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CHAPTER 7

Alcohol and Other Substance Abuse

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Although alcoholism and drug abuse have been historically viewed as individual problems best treated on an individual basis (e.g., Jellinek, 1960), a large and growing body of literature suggests the family often plays a crucial role in the lives of alcoholics and drug abusers (Stanton & Heath, 1997). An increasing number of investigators and treatment providers have explored the interrelation of family factors and substance abuse, with the clinical applications of couple and family therapy to treatment of alcoholism and drug abuse increasing considerably over the last three decades. In fact, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) standard for accrediting substance abuse treatment programs in the United States now requires that an adult family member who lives with an identified substance-abusing patient be included at least in the initial assessment (Brown, O'Farrell, Maisto, Boies, & Suchinski, 1997).

Enthusiasm for understanding the role family members may play in the development, maintenance, and treatment of alcoholism and drug abuse has not been limited to the research community. The sheer volume of texts in the lay press that have appeared on the topics of codependency, adult children of alcoholics, addictive personality, enabling, and so forth, is staggering. For example, an Internet search of a

large online book retailer revealed that over 250 books were currently available for purchase on the topic of codependency alone. Moreover, self-help support groups for family members of alcoholics and drugs abusers (e.g., Al-Anon) are available in virtually every community.

Because relationship problems and substance use disorders so frequently co-occur, it would be very difficult to find clinicians who specialize in the treatment of adult substance use disorders or relationship problems who have not had to address concurrently both sets of issues for many clients seeking help. The purpose of the present chapter is to provide an overview of a behaviorally oriented couple-based treatment for substance use that would be useful to both specialists in either the treatment of alcoholism and drug abuse or the treatment of marital/relationship distress. Our goal is to provide an integrated conceptualization of substance use problems and dyadic relationships grounded in the empirical literature that has evolved over the last 30 years and thus is an alternative to the psychology of family and addiction that dominated the popular press for much of the late 20th century.

ALCOHOLISM AND DRUG ABUSE: A RELATIONSHIP-BASED CONCEPTUALIZATION

Before examining the interrelation of substance abuse and relationship functioning, it is important to provide contemporary diagnostic definitions of alcoholism and drug addiction.

Defining Alcohol and Drug Use Disorders

There are actually several different definitional frameworks for these disorders that have appeared in the literature. The most widely used is the psychiatric diagnostic approach, exemplified in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) and the 10th edition of the *International Classification of Diseases* (ICD-10; World Health Organization, 1992). Using the DSM-IV system as an example, the diagnosis of alcohol or psychoactive substance use disorders includes two general subcategories: abuse and dependence. *Substance dependence* is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use a given psychoactive substance despite significant substance-related problems. To meet diagnostic criteria for dependence on a psychoactive substance, an individual must display at least three of the following seven symptoms: (1) physical tolerance; (2) withdrawal; (3) unsuccessful attempts to stop or control substance use;

(4) use of larger amounts of the substance than intended; (5) loss or reduction in important recreational, social, or occupational activities; (6) continued use of the substance despite knowledge of physical or psychological problems that are likely to have been caused or exacerbated by the substance; and (7) excessive time spent using the substance or recovering from its effects.

In contrast, the essential feature of *substance abuse* is a maladaptive pattern of problem use leading to significant adverse consequences. This includes one or more of the following: (1) failure to fulfill major social obligations in the context of work, school, or home; (2) recurrent substance use in situations that create the potential for harm (e.g., drinking and driving); (3) recurrent substance-related legal problems; and (4) continued substance use despite having persistent social or interpersonal problems caused or exacerbated by the effects of the substance.

Although the ICD-10 and DSM-IV definitions of alcohol and drug use disorders were claimed to be largely atheoretical by their developers, some have argued that the classifications arise from a medical model orientation (e.g., Pattison, Sobell, & Sobell, 1977). In turn, behavioral scientists have proposed an alternative approach to the disease concept of alcoholism and drug abuse that underlies the DSM classifications (e.g., Adesso, 1995; Nathan, 1981). In this framework, alcohol and drug use disorders are not defined as a unitary disease, nor is it implicitly assumed that the observed substance use symptoms are the manifestation of a disease state. Symptoms are viewed as acquired habits that emerge from a combination of social, pharmacological, and behavioral factors. Emphasis is placed on environmental, affective, and cognitive antecedents and reinforcing consequences of substance use. The outgrowth of this functional conceptualization of substance use is that drinking and drug use are ruled by motivation and learning principles, as are other human behaviors (Wulfert, Greenway, & Dougher, 1996).

