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An Introduction to Behavioral Couples Therapy for Alcoholism and Drug Abuse

Alcoholism and drug abuse have traditionally been viewed as individual problems best treated on an individual basis. However, it is now widely recognized that substance abuse affects not only the individual with the drug or alcohol problem, but also the family members with whom they live. In turn, use of family-involved treatments for alcoholism and drug abuse has become a staple of many substance abuse treatment programs, much to the benefit of the patients and their families.

Although there are several well-described family-based models of addictive behavior and its treatment, the family disease approach is the best known and most widely used family approach in substance abuse treatment programs.¹ Based on the 12-step programs of Alcoholics Anonymous (AA) and Al-Anon, this approach views alcoholism or drug abuse as an illness that affects both the substance abuser and the family. Family members are seen as reacting to the substance abuser with characteristic behavior patterns, such as enabling the addiction by protecting the substance abuser from the negative consequences of drinking or drug taking. This set of behaviors is often called “codependence.” The substance abuser is said to suffer from the disease of addiction and the family members from the disease of codependence.

This approach traditionally uses separate parallel recovery programs for the substance abuser and for the family member. The substance abuser gets counseling plus Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). The spouse or family member gets education or counseling plus Al-Anon or Nar-Anon, which involves separate treatment for family members without the substance-abusing patient present. Treatment for the spouse or family member often consists of (1) psychoeducational groups that provide information about the disease concept of addiction and codependency, (2) individual or group therapy to address various psychological issues, and (3) referral to Al-Anon or Nar-Anon. In the recently developed method of Al-

Anon facilitation therapy, the family member meets with a counselor, who uses a systematic strategy to encourage involvement in this 12-step program for families of alcoholics.²

The family disease approach urges the spouse or family member to give up attempts to influence the substance-abusing patient's drinking or drug use. Family members are told to detach themselves from the patient's substance use in a loving way, accept that they are powerless to control the substance abuser, and seek support from other Al-Anon or Nar-Anon members. They are instructed to focus on themselves in order to reduce their own emotional distress and improve their own coping. This approach puts a primary emphasis on increasing the well-being and serenity of the spouse or family member. It does not focus directly or extensively on supporting the substance abuser's abstinence or on improving couple or family relationships.

Recent studies have shown that family members of alcoholics who were referred to Al-Anon or took part in Al-Anon facilitation therapy reduced their emotional distress and improved their coping more than counterparts in a wait-list control group.³ An advantage of the family disease approach is that the individual programs of recovery help the substance abuser and the family member to focus strongly on what each of them needs to do to improve his or her life, which has been torn by addiction.

However, the family disease approach does not deal directly with relationship issues, and it may neglect the need for relationship repair and recovery. Family conflicts that are not dealt with constructively can precipitate relapse. Many relationships break up after the substance abuser gets help. Although precise statistics are lacking, one frequently hears in 12-step circles that many marriages and relationships break up in the first year of recovery. Even when the drinking and drugging are gone, intense conflicts may continue, spouses may have grown apart, or one spouse may be unwilling to set aside the past hurts.

All of this would seem to suggest that, to be most effective, family-involved treatments need to address not only drinking and drug use but also relationship and family issues. Behavioral couples therapy (BCT) is an approach that explicitly focuses on both substance use and relationship issues, and it is readily compatible with self-help groups and other counseling.

WHAT IS BCT?

BCT is designed for married or cohabiting individuals seeking help for alcoholism or drug abuse. BCT sees the substance-abusing patient together with the spouse or live-in partner. Its purposes are to build support for abstinence and to improve relationship functioning. BCT pro-

TABLE 1.1. BCT for Alcoholism and Drug Abuse

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- The purpose of BCT is to support abstinence and improve relationship functioning.
 - The Recovery Contract supports abstinence.
 - BCT increases positive activities and improves communication.
 - BCT fits well with self-help groups, recovery medications, and other counseling.
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notes abstinence with a “Recovery Contract” that involves both members of the couple in a daily ritual to reward abstinence. BCT improves the relationship with techniques for increasing positive activities and improving communication. Table 1.1 notes key aspects of BCT. Before considering the specific methods used in BCT, we examine some of the ideas behind it.

Ideas behind BCT

THEORETICAL RATIONALE

The causal connections between substance abuse and relationship discord are complex and reciprocal. Couples in which one partner abuses drugs or alcohol usually also have extensive relationship problems, with increased risk of separation or divorce, verbal and physical abuse, and adjustment problems for the couple’s children. The negative effects of substance abuse (e.g., lying to cover up substance use, job and legal problems) create relationship problems. Stress from relationship problems, in turn, becomes one more trigger for substance abuse. Thus, as shown in the top half of Figure 1.1, substance abuse and relationship problems create a destructive cycle in which each induces the other.

