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▶ Behavioral couples therapy for substance abusers: where do we go from here?

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Klostermann K., Kelley M.L., Mignone T. et al.
Substance Use & Misuse: 2011, 46, p. 1502–1509.

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Problem drinkers and drug users in a persisting if distressed relationship with a partner do better when the focus is at least partly shifted from the patient to working with the couple to foster sobriety-encouraging interactions. Benefits for patients and the broader society can be remarkable.

Summary Of the psychosocial interventions available to treat problem alcohol and drug use, it could be argued that partner-involved treatments are the most broadly efficacious, not just in terms of substance use and relationship adjustment, but also other dimensions of public health significance including domestic violence and cost–benefit and cost-effectiveness.

Behavioural couples therapy is one of these approaches, based on the insight that distressed couples engage in mutual punishment rather than mutually rewarding behaviours which improve the relationship. Developed as a marital therapy, in the past three decades it has also been shown effective for alcoholism and drug problems.

The therapy assumes that substance use problems and intimate relationships are reciprocally related, such that substance use impairs relationship functioning, and severe relationship distress combined with attempts by partners to control substance use may prompt craving, reinforce substance use, or trigger relapse.

> A presentation from one of the originators of behavioural couples therapy offers a taste of how the therapy looks in practice and reference to a book including practice guidance. See also these guidelines on the therapy.

To break this vicious cycle and transform the relationship in to a positive force, the

therapy aims to build support for abstinence and to improve relationship functioning. It features a 'recovery contract' which 'bans' mention of past substance use and fears of future relapse, and instead involves the couple in a daily ritual to reaffirm and reinforce the user's intention to that day stay drug-free/sober, together with techniques for increasing positive activities and improving communication. A calendar kept by the couple records their progress and 'homework' activities, providing a focus for therapy sessions. Towards the end a continuing recovery plan is agreed for how the couple will tail off therapy-associated activities. A usual requirement for the therapy is that the partner of the problem substance user does not themselves have the same sort of problem.

Main findings

Compared to alternative therapies, research has shown that behavioural couples therapy results in equal or greater likelihood of clients stopping substance, and usually also better relationships between the couple. For women in particular, relationships appear to play a critical role in the maintenance and exacerbation of substance use, suggesting that couples therapy would be a valuable approach. In line with this expectation, a study found behavioural couples therapy more effective than individual therapy for female problem drinkers in terms of both abstinence and heavy drinking days. Among the relationship improvements found in a study of male problem substance users and their non-using female partners was a substantial reduction in domestic violence compared to pre-treatment levels.

It is however important for a therapy to be *cost*-effective as well as effective, and ideally to benefit society (when those benefits have been translated in to financial terms) more than it costs. Two studies have investigated these issues. One found that over the next two years behavioural couples therapy plus individual counselling resulted in cost savings in alcohol-related hospital inpatient and residential treatment and time in prison amounting to $6700 per case. The result was a saving of $8.64 for every dollar spent on supplementing individual counselling with behavioural couples therapy, a ratio not apparent with a different form of supplemental couples therapy.

The second study compared pre- and post-treatment (one year in both cases) health and legal service costs associated with for behavioural couples therapy for alcoholics and their spouses, with or without additional couples relapse prevention sessions. Adding relapse prevention sessions led to less drinking and better marital relationships but net cost savings were lower. The benefit-to-cost ratio decreased from $5.97 for every dollar spent on behavioural couples therapy to just $1.89 for the combined programme. Lower cost meant that behavioural couples therapy alone was more cost-effective in producing abstinence from drinking, though no more cost-effective in improving marital adjustment.

Despite its efficacy, behavioural couples therapy is not yet widely implemented in substance use treatment. In US services it was found to be one of the evidence-based practices staff felt least ready to adopt. Barriers may include perceived relevance, difficulty of implementation, distance from preferred or familiar approaches, and cost.