Prevalence of Alcohol and Drug Use Disorders and Comorbidity with Relationship Problems

Epidemiological surveys of alcohol and drug use disorders indicate they are among the most common psychiatric disorders in the general population. The most recent national survey on the prevalence of alcohol and drug use disorders is the National Longitudinal Alcohol Epidemiologic Survey (NLAES; Grant et al., 1994), in which 42,862 noninstitutionalized respondents living in the contiguous United States, aged 18 years and older, were interviewed regarding their use of alcohol and other substances, using DSM-IV classification criteria. According to the

NLAES, the past year combined prevalence of alcohol abuse and dependence was 7.4%, representing more than 13 million Americans; the lifetime rate was 18.2%, or nearly 34 million Americans.

Prevalence rates of DSM-IV drug use disorders were much lower than those reported for alcohol use disorders. Rates for past year abuse and dependence for most drugs were less than 1%, with the exception of cannabis abuse and dependence combined (1.2%). The prevalence of past year abuse or dependence on any drug was 1.5%. Overall, the lifetime rate of any drug abuse or dependence was 6.1%.

There are several lines of converging evidence that indicate substance abuse and relationship distress covary. Although individuals diagnosed with alcohol abuse or dependence are just as likely to marry as the rest of the population, they are more likely to divorce or separate (Nace, 1982). Moreover, men and women with drinking problems are more likely to divorce than individuals with any other type of psychological disorder (Reich & Thompson, 1985). Several studies have found that levels of relationship distress among alcoholic and drug-abusing dyads are high (e.g., Fals-Stewart, Birchler, & O'Farrell, 1999; O'Farrell & Birchler, 1987). Relationship problems are predictive of a poor prognosis in alcohol and drug abuse treatment programs (Fals-Stewart & Birchler, 1994; Vanicelli, Gingerich, & Ryback, 1983). Finally, poor response to substance abuse treatment is predictive of ongoing marital difficulty (e.g., Billings & Moos, 1983; Finney, Moose, Cronkite, & Gamble, 1983).

In clinical samples, we also see indications that a high comorbidity exists between relationship distress and substance use disorders. In our studies, among adult substance-abusing clients entering treatment, roughly one third are married or cohabiting in stable relationships with romantic partners, with most of these couples reporting moderate to severe relationship distress (e.g., Fals-Stewart, Birchler, & O'Farrell, 1999). Moreover, in a study of 56 men seeking marital therapy, Halford and Osgarby (1993) found that more than one third met the criterion for alcoholism on a standard alcoholism screening interview, one fifth reported drinking at unsafe levels (i.e., 20 alcoholic drinks per week), and more than four-fifths reported frequent marital disagreements about alcohol use.

The Interrelation between Substance Use and Relationship Distress

The causal connections between substance use and relationship discord are complex and appear to interact reciprocally. For example, chronic drinking outside the home is correlated with reduced relationship satis-

faction for spouses (e.g., Dunn, Jacob, Hummon, & Seilhamer, 1987). At the same time, however, stressful marital interactions are related to increased problematic substance use and are related to relapse among alcoholics and drug abusers after treatment (e.g., Fals-Stewart & Birchler, 1994; Maisto, O'Farrell, McKay, Connors, & Pelcovitz, 1988). Thus, the relation between substance use and relationship problems is not unidirectional, with one consistently causing the other, but rather each can serve as a precursor to the other.

Viewed from a family perspective, there are several antecedent conditions and reinforcing consequences of substance use. Poor communication and problem solving, arguing, financial stressors, and nagging are common antecedents to substance use. Consequences of substance use can be positive or negative. For instance, certain behaviors by a non-substance-abusing partner, such as avoiding conflict with the substance-abusing partner when he or she is intoxicated, are positive consequences of substance abuse and can thus inadvertently reinforce continued substance-using behavior. Partners who avoid the substance abuser or make disapproving verbal comments about his or her alcohol or drug use are among the most common negative consequences of substance abuse (e.g., Becker & Miller, 1976). Other negative effects of substance use on the family, such as psychological distress of the spouse and social, behavioral, academic, and emotional problems among children, increase stress in the family system and may therefore lead to or exacerbate substance use (Moos, Finney, & Cronkite, 1990).