In the perpetuation of this cycle, couple and family problems (e.g., poor communication and problem solving, habitual arguing, financial stressors) often set the stage for excessive drinking or drug use. There are many ways in which family responses to the substance abuse may then inadvertently promote subsequent abuse. In many instances, for example, drinking or drug use serve relationship needs (at least, in the short term), as when it elicits the expression of emotion and affection through caretaking of a partner suffering from a hangover. Finally, even when recovery from the alcohol or drug problem has begun, couple and family conflicts may often lead to relapse.

This strong interrelationship between substance abuse and relationship issues is largely ignored by standard treatments for substance abuse, which focus mainly on the individual substance-abusing patient. Recognizing these interrelationships, BCT has three primary objectives:

- To eliminate abusive drinking and drug abuse;
- To engage the family’s support for the patient’s efforts to change; and
- To change couple and family interaction patterns in ways conducive to long-term, stable abstinence and a happier, more stable relationship.

As shown in the bottom half of Figure 1.1, BCT attempts to create a constructive cycle between substance use recovery and improved relationship functioning through interventions that address both sets of issues at the same time.

CLINICAL STANCE

BCT encourages a good-faith–individual-responsibility approach in which each member of the couple freely chooses to make needed changes in his or her behavior independent of whether or not the partner makes corresponding changes in behavior. Thus, we ask each partner to volunteer to make changes that are needed to help the patient stay abstinent and to improve the

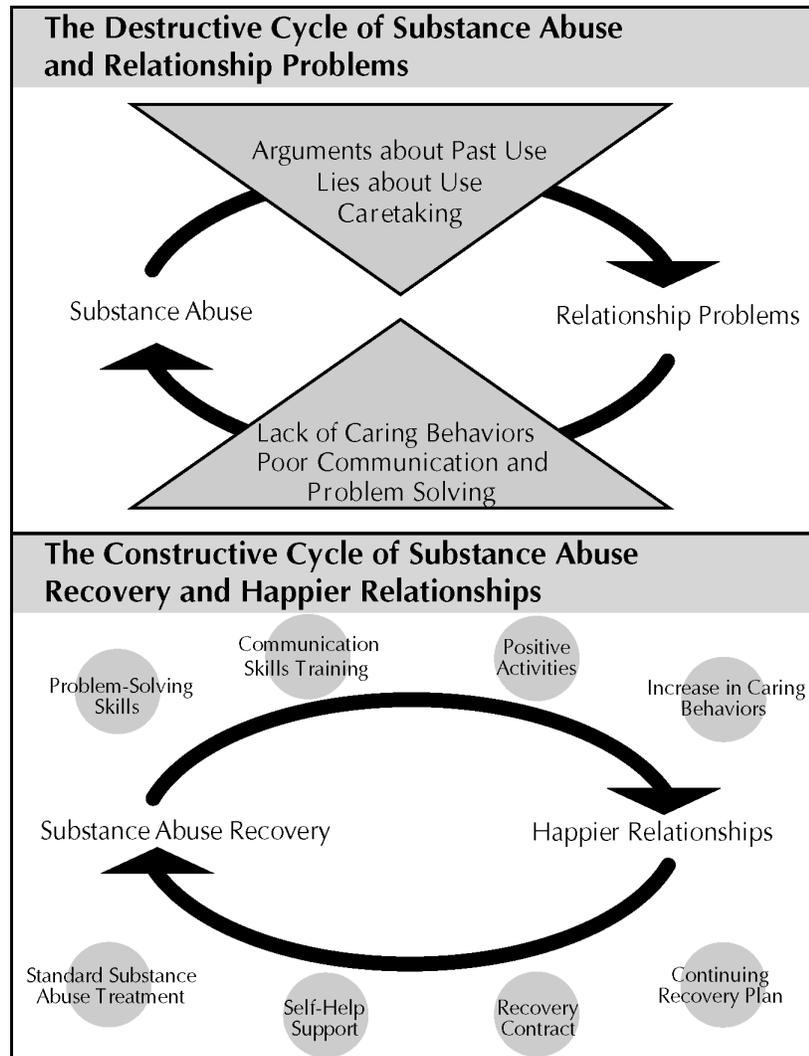


FIGURE 1.1. Reversing a destructive cycle through BCT. From “Behavioral Couples Therapy for Substance Abuse: Rationale, Methods, and Findings,” by W. Fals-Stewart, T. J. O’Farrell, and G. R. Birchler, 2004, *Science and Practice Perspectives*, 2, p. 32. Adapted from original, which is in the public domain.

couple’s relationship. In BCT we emphasize abstinence as a primary goal that must be achieved before lasting change in couple and other problems is possible. It is only human nature that each member of the couple will want the other to change first and also will want to stop his or her own efforts if the partner does not seem to be making a serious effort to change. The counselor can help both partners understand that really giving their relationship a good chance to improve by changing how they act with each other requires risk and vulnerability—but there is no other way.

