinokur, & van Rooijen, 1975) is a 13-item questionnaire. SMAST requires only a few minutes to complete. It was developed from the Michigan Alcoholism Screening Test and evaluation data indicate that it is an effective diagnostic instrument. All questions are answered with 'Yes' or 'No' answers.

Self-efficacy The Alcohol Abstinence Self-Efficacy Scale (AASE; DiClemente, Carbonari, Montgomery, & Hughes, 1994) is a 20-item self-reported measure to assess Bandura's constructs of self-efficacy applied to alcohol abstinence. The four five-item subscales measured types of relapse temptations labeled negative affect, social positive, physical and other concerns and withdrawal and urges. The AASE represents a brief, easy to use and psychometrically sound measure of an individual's self-efficacy in abstaining from drinking (DiClemente et al., 1994). Patients were asked to respond how 'tempted' they would be to drink in various situations on a five-point scale ('not at all' to 'extremely').

Dyadic adjustment The Revised Dyadic Adjustment Scale (DAS-16; Antoine, Christophe, & Nandrino, 2008) is a 16-item self-reported evaluation of marital adjustment. Evaluation data highlight both a unidimensional and two-dimensional (*agreement in couple* and *quality of the dyadic interactions*) structure of the marital adjustment. The structure is stable from one sample to another and similar for men and women. Partners were both asked to rate the perceived quality of the dyadic interactions on a six-point scale.

Caregiver strain The Caregiver Reaction Assessment (CRA; Given et al., 1992) is a 24-item assessment that evaluates the embarrassment or role overload that may be experienced by the caregiver. This tool was developed and tested in a study conducted among caregivers of patients with various disorders. The five dimensions of caregiver reactions were identified through exploratory factor analysis: impact on disrupted schedule, financial problems, lack of family support, health problems and the impact on self-esteem. Caregivers were asked to rate the perceived impact of caregiving for each item on a five-point scale.

Collateral reports Collateral reports concerning average weekly consumption, alcohol abuse screening, types of relapse temptations and patients' dyadic adjustment were obtained from spouses. On the other side, collateral reports about the spouses' dyadic adjustment and strain were obtained from patients. The questionnaires concerning the spouse were printed on a separate sheet. The initial instructions were 'We are now trying to understand what your spouse experiences. We will therefore ask you to answer the following questions by circling the statement that, according to you, corresponds to what your spouse experiences.' The instructions for each questionnaire were modified in the same way, for example 'indicate for each statement if it corresponds to what your spouse has felt or experienced over the past two weeks'.

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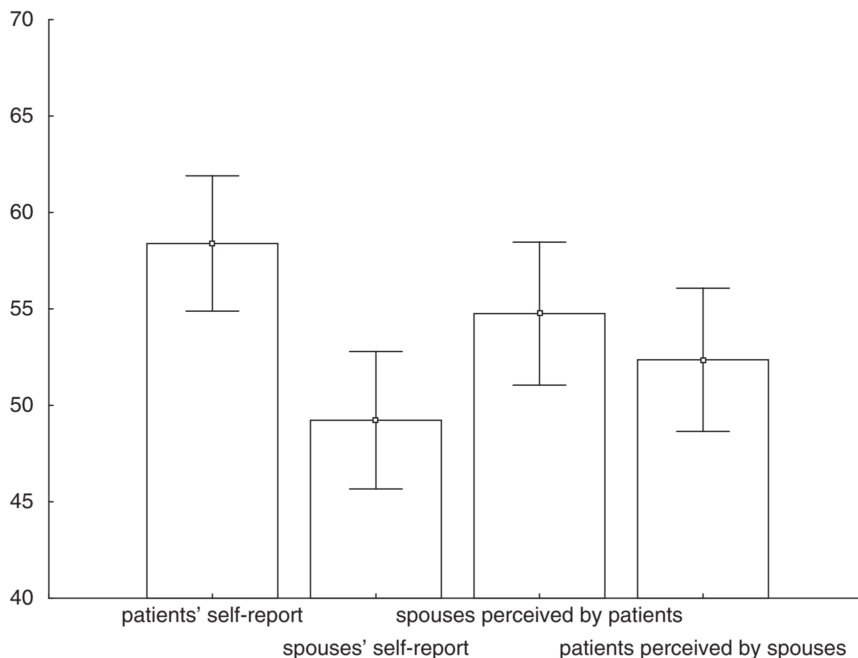

Figure 1. Comparisons between crossed evaluations of dyadic adjustment.