CLINICAL IMPLICATIONS FOR COUPLE THERAPY

Our behaviorally oriented approach to couple therapy, which we refer to as behavioral couple therapy (BCT), with substance-abusing clients and their romantic partners does not have a unique set of assumptions about how people change but rather encompasses current notions about how people change in terms of the widely known stages-of-change model (Prochaska & DiClemente, 1983). In this model, individuals progress through different stages of change: (1) precontemplation, in which the individual is not concerned about changing his or her behavior; (2) contemplation, in which the individual becomes concerned about and begins to consider changing the behavior; (3) action, in which the individual changes the behavior and stabilizes this change for an initial period; (4) maintenance, in which the behavior change remains stable; and (5) relapse, in which the individual returns to the problem behavior. The family model we espouse in this chapter emphasizes the role of the spouse in influencing a person's progression

through these stages. For example, a spouse's concern about their partner's alcohol or drug problem may move the individual from the precontemplation into the contemplation stage of change. In turn, this stages-of-change model helps guide the assessment and treatment of substance-abusing clients with couple-based therapy, whether the married or cohabiting substance-abusing individual is initially seeking substance abuse treatment or relationship therapy.

Assessment

The multifaceted aspects of both substance using behavior and relationship adjustment are targets of assessment procedures with alcoholic and drug-abusing couples. We advocate a multimethod assessment approach with these couples, typically including semistructured conjoint and individual interviews, paper-and-pencil questionnaires, and observed samples of couple problem-solving communication. Although beyond the scope of the present chapter, Fals-Stewart, Birchler, and Ellis (1999) provide a detailed description of assessment procedures often recommended with couples in which partners abuse alcohol or drugs.

The assessment phase includes both an evaluation of substance use severity and dyadic adjustment. The assessment of substance use involves inquiries about recent types, quantities, and frequencies of substances used, whether the extent of physical dependence on alcohol or other drugs requires detoxification, what led to help seeking at this time, the outcomes of prior efforts to seek help, and the goals of the substance abuser and the family member (e.g., reduction of substance use, temporary or permanent abstinence). Along with alcohol and drug use severity, it is strongly recommended that assessment include an evaluation of problem areas likely to be influenced by substance use, including (1) medical problems; (2) legal entanglements; (3) financial difficulties; (4) psychological distress; and (5) social/family problems (McLellan et al., 1985).

Concurrently, various aspects of partners' dyadic adjustment are also assessed. Birchler and Fals-Stewart (2000) have developed a conceptual framework called the "7 Cs," which describes seven critical elements of a long-term intimate relationship that need to be evaluated as part of any comprehensive couple assessment: (1) character features (e.g., personality traits); (2) cultural and ethnic factors (i.e., cultural, racial, ethnic, religious, family-of-origin, and socioeconomic variables); (3) contract (i.e., explicit and implicit expectations about partners' roles and what they expect to derive from the relationship); (4) commitment (i.e., to be involved, remain loyal, and to maintain the stability

and quality of the relationship over time); (5) caring (i.e., partners' abilities to express relational behaviors that promote emotional and physical intimacy); (6) communication (i.e., open and honest sharing of information between partners); and (7) conflict resolution (e.g., skills in the areas of problem solving, decision making, and anger management). This would include a multimethod evaluation of partners' general relationship satisfaction and stability of the relationship (i.e., current or planned separations as well as any past separations) along with an assessment of each partner's psychological and personality functioning. Furthermore, several studies now suggest that spousal violence is alarmingly high among both alcohol- and drug-abusing couples (e.g., O'Farrell & Murphy, 1995); thus, evaluation of family violence and fears of recurrence must be assessed.

In our first meeting with clients, we typically inform them that the first two to three sessions are used to gather assessment information and that neither they nor the therapist are committing to engaging in treatment. After the assessment phase is complete, the partners and the therapist mutually determine whether the data gathered as part of the assessment suggest that treatment would be helpful, with the information garnered from the assessment used to develop and implement couple-specific treatment plans. Because there are clear therapeutic benefits to participating in the assessment (i.e., increased knowledge about substance use, rapport building, facilitating the contemplation of change) the discrimination between assessment and treatment is, in reality, a false dichotomy. But making this distinction serves an important purpose; for many clients, participating in an "initial assessment" is less threatening than delving directly into treatment.

