Couple Therapy and Addictions

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SUMMARY. Therapies for alcoholism, substance abuse, and other addictions traditionally focus on characteristics of individuals such as behaviors, thoughts, and emotions. These kinds of programs tend to target problems inside the abusing person rather than a relational system. Treatments that are more recent locate the problems within systems of people. Regardless of the locus or cause of the abuse or addiction, seen as arising from disease processes, systemic dynamics, or other mechanisms that lead to unfortunate habits and behaviors, utilizing the individual's partner or family in therapy has become an important part of successful treatment. This article reviews models of couple treatment for alcoholics and substance abusers in terms of initiation into treatment, primary treatment, and relapse prevention. doi:10.1300/J398v06n01_05

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INTRODUCTION

Therapies for alcoholism and substance abuse traditionally focus on characteristics of individuals such as behaviors, thoughts, and emotions. Treatment frequently consists of attending 12-step meetings such as Alcoholics Anonymous, various outpatient counseling programs that use primarily psychoeducation and behavioral interventions, and inpatient detoxification and other treatments. All of these kinds of programs tend to target problems inside the abusing person rather than a relational system. When a person's context *is* included as part of the conceptualization of treatment, interventions often focus on ways the individual can cope with or respond differently to the environment. Treatments that are more recent have been developed that locate the problems within systems of people–for example, couples and families. Interventions might include using partners and other people in ancillary treatment, including them in various treatments that target the index person, including them as conceptualized parts of the system as a whole needing or benefiting from treatment, or a combination of all of these different perspectives.

Utilizing the individual's partner or family in therapy has become an important part of successful treatment. Partners and families have been seen variously as victims, as reinforcers or enablers, and as causes of addictions and addictive behavior. However, it has become more and more clear that when partners are included in treatment, regardless of their roles, success is more likely. This article reviews models of treatment for addictions that include intimate partners and research using them.

ALCOHOL ABUSE

In 1995, Edwards and Steinglass reviewed 21 of the most extensive articles on the effectiveness of various family-involved alcohol abuse treatments published between 1972 and 1993. Included within these studies were several treatments utilizing non-alcoholic spouses or partners as the focus of intervention (e.g., unilateral family therapy; UFT) or that engaged both the alcoholics and their partners in conjoint sessions (e.g., cognitive behavioral therapy; CBT). A more recent review

of marriage and family therapy outcomes for alcohol abuse (O'Farrell & Fals-Stewart, 2002) included several more couple-involved treatments.

Initiation of Treatment

Alcohol abusers frequently are reluctant to enter treatment on their own. The Johnson Institute intervention (Johnson, 1986) addressed reluctance by involving the family or caring others of the alcoholic in a series of sessions that prepares them as a group to confront the resistant alcoholic. Miller, Meyers, and Tonigan (1999) showed that only 30% of the family or caring others in their study were successful at engaging the alcoholic in treatment when using the Johnson Institute intervention.

Community reinforcement training (CRT; e.g., Azrin, 1976) and the enhanced version of CRT, community reinforcement and family training (CRAFT), educate caring others about ways to engage their reluctant alcoholic partners in treatment when the alcoholic expresses some motivation to change. Additional goals of CRT are to reduce dependency on the alcoholic relationship through other activities, and to facilitate sobriety in the alcoholic spouses.

UFT was born out of CRT and focuses on helping the nonalcoholic spouse to assist the alcoholic spouse into treatment. Through the course of UFT treatment, nonalcoholic spouses learn about alcohol abuse, its effects on family dynamics, and how to initiate a confrontation with the spouse aimed at easing them into treatment one step at a time. The alcoholic spouses are not included in this treatment; its sole purpose is to help the nonalcoholic spouses engage the alcoholics in treatment. Two studies of UFT indicated both statistically and clinically significant findings (Thomas, Santa, Bronson, & Oyserman, 1987; Thomas, Yoshioka, Ager, & Adams, 1993, cited in Edwards & Steinglass, 1995). The authors found that more alcoholics entered treatment and reduced drinking when their spouses received UFT treatment; UFT was related to decreases in alcohol-enabling and control behaviors in spouses and increases in marital satisfaction.