Results

Description of the sample

The mean relationship length was 16 years (ranging from two to 41 years, SD 11.4). Of the patients, 16 (24%) were female and 50 (76%) were male, with a mean age of 43 years (ranging from 25 to 65 years, SD 10.5). The mean age of the spouses was 43 years (ranging from 25 to 65 years, SD 11.7). The majority of the participants (58% of patients and 62% of spouses) were employed. Most of the patients (51, or 77%) had a history of treatment for alcohol problems. Before treatment, 41 (62%) were drinking daily. The mean duration of abstinence was three months (ranging from 0 to 12 months, SD 2.6).

Dyadic adjustment

The dyadic adjustment self-reports of the patients and spouse groups were 58.4 (± 14.3) and 49.2 (± 14.5), respectively. The difference between groups was significant ($t_{65} = 6.5$; $p < .0001$). Patients reported higher adjustment than their spouses (Fig. 1).

Crossed evaluations

Crossed evaluations were compared (two-tailed *t*-test) (Table 1).

When participants were asked to estimate the dyadic adjustment of their partner, patients were likely to overestimate their partners' adjustment ($M = 54.8 \pm 15.1$; $t_{65} = 3.9$; $p < .001$). Conversely, spouses were likely to underestimate their partners' adjustment ($M = 52.4 \pm 15.1$; $t_{65} = 4.4$; $p < .0001$) (Fig. 1).

No significant group effect was found for evaluations of strain as measured by the CRA. The differences did not reach statistical significance for the subscores of *self-esteem* ($t_{65} = 1.66$; $p = .10$), *disrupted schedule* ($t_{65} = 1.91$; $p = .06$), *lack of family support* ($t_{65} = 1.5$; NS), *health problems* ($t_{65} = 1.8$; $p = .08$) or *financial problems* ($t_{65} = 0.5$; NS).

Concerning alcohol consumption and its consequences, no discrepancy was found between patients' self-reports and spouses' reports for past consumption ($t_{65} = 1.22$; NS) or the psychosocial repercussions as measured by SMAST ($t_{65} = 0.21$; NS). However, all *t*-tests reached significance for discrepancies of temptation measured using the AASE. More specifically, spouses rated the temptation as higher than their partner for all assessed contexts: *negative affect* ($t_{65} = 5.6$; $p < .0001$), *social positive* ($t_{65} = 5.3$; $p < .0001$), *physical and other concerns* ($t_{65} = 5.9$; $p < .0001$) and *withdrawal and urges* ($t_{65} = 4.8$; $p < .0001$).

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Table 1. Mean, SD, comparisons and intercorrelations between crossed perceptions

	Patient		*Conjoint*			
Measures	*M*	*SD*	*M*	*SD*	*t*	*r*
Consumption	19.95	15.18	*18.45*	*14.44*	1.22	.78***
SMAST	21.02	7.72	*20.85*	*6.81*	.21	.59***
AASE negative affect	15.62	5.97	*19.11*	*5.23*	5.66***	.61***
AASE social positive	12.98	5.68	*16.15*	*5.44*	5.35***	.63***
AASE physical	10.44	4.17	*13.35*	*5.10*	5.90***	.64***
AASE withdrawal/urges	12.65	4.56	*15.18*	*5.11*	4.77***	.61***
DAS-16 (patient)	58.39	14.27	*52.36*	*15.10*	4.36***	.71***
DAS-16 (conjoint)	*54.76*	*15.08*	49.23	14.49	3.86***	.69***
CRA disrupted schedule	*14.32*	*4.07*	15.50	4.48	1.91	.31*
CRA financial problems	*7.64*	*2.77*	7.83	3.09	.53	.48***
CRA lack of family support	*14.30*	*4.15*	15.11	4.54	1.49	.50***
CRA health problems	*10.85*	*3.71*	11.77	3.77	1.76	.35**
CRA impact on self-esteem	*24.20*	*6.15*	22.86	6.69	1.66	.48***

Note: Collateral reports are indicated in italics. Reports are compared with two-tailed *t*-tests. $N = 66$
$^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$

For each of the comparisons listed in Table 1, correlations between the scores provided by patients and spouses were calculated and are included in the table. It will be noted that these were generally high (.61 to .78) except for the five measures of strain on spouse which were considerably lower (.31 to .50).