After assessment information has been gathered, the clients and therapists meet for a feedback session, which we refer to as a "roundtable discussion," in which the therapist provides an overview of the findings from the evaluation, including impressions of the nature and severity of both the substance abuse and relationship problems. Partners are asked to be active participants in this discussion, sharing their impressions and providing any critical information they deem to be missing, inaccurate, or incomplete. The goals of this feedback session are to (1) provide the partners with objective, nonjudgmental information about the couple's relationship functioning and the negative consequences of the substance misuse, and (2) increase motivation for treatment.

Treatment

Nearly 30 years ago, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) described couple and family therapy for alcohol de-

pendent clients as “one of the most outstanding current advances in the area of psychotherapy of alcoholism” and called for controlled clinical trials to evaluate the effectiveness of this class of interventions (Keller, 1974, p. 161). Of the many forms of family-based therapies, one that held particular promise was BCT, also referred to as behavioral marital therapy (BMT), which has been shown to produce superior dyadic functioning among distressed couples compared to no treatment or nonspecific control conditions (Hahlweg & Markman, 1988), and to be equally or more effective than other therapies in terms of reducing relationship distress (Gurman, Kniskern, & Pinsof, 1986). Since the time NIAAA called for empirical examinations of family-based treatments for alcoholism, BCT has been evaluated rigorously in several controlled clinical trials. Results from these studies, which are summarized later in the chapter, provide very strong empirical support for the effectiveness of BCT with substance-abusing clients and their intimate partners.

Typical Treatment Goals

The two primary goals of BCT are to (1) eliminate abusive drinking and drug use and support the substance abuser’s efforts to change, and (2) alter dyadic and family interaction patterns to promote a family environment that is more conducive to sobriety. Viewed from a relationship context, a high priority is to change substance-related interaction patterns between partners, such as nagging about past drinking and drug use and ignoring or otherwise minimizing positive aspects of current sober behavior. The stance we recommend treatment providers assume is to encourage abstinent alcohol- and drug-abusing clients and their partners to engage in behavior more pleasing to each other. Continued discussions about and focus on past or “possible” future drinking or drug use increases the likelihood of relapses (Maisto et al., 1988).

Therapists also help partners begin the process of repairing the extensive relationship damage that is often incurred over many years of conflict resulting from drinking and drug use. This is typically the most difficult aspect of treatment and involves not only allowing the non-substance-abusing partner to discuss the emotional pain they incurred during the course of their partner’s drinking, but also eventually working toward a certain degree of forgiveness (while not committing to the unrealistic goal of forgetting the past). In turn, the substance-abusing partner must be able to tolerate the negative affect of these exchanges. It is the role of the therapist to help the non-substance-abusing partner modulate his or her negative affect, which can be very strong, so that these interactions are not overwhelming or otherwise destructive, while also assisting the substance-abusing partner to process the affect and ex-

press his or her feelings within the context of a constructive dialogue. Moreover, therapists help partners find solutions to relationship difficulties that may not be directly related to substance abuse. As therapy progresses, partners learn to confront and resolve relationship conflicts while avoiding relapse.

BCT works directly to increase relationship factors conducive to abstinence. A behavioral approach assumes that family members can reward abstinence—and that alcohol- and drug-abusing clients from happier, more cohesive relationships with better communication have a lower risk of relapse. The substance-abusing client and the partner are seen together in BCT, typically for 15–20 outpatient couple sessions over 5–6 months. Generally couples are married or cohabiting for at least a year, without current psychosis, and one member of the couple has a current problem with alcoholism, drug abuse, or both. The couple starts BCT soon after the substance user seeks help.

BCT Treatment Methods

BCT sees the substance-abusing client with the partner to build support for sobriety. The therapist arranges a daily sobriety contract in which the client states his or her intent not to drink or use drugs that day (in the tradition of one day at a time), and the partner expresses support for the client's efforts to stay abstinent. For alcoholic clients who are medically cleared and willing, daily Antabuse ingestion witnessed and verbally reinforced by the partner also is part of the sobriety contract. The partner records the performance of the daily contract on a calendar provided by the therapist. Both members of the couple agree not to discuss past drinking or fears about future drinking at home to prevent substance-related conflicts that can trigger relapse, but rather to reserve these discussions for the therapy sessions. At the start of each BCT couple session, the therapist reviews the sobriety contract calendar to see how well each member of the couple has done their part. If the sobriety contract includes 12-step meetings or urine drug screens, these are also marked on the calendar and reviewed. The calendar provides an ongoing record of progress that is rewarded verbally at each session. The couple performs the behaviors of their sobriety contract in each session to highlight its importance and to let the therapist observe how the couple does the contract, providing corrective feedback as needed.