BCT does not assume that substance abuse is a symptom of underlying couple dynamics or that, if the couple's dynamics are changed, then the substance-abusing member will no longer need to abuse drugs. Although some early family therapists believed this notion, it no longer has much acceptance because it was not supported by clinical experience. For example, many a family therapist has apparently resolved a couple's relationship problems successfully, only to find that the couple returns to bitter conflict when the substance-abusing member returns to drinking or drug use. From the perspective of BCT, substance abuse is a complex biopsychosocial problem, arising from an individual's vulnerabilities and choices, which is expressed in a social context that includes the couple relationship. In BCT the spouse supports the patient's abstinence and the couple works together to make a happier relationship. BCT is based on the patient's commitment to and pursuit of abstinence and each partner's good-faith commitment to do what they can to improve the relationship.

BCT and 12-Step Concepts

An important strength of BCT is that it can be easily integrated into other intervention services provided by substance abuse treatment programs (e.g., individual counseling, group therapy). The underlying philosophy of, and methods used in, BCT are consistent with the 12-step treatment model that is used in the vast majority of community-based treatment programs. As summarized in Table 1.2, BCT and 12-step work well together. BCT counselors and self-help group members usually share the same treatment goal of abstinence, and both use behavioral and cognitive techniques to achieve their goals. BCT tries to increase and reward behaviors that support abstinence and long-term recovery. Participation in AA and NA are actions that support abstinence and a changed lifestyle conducive to long-term recovery. So it is practical and relatively easy to encourage self-help group involvement and integrate it into BCT. Participation in AA or NA for patients and Al-Anon or Nar-Anon for partners is strongly encouraged in BCT. For those who choose them, these commitments are reviewed at each BCT session, and the counselor reinforces not only attendance at meetings but also the actions of getting a sponsor, speaking at meetings, and so forth. Moreover, when completing a "continuing recovery plan" toward the end of weekly BCT sessions, continued participation in self-help groups is encouraged to help prevent relapse.

TABLE 1.2. BCT and 12-Step Work Well Together

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- Both have abstinence as goal.
 - BCT rewards behaviors that support abstinence and long-term recovery.
 - 12-step supports recovery.
 - BCT Recovery Contract often includes 12-step participation.
 - Many BCT studies were done in settings with 12-step orientation.
 - Many counselors in BCT studies were 12-step proponents.
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Most of our studies of BCT were done in settings with a strong 12-step orientation, and nearly all the BCT counselors were proponents of the disease model of addiction. Thus, in our experience, BCT and the disease model of treatment can be easily integrated.

Overview of BCT Methods

Thus far, we have provided a theoretical overview of BCT and a discussion of its easy integration into existing intervention services provided in community-based treatment programs. Yet this begs the question “What is involved in delivering and using BCT with alcoholic and drug-abusing couples?” Although much of this book is devoted to answering this very question, here is a brief preview.

Generally BCT consists of 12–20 weekly couple sessions, each of which lasts 50–60 minutes. Sessions tend to be moderately to highly structured, with the counselor setting the agenda at the outset of each meeting. Typically, the first few BCT sessions focus on establishing a Recovery Contract to support abstinence for the patient and to decrease couple conflicts about past or possible future substance abuse. This contract decreases tension about substance use and builds good will. When abstinence and attendance at BCT sessions have stabilized, the counselor adds relationship-focused interventions to increase positive activities and improve communication. Finally, when abstinence has been maintained for 3–6 months, the counselor plans for continuing recovery to prevent or minimize relapse and reduces BCT sessions from weekly to less frequent sessions.

Table 1.3 lists the main methods used to achieve the four key objectives of BCT: (1) engaging the couple, (2) supporting abstinence, (3) improving the relationship, and (4) continuing recovery. We discuss briefly how BCT supports abstinence and improves the relationship next. Remaining chapters give more details about these and other aspects of BCT.