In addition to the goals of CRT, CRAFT adds UFT components to CRT (Stanton, 2004). A large, controlled study of CRAFT treatment compared to the Johnson intervention and a traditional Al-Anon program (Miller et al., 1999) supported CRAFT's effectiveness in engaging couples in treatment. Sixty-four percent of the CRAFT participants entered treatment within six months while only 30% of the Johnson intervention participants entered treatment.

Another approach based on both CRT and UFT prepares nonalcoholic spouses to apply increasing levels of pressure to their alcoholic spouses who are resistant to entering therapy in a briefer period of time than CRT and UFT: the Pressure to Change approach (PTC; Barber & Crisp, 1995). The PTC approach sometimes leads to the Johnson intervention, in which case, 4-6 weeks are added to regularly scheduled weekly treatments (Stanton, 2004). In three studies to date, PTC was found to move alcoholics toward significant change, defined as "… the drinker either (a) seeking treatment, (b) ceasing drinking, or (c) reducing drinking to a level acceptable to the partner and maintaining this change for at least 2 weeks" (O'Farrell & Fals-Stewart, 2002, p. 129).

Primary Treatment

Behavioral couple therapies. Behavioral couple therapy (BCT) typically focuses on aspects of couple interaction such as communication skills training, problem-solving skills, and caring exchanges (e.g., Jacobson & Margolin, 1979). BCT and interactional therapy (IT; McCrady, Paolino, Longabaugh, & Rosi, 1979) were compared with standard individual treatment for alcoholics who were released from inpatient rehabilitation or detoxification programs (O'Farrell, Cutter, & Floyd, 1985). In 6-month and 24-month follow ups, days of abstinence had decreased for all three groups with the greatest drop occurring in the standard treatment group. Marital satisfaction improvements found at 6-month posttreatment did not hold at the 24-month follow up (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992).

BCT for treatment of alcoholics has evolved into what is now known as alcohol behavioral couple therapy (ABCT; Epstein & McCrady, 2002). One form was developed to work alone as a treatment for alcoholic couples (Epstein & McCrady); a second was developed by O'Farrell and Fals-Stewart (2000) to be used in association with or after more traditional BCT. Epstein and McCrady's version (ABCT) is an integration of three major treatments: cognitive behavioral therapy (CBT), UFT, and BCT. Therapies using BCT as described by O'Farrell and Fals-Stewart (2002) "… sees the alcoholic patient together with the spouse or cohabitating partner to build support for abstinence and to improve relationship functioning" (p. 131). It includes a behavioral contract component through which the alcoholic agrees to commit to abstinence each day, attend after-care treatment, or take disulfiram. ABCT has become one of the most empirically supported treatments for alcohol abuse, usually

yielding decreases in alcohol use and increases in couple functioning (e.g., McCrady, Epstein, & Hirsch, 1999; O'Farrell & Fals-Stewart, 2000). In addition, one study revealed positive outcomes for the children of couples who were involved in BCT (Kelley & Fals-Stewart, 2002) and others showed decreases in social costs (O'Farrell et al., 1996a; O'Farrell et al., 1996b).

Couple Group Therapy. Four family systems-oriented studies were reviewed by Edwards and Steinglass (1995). Outcomes from Corder and colleagues' (Corder, Corder, & Laidlaw, 1972) study of a couple treatment (CT) component included in a traditional inpatient program (TP) were both statistically and clinically significant. Cadogan (1973) used a couple group therapy approach in a study of 35 male and 5 female alcoholics and their spouses. Results showed that treatment in the couple group therapy yielded 45% abstinence as compared with 10% abstinence for a wait-list control group. Cadogan's study was similar to Corder et al.'s (1972) in that it involved couple groups. However, Cadogan's treatment focused more on improving emotional expression, communication, and problem solving skills.