Typically partners who have both been diagnosed with a substance use disorder have been excluded from behavioural couples therapy trials. Treating dual-using couples is a serious challenge for both men and women, but especially for women because of social

and gender norms. Experience is that generally neither achieves abstinence, and that when one partner does, this seems to change the dynamic in a way which ends the relationship. Behavioural couples therapy has not been sufficiently researched with these couples, though contingency management (providing voucher incentives for attendance and abstinence by both partners) has had some success.

Other research gaps include trials for gay and lesbian couples, identifying *how* behavioural couples therapy works – in particular which components are positive active ingredients and which may be counterproductive – whether supplementary components like parent skills training and partner violence reduction strategies add value, and developing and testing interventions whose intensity and type adapt to the patient's response, potentially conserving resources and making these approaches more acceptable.

FINDINGS As previously noted by Findings (1 2 3), for the minority of patients for whom it suitable, acceptable and safe, behavioural couples therapy seems a good option relative to other therapies, one whose benefits are more likely to extend to the whole family and to persist because an altered family dynamic embeds positive sobriety interactions and incentives in to the 24-hour a day joint life of couples who despite their troubles have stayed together. For such couples, joint therapy could profitably replace some of the counselling targeted on the problem substance using partner, creating better lasting outcomes but not necessarily at greater cost. The results are better outcomes for patient and partner and greater benefits for society per unit cost of treatment.

Despite its widely accepted standing as an evidence-based practice, behavioural couples therapy has a narrow support base in terms of the approaches with which it has been compared and the researchers doing the comparing. In particular, trials conducted by people who did not themselves develop the therapies are few and their results among the least convincing; details ▶ below.

Strengths and limitations of the evidence base

A review of family interventions for mental health problems found behavioural couples/ family therapy much the best supported in terms of its performance vis à vis individual-oriented therapies in reducing substance use and improving relationships. Most notably, effects eroded more slowly than after individually-oriented treatment. However, the analysts noted that eight of the 11 trials of behavioural couples therapy had been conducted by the same research team. The remaining three were still supportive of the therapy, but this limitation led the analysts to consider the evidence as "moderate" rather than any stronger.

A similar mixture of strengths and limitations emerged from a meta-analytic review aggregating findings from trials available up to early 2007 which had randomly allocated problem substance users to treatment with or without supplementary behavioural couples therapy, or to this therapy versus an alternative approach.

Across the studies there was a clear advantage for treatment incorporating behavioural couples therapy versus solely individual-based treatment. Effects were slightly greater for the adverse consequences of substance use and relationship satisfaction than for the frequency of substance use, but this pattern varied with time. Immediately after treatment, couples therapy was superior to comparison treatments only in respect of

relationship satisfaction, later, in respect of all three types of outcomes and to roughly the same degree. The conclusion was that when married or cohabiting couples seek help for substance dependence problems confined to one of the partners, behavioural couples therapy results in better substance use outcomes than more typical individual-based treatments. Benefits extend to related problems and the quality of the relationship. Immediate improvements in relationships seem to pave the way for later relative gains in substance use outcomes.

Of the 12 trials on which these verdicts were based, eight dealt solely with drinking problems, and in all but two couples therapy had supplemented other approaches. Eight of the studies compared couples therapy with cognitive-behavioural therapy. One assumption underlying the analysis – that the studies were entirely independent of each other – was certainly violated because eight of the 12 involved one or both of the developers of the therapy. Another (1 2) involved the developer of a similar couples therapy which was tested in the trial. Among the remaining three were the least convincing results across all follow-up points, raising the issue of whether outcomes depend on who is organising the study. Research conducted by teams linked in some way to the intervention they are testing has been found to produce more positive findings than fully independent research. In relation to psychosocial therapies for drinking problems, an analysis of relevant studies concluded that therapies were generally equivalent, and that when they were not, the researcher's 'allegiance' to the therapy accounted for a significant portion of the differences.