Using a series of behavioral assignments, BCT increases positive feelings, shared activities, and constructive communication because these relationship factors are conducive to sobriety. *Catch Your Partner Doing Something Nice* has each partner notice and acknowledge one pleasing behavior performed by the other person each day. In the *Car-*

ing Day assignment, each person plans ahead to surprise their partner with a day when they do some special things to show their caring. Planning and doing *Shared Rewarding Activities* is important because many substance abusers' families have stopped shared activities that are associated with positive recovery outcomes (Moos et al., 1990). Each activity must involve both partners, either by themselves or with their children or other adults, and each activity can be carried out at home or away from home. Teaching *Communication Skills* can help partners deal with stressors in their relationship and in their lives, and this may reduce the risk of relapse.

Relapse prevention is the final activity of BCT. At the end of weekly BCT sessions, each couple completes a *Continuing Recovery Plan* that is reviewed at quarterly follow-up visits for an additional 2 years.

Typical Structure of Therapy Sessions

BCT sessions tend to be moderately to highly structured, with the therapist setting the agenda for the sessions from the outset of each meeting. A typical BCT session begins with an inquiry about any drinking or use of drugs that has occurred since the last session. Compliance with any sobriety contract that has been negotiated is also reviewed and any difficulties with compliance are discussed and addressed. The session then moves to a detailed review of homework assigned during the previous session and the partners' success in completing the assignment. The therapist then identifies any relationship or other types of problems that may have arisen during the last week that can be addressed in session, with the goal of resolving the problems and designing a plan for resolution. Therapists then introduce new material, such as instruction in and rehearsal of skills to be practiced at home during the week. Toward the end of the session, partners are given specific homework assignments to complete during the subsequent week.

During initial sessions, BCT therapists focus on decreasing negative feelings and interactions about past and possible future drinking or drug use and increasing positive behavioral exchanges between partners. Later sessions move to engaging partners in communication skills training, problem-solving strategies, and negotiating behavior change agreements.

Research on BCT with Alcoholism

A series of studies has compared drinking and relationship outcomes for alcoholic clients treated with BCT or individual alcoholism counseling. Outcomes have been measured at 6-month follow-up in earlier

studies and at 18–24 months after treatment in more recent studies. The studies show a fairly consistent pattern of more abstinence and fewer alcohol-related problems, happier relationships, and lower risk of marital separation for alcoholic clients who receive BCT than for clients who receive only individual treatment (Azrin, Sisson, Meyers, & Godley, 1982; Bowers & Al-Rehda, 1990; Hedberg & Campbell, 1974; McCrady, Stout, Noel, Abrams, & Nelson, 1991; O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992). Domestic violence, with more than 60% prevalence among alcoholic couples before entering BCT, decreased significantly in the 2 years after BCT and was nearly eliminated with abstinence (e.g., O'Farrell & Murphy, 1995). Cost outcomes in small scale studies show that reduced hospital and jail days after BCT save more than five times the cost of delivering BCT for alcoholic clients and their partners (O'Farrell et al., 1996). Finally, for male alcoholic clients, BCT improves the psychosocial adjustment of couples' children more than does individual-based treatment (Kelley, Fals-Stewart, Clarke, Cooke, & Winters, 2000), even though children are not directly treated in either intervention. Thus, there may be a "trickle down" effect of the communication skills training used as part of BCT, with improved methods of interacting permeating the whole family system.

Research on BCT with Drug Abuse

The first randomized study of BCT with drug-abusing clients compared BCT plus individual treatment to an equally intensive individual-based treatment (Fals-Stewart, Birchler, & O'Farrell, 1996). Clinical outcomes in the year after treatment favored the group that received BCT on both drug use and relationship outcomes. Compared to those who participated in individual-based treatment, BCT participants had significantly fewer cases that relapsed, fewer days of drug use, fewer drug-related arrests and hospitalizations, and longer time to relapse. Couples in BCT also had more positive relationship adjustment on multiple measures and fewer days separated due to relationship discord than couples whose partners received individual-based treatment only.

Cost-benefit outcomes analyses of participants in this study also favor BCT over individual treatment (Fals-Stewart, O'Farrell & Birchler, 1997). Social costs in the year before treatment for drug abuse-related health care, criminal justice system use for drug-related crimes, and income from illegal sources and public assistance averaged about \$11,000 per case for clients in both treatment groups. In the year after treatment, for the group that received BCT, social costs decreased significantly to about \$4,900 per case, with an average cost savings of about \$6,600 per client.