McCrady and colleagues (1979) found that couples assigned to either a couple involvement (CI) or joint admission (JA) treatment showed greater clinically significant levels of abstinence (83% and 61% respectively) after treatment than their counterparts in individual treatment (43% abstinence). Although there were no statistically significant differences among the groups, the study suggests that couple therapy is helpful.

Family systems therapy (FST) was reviewed by O'Farrell and Fals-Stewart (2002) as therapy that could be used with families or couples. In its generic form, FST uses several family systems concepts and is administered in several forms (e.g., brief strategic family therapy, Milan family therapy, experiential systemic couple therapy). In their review of several studies, O'Farrell and Fals-Stewart reported that although FST effected greater reduction in drinking and positive outcomes in marital/family relationship measures, treatment group results did not differ significantly from those of the control groups, which used individual or group therapy.

Treatment Maintenance

Few studies have investigated the involvement of couples in the maintenance phase of the treatment of alcohol abuse. In one study of BCT with a relapse prevention additive, O'Farrell, Choquette, Cutter,

Brown, and McCourt (1993) found that after one year post-treatment, participants maintained 94% days of abstinence while those who received BCT only maintained 82% days of abstinence.

McCrady, Epstein, and Hirsch (1999) studied the effects of a relapse prevention (RP) component on ABCT treatment outcomes. Randomly assigning 90 male alcoholics and their female partners to ABCT alone, ABCT plus RP, or ABCT plus Al-Anon treatment, McCrady et al. found that all groups increased abstinence, decreased heavy drinking, and showed general improvement. In addition, if subjects participated in post-treatment as planned in the ABCT plus RP and ABCT plus Al-Anon models, "they were more likely to be abstinent than those who did not" (cited in O'Farrell & Fals-Stewart, 2002, p. 139).

Whether in the initiation, primary, or maintenance phase of treatment, different models of couple therapy often yield more improvements than traditional inpatient, outpatient, and individual treatments. However, more research needs to be done on the effectiveness of couple treatments in the treatment maintenance phase, with non-traditional alcoholic couples, and with female alcoholics as relatively untouched areas by past research (Edwards & Steinglass, 1995). Finally, as seems obvious through this review, much of the literature is old and needs to be updated through research.

SUBSTANCE ABUSE

Few models of couple therapy for adult substance abuse exist. However, several researchers have maintained that the more plentiful research done on treatments for adult alcohol abuse hold promise for similar positive outcomes for substance abuse clients (Rowe & Liddle, 2002; Stanton & Shadish, 1997). In addition, outcomes related to adult substance abuse recovery often match outcomes for adolescents, especially in terms of family functioning and cost effectiveness (Rowe & Liddle).

In terms of initiating treatment for substance abuse, CRT was the treatment of choice in one study (Kirby, Marlowe, Festinger, Garvey, & LaMonica, 1999), which found that after 10 weeks of treatment, family and significant others in the CRT group were found to have high treatment retention rates and their substance abusing others were more apt to enter treatment.

A recent study (Meyers, Miller, Smith, & Tonigan, 2002) compared CRAFT alone and CRAFT with an aftercare option for spouses with

Al-Anon and Nar-Anon groups. Ninety adult substance abusers and their caring others participated, with results showing that of the three groups studied, the two CRAFT groups were able to engage 67% of the abusers in treatment.

BCT has been the most recently and repeatedly studied couple therapy for substance abusers. Rowe and Liddle (2002) reviewed the effectiveness of substance abuse treatments in marriage and family therapy and offered a comprehensive outline of several of the studies that reported effectiveness of BCT. For example, the initial study of BCT with 80 substance abusing males and their spouses showed that "[C]ouples who received BCT (individual, group, and couple sessions) had better relationship outcomes and husbands had fewer days of substance use, longer periods of abstinence, and fewer substance-related arrests and hospitalizations up to 1-year follow-up than those in individual therapy (involving cognitive and behavioral coping skills training)" (Rowe & Liddle, p. 73). Similar to BCT studies of alcohol treatment, Rowe and Liddle's reviewed studies showed decreases in domestic violence (Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002), better cost outcomes (Fals-Stewart, O'Farrell, & Birchler, 1997), behavioral improvement in the children of the substance abuser (Kelley & Fals-Stewart, 2002), and greater medical treatment compliance among substance abusers (Fals-Stewart, O'Farrell, & Birchler, 2001). In addition, one study replicated positive outcomes in both relationship and abstinence measures for 75 female substance abusers (Winters, Fals-Stewart, O'Farrell, Birchler, & Kelley, 2002).