However, in one of these independent tests, equivalent treatment-end outcomes had diverged six months later as behavioural couples therapy did better at sustaining improvements. In another, involving spouses in alcohol treatment *did* improve drinking outcomes, but not to any greater extent when behavioural couples therapy replaced the half of the sessions otherwise devoted to jointly participating in lectures on alcohol and health. This was perhaps because both relationship distress and drinking were relatively mild in this study whose programme was advertised as "not designed for alcoholics". The third was a randomised but otherwise relatively 'real world' Dutch trial, in which the couples treatment and the comparator 'standard' individual cognitive-behavioural programme were delivered by addiction counsellors who were not highly experienced in these approaches, and as few patients as possible were excluded from the trial. Though patients did well in both approaches, neither at the end of treatment nor six months later were there any significant or substantial extra drinking reductions, and at the final follow-up relationship satisfaction too had not improved significantly more as a result of couples therapy.

In one respect the research base has broadened from that reflected in the featured review; there *is* now a study of behavioural couples therapy with gay and lesbian couples. In this study of treatment for drinking problems, couples therapy replaced 12 of 32 individual counselling sessions. In the year after treatment ended, including couples therapy resulted in significantly more sustained drinking reductions and improved relationships amongst both the male and female couples.

Cost versus benefits

Along with other studies of behavioural couples therapy, a review of the cost-effectiveness of family-based substance use treatment included the two studies cited in the featured review. It found a more mixed picture than that portrayed by the featured review. Analysing the studies in greater detail (▶ background notes), it seems that when behavioural couples therapy replaced individual counselling sessions (and therefore did not greatly increase costs) it was the most cost-effective in reducing substance use. But

when it was in whole or part additional (meaning greater costs), it might be more effective, but not more *cost*-effective. The practice implication for cost-benefit conscious service planners is that for people in stable relationships, where possible including behavioural couples therapy *instead* of counselling focused on the substance using partner is likely to net more benefit per unit cost, but this is unlikely to be the case if the couples therapy is *additional*.

UK guidance

Behavioural couples therapy was one of only two psychosocial therapies recommended by Britain's National Institute for Health and Clinical Excellence (NICE) for the treatment of problems related to illicit drug use. In particular, NICE said it should be considered for problem users of stimulants or opioids who are in close contact with a non-drug-misusing partner. Among other therapies, NICE guidance on the treatment of alcohol problems also recommends behavioural couples therapy for service users with a regular partner willing to participate. An update to that guidance cited a review by family intervention experts working in Britain which concluded that couples therapy results in positive drinking and marital adjustment outcomes and that behavioural couples therapy in particular "clearly ... out-performs the comparison individually oriented treatments". Experts reached a similar conclusion after reviewing the alcohol treatment literature for England's National Treatment Agency for Substance Misuse.

All these documents noted the therapy's limited applicability: the patient must share an intact, live-in relationship with a relative or partner not also experiencing substance use problems, and the relationship must be sufficiently supportive for both to productively engage with the therapy. This will be the case for many (especially male) drinkers, but usually not for long-term dependent users of cocaine or heroin. Care will also be needed to exclude the risk that such therapies, particularly when they engage women in the treatment of male substance users, might perpetuate or aggravate victimisation by abusive partners.

Another major limitation is the availability of family therapy of any kind. The dominant paradigm sees addiction as a disorder of the individual and treats it accordingly. Few drug misuse professionals have been trained in family approaches and in the UK there has been no appreciable national drive to widen their perspective, though the recent emphasis on addressing not just substance use but also other recovery-relevant issues in the patient's life may alter this situation.

A census of UK alcohol treatment agencies conducted in 1996 made no mention of family therapy at all. Calling for greater family involvement, in 2002 an article cited a "recent survey" of one of Britain's largest non-statutory alcohol agencies. During the census period, family members were involved (as couples) in the client's therapy in just three of 174 client contacts. In 2006 guidance on alcohol treatment from the English Department of Health and the National Treatment Agency for Substance Misuse did not specifically mention family therapy, mainly seeing the family as a beneficiary of treatment rather than a participant.

Thanks for their comments on this entry in draft to Timothy O'Farrell of the Harvard Medical School Department of Psychiatry at the VA Boston Healthcare System, based in Brockton in the USA. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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