Results of cost-effectiveness analyses also favored the BCT group. BCT produced greater clinical improvements (e.g., fewer days of substance use) per dollar spent to deliver BCT than did individual treatment. Therefore, this study showed that in treating drug abuse, BCT as part of individual-based treatment is significantly more cost-effective and cost-beneficial than individual treatment alone.

Domestic violence outcomes in this same study also favored BCT (O'Neill, Freitas, & Fals-Stewart, 1999). Although nearly half of the couples reported male-to-female violence in the year before treatment, the number reporting violence in the year after treatment was significantly lower for BCT (17%) than for individual treatment (42%).

In a second randomized study of BCT with drug-abusing clients (Fals-Stewart, O'Farrell, & Birchler, 2001), 30 married or cohabiting male clients in a methadone maintenance program were randomly assigned to individual treatment only or to BCT plus individual treatment. The individual treatment was standard outpatient drug abuse counseling for the drug-abusing partner. Results during the 6 months of treatment favored the group that received BCT on both drug use and relationship outcomes. BCT compared to individual treatment had significantly fewer drug urine screens that were positive for opiates, fewer drug urine screens that were positive for any of the nine drugs tested, and more positive relationship adjustment measured with a standard questionnaire.

A third study (Fals-Stewart & O'Farrell, 1999) randomly assigned 80 married or cohabiting men with opioid addiction to equally intensive naltrexone-involved treatments: (1) BCT plus individual treatment (i.e., the client had both individual and couple sessions and took naltrexone daily in the presence of his spouse), or (2) individual treatment only (i.e., the counselor asked the client about naltrexone compliance but there was no spouse involvement or compliance contract). In the year after treatment, BCT had significantly more days abstinent from opioids and other drugs, longer time to relapse, and fewer drug-related legal and family problems than did individual treatment.

ADDITIONAL TREATMENT CONSIDERATIONS

BCT for alcoholism and substance abuse is most often delivered in the context of other services and self-help support. In some of our studies, BCT is used as part of a comprehensive treatment package that includes individual and group therapy for the identified substance-abusing client. In other trials, BCT is used as a "stand-alone" treatment; in both situations, BCT appears to be very effective.

It should be noted that, over the last 3 decades, proponents of the disease model of substance abuse (i.e., AA and related 12-step facilitation approaches) and behavior therapy have clashed over the nature of addictive behavior and the most effective methods for its treatment (McCrary, 1994). Because the disease model is, by far, the most common treatment philosophy espoused by treatment providers and treatment programs (e.g., Fuller & Hiller-Sturmhofel, 1999), the conviction that BCT, because of its behavior therapy underpinnings, may be at odds with the treatment philosophies of many programs is a major roadblock in the widespread use of BCT in community-based settings. This concern about the compatibility of BCT and program philosophy has been raised often by treatment providers who have attended workshops and practitioner-oriented presentations that we have conducted about BCT.

However, the BCT intervention we have used in our clinical trials is far from incompatible with a disease-model treatment orientation; in fact, in all of our current studies, BCT is being provided in settings in which nearly all the BCT therapists are proponents of the disease model of addiction. Moreover, as part of the BCT intervention, we strongly encourage clients to attend Alcoholics Anonymous, Narcotics Anonymous, and other self-help support programs. Thus, in our experience, BCT and the disease-model treatment orientation can be easily integrated, with BCT typically delivered within the context of a disease model framework. Understandably, most treatment providers are more comfortable with BCT once they become aware that it is compatible with a disease-oriented treatment approach.

CASE ILLUSTRATION

To illustrate some of the procedures we have described thus far, a case example is provided, based on a couple treated by a therapist under the supervision of the first author. Although selected background data have been changed to protect these partners' confidentiality, the methods used and results obtained have not been altered. To illustrate the communication patterns we have often observed in these couples, a partial transcript of a conflict-resolution discussion between the partners is also provided.

David was 35 years old and was referred to outpatient substance abuse treatment by a local judge after being convicted of driving while under the influence of alcohol. During a psychosocial assessment, the client described an extensive history of problematic alcohol use. David reported that, in his early 20s, he drank nearly every day, usually consuming three to five beers on each occasion. By his mid-20s, he began

drinking greater quantities of alcohol on weekends (i.e., eight to ten drinks on Fridays after work and Saturday evenings) and experienced occasional blackouts.