Systemic Couple Therapy for Substance-Abusing Women

McCollum, Lewis, Nelson, Trepper, and Wetchler (2003) hypothesized that including intimate partners in substance abuse treatment for women would be less disruptive in the couple dynamics, thus enhancing the probability that the woman would stay in treatment and would benefit longer. A model for addressing relationship issues that impact women's substance use was developed as an add-on for standard psychoeducational substance abuse treatment and was tested with three groups: women whose partners participated in conjoint therapy (Systemic Couple Therapy; SCT); women whose partners did not participate in conjoint therapy, but whose therapy included a focus on relationship issues (Systemic Individual Therapy; SIT); and women who participated in a standard treatment only (Treatment as Usual; TAU). One hundred

twenty-two women were randomly assigned to one of the three groups and they and their partners participated in extensive research testing that included substance use measures, urinalysis assessment, individual measures, and couple measures.

The treatment model included components of structural (Minuchin, 1974), strategic (Watzlawick, Weakland, & Fisch, 1974), Bowen (1978), behavioral (primarily communication training; Jacobson & Margolin, 1979), and solution-focused (e.g., de Shazer, 1982) therapies (Nelson, McCollum, Wetchler, & Trepper, 1996). At the 3-month phase of testing, women who participated in one of the systemic groups reported higher severity of alcohol use than those in TAU (McCollum et al., 2003). At all other times, no differences appeared among the groups for alcohol use. In contrast to results for alcohol use, McCollum and colleagues' results for substance abusing women suggested a decrease in severity for all three groups. Women in SIT and SCT fared better than those in TAU at six months and one year post-treatment. In addition, scores for the participants' need for treatment decreased at six months and one year for women in the systemic couple treatment groups. The authors concluded that systemic treatment helped the women in the study to better maintain gains than women in the standard treatment alone.

A second analysis of data from the study (McCollum, Nelson, Lewis, & Trepper, 2005), yielded apparently confusing results. Women whose partners perceived their marital quality as high did not fare as well in the systemic substance abuse treatment. These women reported more days of substance use at post-test and were less likely to complete treatment. The authors conjectured that partners who were satisfied with the quality of their relationships did not find substance use a problem and thus were not as likely to be supportive of reduced use or abstinence. McCollum et al. found that women most at risk of continued substance use and dropping out of treatment were those who rated their relationship quality as low while their partners rated quality as high.

CONCLUSION

This review suggests that couple therapy for addictions is a mixed bag. It appears that definitions of what constitutes couple therapy may affect outcomes. For example, it appears that unilateral treatment of non-abusing spouses and partners may assist abusers' entering treatment.

Specifics of including partners during treatment are not clear. Conjoint treatments that merely include partners in the same treatment as the abusers seem to enhance treatment outcomes as do treatments that are based on systemic or recursive relationship dynamics principles. Reviews did not reveal differences among treatment models or modalities, differences when applied to abusers with differing characteristics, differences among different kinds of addictions, differences among ethnic populations, or differences on different levels of abuse (misuse, abuse, addiction). One study (McCollum et al., 2003), however, that utilized systemic family therapy principles with substance abusing women, found that for the women in the study, attention to relationship issues and dynamics helped women to reduce their substance use and, more specifically, to maintain the gains they had made in treatment. When partners of these women perceived the relationship quality to be high, however, the women did less well in treatment and tended more to drop out of treatment. To the current authors, these results suggest that more work needs to be done to tease out specific factors that affect treatment outcomes so that treatments can be developed that optimize positive results, treating abusers (and, perhaps, their partners) based on identifiable characteristics rather than using single models for all abusers.

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