ENGAGING THE COUPLE AND STARTING BCT

Generally we have run our BCT programs as part of larger substance abuse treatment centers. In such settings the alcoholic and drug-abusing patients have already sought help and begun treatment for themselves. The challenge for the BCT counselor is to get the patient and the spouse to attend an initial session together as a couple. Many substance abuse counselors have had experiences in which they were unsuccessful at engaging the patient and spouse together. We have found it is not that difficult if the counselor follows a few simple steps.

To engage the spouse and the patient together in BCT, first the counselor must get the substance-abusing patient’s permission to contact the spouse. Next, the counselor talks directly to the spouse to invite him or her for a joint interview with the patient. Then the counselor takes small steps to gain the couple’s commitment to trying BCT. In the joint couple interview, an initial couple session that does not assume further meetings as a couple, the counselor aims to establish rapport and determine if the couple is interested in, and appropriate for, BCT.

If the couple decides to try BCT, it starts in earnest at the second couple session. In this session the couple makes four promises (e.g., not to threaten separation or violence) designed to launch BCT on a positive note. The rest of the second couple session involves negotiating the Recovery Contract to support abstinence, as described next.

TABLE 1.3. Therapeutic Tasks and Specific Procedures in BCT for Alcoholism and Drug Abuse

Engaging the couple for initial sessions

1. Engagement
2. Initial interviews
3. Assessment for BCT
4. Gaining commitment and starting BCT

Supporting abstinence

- Recovery Contract
 1. Daily Trust Discussion
 2. Self-help involvement
 3. Urine drug screens
 4. Medication to aid recovery
- Other support for abstinence
 1. Review substance use or urges to use
 2. Decrease exposure to alcohol and drugs
 3. Address stressful life problems
 4. Decrease behaviors that reward use

Improving the relationship

- Increasing positive activities
 1. “Catch Your Partner Doing Something Nice”
 2. Shared Rewarding Activities
 3. Caring Days
- Improving communication
 1. Communication Sessions
 2. Listening skills
 3. Expressing feelings directly
 4. Negotiating for requests
 5. Conflict resolution
 6. Problem solving

Continuing recovery

1. Continuing Recovery Plan
 2. Action plan to prevent or minimize relapse
 3. Check-up visits for continuing contact
 4. Relapse prevention sessions
 5. Couple and family issues in long-term recovery
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HOW BCT SUPPORTS ABSTINENCE

Dynamics of the Early Recovery Period

Before the substance abuser seeks help, the substance problem often becomes the focus of much of the couple's interactions. The negative effects of substance abuse lead the couple into an intense, hostile struggle in which the spouse tries desperately to control the substance abuse. In turn the substance abuser, although at times promising to reform or staying abstinent for short periods, continues to drink or use drugs. Such repeated unkept promises to change, and the problems caused by the substance abuser's continued use, lead to a high level of distrust and anger in the spouse.

Frequently by the time the substance abuser seeks help, the couple's interactions have become so intensely focused on substance abuse that although drinking and drug use may have stopped, it is by no means forgotten. The spouse has considerable resentment about past drinking and drug use and fear and distrust about the possible return of substance abuse in the future. The substance abuser, although feeling guilty about problems caused by past drinking or drug use, wants the spouse to recognize his or her efforts to change.

This atmosphere of distrust and conflict often leads to arguments about past or possible future substance abuse—and such conflicts can trigger relapse. In addition, the spouse may complain about past substance abuse, ignore current sober behavior, and question the amount of time that recovery meetings take away from the family. These behaviors are understandable because generally, the spouse has suffered considerable stress from the substance abuse. Nonetheless, the early recovery period is a time when the substance abuser needs support for a new way of life that emphasizes abstinence and a lifestyle that is conducive to abstinence.

The Recovery Contract

COMPONENTS OF THE BCT RECOVERY CONTRACT

The BCT Recovery Contract addresses the issues and dynamics of the early recovery period. It specifies behaviors that each member of the couple can do to reduce distrust and conflict about substance abuse and to reward abstinence and actions leading toward abstinence. The Recovery Contract starts with the "trust discussion" in which the patient states his or her intent not to drink or use drugs that day, the spouse expresses support for the patient's efforts to stay abstinent, and the patient thanks the spouse for the encouragement and support. For patients taking a recovery-related medication (e.g., disulfiram, naltrexone), daily medication ingestion is witnessed and verbally reinforced by the spouse during the trust discussion. Self-help meetings and drug urine screens are part of the contract for most patients. The spouse records performance of the discussion on a calendar, which is provided. Performance of other recovery activities (self-help meetings, drug screens, medication) also is marked on the calendar. The couple agrees not to discuss substance-related conflicts that can trigger relapse, reserving these discussions for the counseling sessions.