David noted that he had entered a 28-day inpatient treatment program about 5 years before the present evaluation and stayed sober for roughly 1 year after treatment. He reported that financial problems, arguments with his wife, and stress at work contributed to his relapse. He also reported that, during the last 4 years, he drank daily, but that there had been a steady increase in daily alcohol consumption over that time period. It started at two to three drinks daily but had more recently become six to eight drinks each day. David stated that he drove his car while intoxicated on "too many nights to count." David met DSM-IV criteria for alcohol dependence. Although he had used marijuana occasionally in his early 20s, David did not abuse drugs other than alcohol.

David was asked if he was willing to participate in marital assessment with his wife, Janice. Although David acknowledged that he was reluctant to participate, he stated he would if his wife agreed to participate. He signed a release of confidentiality form to allow his therapist to discuss the possibility of participation with Janice. She agreed to come to the clinic with David; the assessment procedures to be used were described to the partners. It was also emphasized that this was only an assessment and participation in this evaluation did not commit either the couple or the therapist to treatment. Both partners agreed to complete the assessment.

During the assessment, the therapist collected background data from Janice and information about the couple's marriage. Janice was 31 years old and was employed part-time as an accounts payable clerk in an apartment rental agency. She reported she had never abused alcohol or used other drugs. David and Janice married after a 1-year courtship. Janice noted she knew David drank "heavily," but was not aware of the extent of his drinking until he entered inpatient treatment.

Both partners described their relationship as unstable and had recently discussed divorce. David added that Janice would state that she wanted a divorce every time the partners had a disagreement. David's primary complaint was that Janice "is never satisfied with anything and criticizes me for any and everything." Janice reported that David spent money they "could not afford to give up" to buy alcohol, which exacerbated their financial problems. Because of limited income, the partners reported that they could not afford to have and support a child, although both wanted to have children.

Along with financial problems, Janice said she felt neglected because David spent so much time with his friends drinking. Janice added

that the partners rarely spoke to each other for more than 10 minutes on a given day and had not spent time engaging in recreational activities they enjoyed (e.g., going to the movies, eating out). Neither partner reported any episodes of spousal violence.

As part of the assessment, the partners were asked to discuss a problem they both agreed existed in their relationship while the therapist observed. This discussion was scheduled to last 10 minutes and was videotaped. The topic the partners chose was "financial problems." As part of this conflict resolution task, the partners were asked to describe the problem and work toward a solution. The following is a partial transcript of the partners' discussion, occurring about 1 minute after the task was initiated:

WIFE: Why is it that your priorities are your f**king friends, bars, spending our money? It makes me sick.

HUSBAND: Can you give me a good reason why I would want to be home? When I'm there, you crack on me about my drinking and about all the s**t I've done when I've been drunk. When I'm out, you bitch. I can't win . . . which is the way you like it.

WIFE: That's not fair. I want you to care about me and stop drinking.

HUSBAND: I've tried, but even when I am sober for a few days, you just bitch at me about what I did when I was drunk.

WIFE: It is the only time I can talk to you. You come home drunk, go to sleep, we never talk, we don't have sex. . . . You come in and pass out on the couch and leave before I get up. I go days without seeing you.

HUSBAND: I know. . . . For all I know, I thought you would be happy with this.

WIFE: That's bulls**t and you know it. We never talk about anything, never go out . . . the car needs to be fixed, you need to talk to your brother. . . . I'm left to solve everything and you are judge and jury. And, by the way, I hear you say you've not been drinking, but I never believe it . . . never. . . .

HUSBAND: If you won't let me off the mat . . . if I stop drinking, you use that time to piss all over me about what I did when I drink and you don't believe I am sober anyway . . . if I drink, you don't deal with me and I will not deal with you.

WIFE: I am just so lonely. I want to move back home near my parents so at least I can talk to someone.

HUSBAND: Yeah, to talk to them about me. . . .

This exchange revealed not only significant deficits in these partners' communication patterns, but also a lack of mutual caring and a general level of interpersonal antagonism. Although the agreed topic was financial problems, they introduced several other conflict areas without addressing the problem at hand. The content of the communication sample revealed the corrosive effects of alcohol on the marriage, with David's drinking at least appearing to interfere greatly with important relationship activities (e.g., talking to each other, having sex).