Discussion

There is discrepancy between partners concerning dyadic adjustment. Patients reported higher dyadic adjustment than their spouses. There is a body of research indicating that: (1) spouses of problem drinkers are often depressed (as shown in Moos, Finney, & Cronkite, 1990); (2) alcohol abuse is associated with poorer marital functioning; and (3) even if patients follow drinking therapy, self-reported assessment of the distress of their partners shows no significant improvement (Rotunda & Doman, 2001).

The focus of this article is more on crossed evaluations of strain, dyadic adjustment and alcohol problems in patients and their spouses. As seen in the results, we found a greater degree of agreement between patient and spouse reports when the focus was on caregiver strain, regardless of the domain of difficulty. On the other hand, there is a large discrepancy with regard to crossed evaluations of dyadic adjustment. Patients overestimated and spouses underestimated the marital adjustment of their partner. The evaluation from the spouse as well as the patient's own reports of problem with drinking or alcohol consumption were in agreement. These results are consistent with previous research about collateral reports of objective indicators (like mean drinks per drinking day). Several studies have found a large degree of agreement between patient and collateral reports when the collateral is a spouse (e.g. Connors & Maisto, 2003). On the other hand, we found a greater discrepancy when the focus is more subjective, like temptation. The stability of this result in all of the contexts of consumption is an important issue. Spouses seem to view the problem to be more serious than the patients, while the patient has more confidence in their capability to control their consumption. Several causes and consequences are possible for the dissimilar subjective evaluations. There is no a priori reason to believe that spouse reports would be more accurate than those provided by the patient. First, divergence can occur as a result of spouse overstatement of the drinking risk and minimization of patients' self-efficacy. As such, the patient may feel that their relative does not place their confidence in him/her and thus may not feel encouraged to sustain their efforts. Second, divergence can occur as a result of patient minimization of the problem. It is possible that the spouse is the first one to become and stay aware of drinking problems, even before the drinker him/herself has any concerns. As such, the spouse may feel discouraged and tend to use dysfunctional coping behaviors such as controlling or overprotective strategies. In any case, we can make the hypothesis that behavioral reactions and coping depend on each

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partner's perception of the problem. Whatever the interpretation of these results may be, they provide many implications for treatment. The evidence of divergent perceptions implies that the spouse may need to be reassured and that the patient may need to be more careful. It also seems important to understand how and why the spouse perceives the situation differently and to re-establish the basis of a healthy communication. Whether the family changes its collective lifestyle or adopts certain strategies to regulate the alcohol problem, it seems appropriate to begin by building a consensus, first concerning the situation, and then concerning the measures that are to be put into place to deal with the situation. Hence, the spouse may be involved during the entire treatment or during the more strategic moments, such as at the beginning and end of treatment.

This study has some limitations. It was conducted on a French population in which the spouses are seldom involved in therapy. Further studies are needed to see whether these discrepancies are also present in other populations. All of the patients were abstainers. It is important to apply this protocol to couples with an actual alcohol problem. Only the spouses were taken into consideration because they would be the most directly affected by the patient's drinking and they would also have the most influence on the patient. However, we can extend this type of study to a larger social network. Furthermore, the study focused solely on couples in which only one of the partners has a drinking problem. Other studies are necessary for couples in which both partners have a drinking problem. Longitudinal studies are needed to investigate the consequences of divergent perceptions on dyadic adjustment and distress. It is likely that the relationship between dyadic adjustment and drinking pattern is bidirectional and that both of these factors should be studied in future studies. Perception patterns may moderate the link between drinking behavior and dyadic functioning. Among potentially relevant topics are the influence of the spouse's perception toward drinking and the extent to which the spouse's representations may bias reports. Conversely, studies are needed to explore the extent to which the accuracy of spouses' reports might be distorted by perceived caregiver strain.

A better understanding of: (1) the influence of the spouse in how a patient becomes aware of and regulates their own drinking; and (2) the impact of the patients' behaviors on the distress of their partner may be useful when designing help for at-risk couples. These findings are also important when planning treatment and prevention strategies for drinkers and their relatives.

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