The partners ultimately agreed to participate in treatment. Early sessions involved introducing and following through with a negotiated sobriety contract which included five primary components: (1) David agreed to take Antabuse (for which he was medically evaluated) while being observed by Janice; (2) the couple agreed to a positive verbal exchange at the time when David took the Antabuse (i.e., David reporting he had stayed sober during the last day and promising to remain sober for the ensuing day and Janice thanking him for remaining sober); (3) Janice agreed not to bring up negative past events concerning David's drinking; (4) David agreed to attend Alcoholics Anonymous (AA) meetings daily; and (5) the partners would not threaten to divorce or separate while at home and would, for the time being, bring these thoughts into the sessions.

The partners reported that David's use of Antabuse was very helpful to both of them; David did not consider drinking while on Antabuse and Janice, because she watched David take the Antabuse, trusted that he was not drinking and thus had much greater peace of mind. The positive verbal exchange between the partners made the daily sobriety contract a caring behavior rather than a "checking up" procedure. David said there was less stress in the home because Janice did not bring up his past drinking. David's AA involvement provided him with a support network that did not include friends with whom he drank. Janice reported she occasionally attended an Al-Anon group for wives of alcoholics, which gave her a supportive forum to discuss her marriage.

Communication skills training focused on slowing down the partners' verbal exchanges, with an emphasis on recognizing and stopping "kitchen sinking" (i.e., talking about a multitude of problems rather than focusing on a single agreed-upon topic area). Partners were trained to make positive specific requests and to use "I" statements as a way to own their feelings rather than attributing how they feel to their spouse.

Later sessions addressed identified relationship problems. Assignments such as Catch Your Partner Doing Something Nice and Shared

Rewarding Activities served to increase positive verbal exchanges and mutual caring, along with reestablishing a long-term commitment to the relationship. Toward the end of therapy, the partners reported that BCT helped them learn to “enjoy each other again.” They noted their sex life had improved dramatically and, with the help of the therapist, that they had sought the services of a credit counselor to assist them with some of their financial problems.

During the 2-year posttreatment follow-up interviews, David reported he had remained sober and continued to take Antabuse. Both partners reported that they made a point of doing something fun together at least once per week. David was attending AA meetings three times weekly. Although the partners continued to have money problems, Janice received a work promotion, which helped to alleviate some of the stress.

CONCLUSION AND FUTURE DIRECTIONS

Results from multiple studies conducted over the last 2 decades indicate that behavioral couple therapy (BCT) is an effective treatment for married or cohabiting alcohol- and drug-abusing clients, both in terms of reduced substance use, reduced spousal violence, and improved relationship satisfaction. To assist clinicians who wish to use BCT with substance-abusing clients and their partners, several overviews and detailed therapist manuals are available (e.g., McCrady, 1982; O’Farrell, 1993; O’Farrell & Fals-Stewart, 2000; Wakefield, Williams, Yost, & Patterson, 1996).

However, despite a large and growing body of empirical support, BCT for substance abuse is not frequently used in community-based treatment settings (Fals-Stewart & Birchler, 2001). Given the positive effects of BCT, this is most unfortunate. Thus, even more than additional BCT research, we need to concentrate on technology transfer (i.e., moving empirically supported treatments from research settings to practice) so that clients and their families can benefit from what we have already learned about BCT for alcoholism and drug abuse. The Institute of Medicine (1998) has documented a large gap between research and practice in substance abuse treatment. BCT is one example of this gap and is a general problem in behavior therapy in particular (Hayes, 1998) and in health care overall (Ferguson, 1995).

Thus, in terms of future directions, there needs to be more involvement in BCT research activities by clinicians who practice in treatment programs, who can identify those aspects of BCT that impede its move from research settings to community-based treatment facilities. In our

recent trials, we have involved and solicited extensive feedback from practicing clinicians about the BCT intervention we use with clients. Among the fundamental concerns about BCT that have been raised by these clinicians are the following:

1. BCT often involves too many therapy sessions and needs to be abbreviated.
2. BCT is typically delivered by master's-level clinicians, even though most community-based treatment programs employ bachelor's-level and paraprofessional counselors.
3. BCT has not been extensively evaluated with female substance-abusing patients, gay and lesbian couples, and dyads in which both partners use drugs or alcohol.

These concerns have pointed the way for our future research. Addressing these issues in future studies (e.g., exploring the effectiveness of an abbreviated version of BCT compared to standard BCT, examining the comparative clinical effectiveness of BCT delivered by master's-versus bachelor's-level counselors) may help BCT to continue its progress from the ivory tower, where it frequently resides, into the hands of providers who routinely treat these clients, which is where it truly belongs.

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