DEVELOPMENT AND EVOLUTION OF THE BCT RECOVERY CONTRACT

The BCT Recovery Contract developed from behavioral contracts used to maintain disulfiram (Antabuse) ingestion among alcoholic patients. Disulfiram is a drug that produces extreme nau-

sea and sickness if the person taking it ingests alcohol. Traditional disulfiram therapy often is not effective because the drinker stops taking it when he or she wants to drink. The disulfiram contract was designed to maintain disulfiram and abstinence by having a spouse or significant other witness the medication taking each day. Two slightly different versions of the disulfiram contract appeared in the literature at about the same time.

The BCT version, first described by Peter Miller,⁴ included the following elements:

1. Observed ingestion of disulfiram, with mutual thanking by alcoholic and spouse;
2. An early warning system for couple to call if contract was missed 2 days in a row;
3. An established length of time for observing the contract; and
4. Commitment to refrain from discussions about the alcoholic's drinking.

Like all disulfiram contracts, the BCT version seeks to maintain disulfiram ingestion and abstinence. The BCT version also seeks to restructure the couple's relationship to reduce conflicts about past drinking or likelihood of future drinking and to decrease the spouse's anxiety, distrust, and need to control the alcoholic. Such conflicts can lead to relapse.⁵ The BCT version tries to deal with these presumed relationship dynamics of the early sobriety period in order to increase support for abstinence and reduce the risk of relapse.

The community reinforcement approach (CRA) version derives from Azrin's⁶ attempt to augment the effectiveness of his CRA approach to alcoholism treatment by adding a disulfiram component to it. The CRA version of the disulfiram contract is identical to the BCT version, except that CRA does not include the item restricting discussions about drinking. Multiple outcome studies show that disulfiram contracts in combination with BCT and with CRA increase medication compliance and reduce drinking and alcohol-related problems.⁷

Disulfiram contracts have certain limitations, however. They cannot be used with alcoholic patients who are unwilling or not medically cleared to take disulfiram. They do not apply to most patients who have a primary drug abuse problem. Many treatment programs do not use this medication. The solution to this problem was the Sobriety Trust Contract, first used by Daniel Kivlahan and Elizabeth Shapiro⁸ with alcoholic patients who were not taking disulfiram. This procedure is very similar to the trust discussion we currently use in the BCT Recovery Contract, as described above. The trust discussion was a major advance. Although we began using it as a way to include alcoholic patients in BCT who were not taking disulfiram, the clinical response led us to use it with all our BCT patients. Couples responded very favorably to the trust discussion, often embellishing it in highly personal and meaningful ways (e.g., adding a prayer or a hug). It also led to very productive research on BCT with drug-abusing patients.

The most recent evolution over the past decade has involved adding self-help meetings and urine drug screens to the contract. We had always used these with many of our patients but had not integrated them into the contract or recorded them on the contract calendar. We added these components to the contract as we expanded the goals to broadly support abstinence and behaviors leading to abstinence. Couples and clinicians liked these additions, so we have continued them.

Other Support for Abstinence

The Recovery Contract is a major source of support for abstinence. BCT also uses four other methods to promote abstinence, which we describe next.

REVIEWING SUBSTANCE USE OR URGES TO USE

Reviewing substance use or urges to use is part of each BCT session. Discussing situations, thoughts, and feeling associated with urges helps identify potential triggers for alcohol or drug use. Such discussions also can identify successful coping strategies the patient used to resist an urge. If substance use has occurred, crisis intervention is important. BCT works best if the counselor intervenes before the substance use goes on for too long a period. The counselor should help the patient stop using and see the couple as soon as possible to use the relapse as a learning experience. While each BCT session reviews urges or use, time spent on the remaining supports for abstinence depends on the needs of the couple.

DECREASING EXPOSURE TO ALCOHOL AND DRUGS

Exposure to situations where alcohol or drugs are available or others are using such substances is a high risk for relapse among individuals in treatment for substance abuse. BCT sessions can reduce the risk of relapse by discussing how the patient and spouse will deal with such situations. The BCT counselor helps each couple develop their own plan for dealing with common exposure situations, such as whether to have alcohol in the house.

ADDRESSING STRESSFUL LIFE PROBLEMS

Stress caused by unresolved life problems can be a trigger for relapse. Using BCT sessions to help couples resolve or work on life problems, such as financial or legal issues, reduces relapse risk and makes abstinence more rewarding. It also strengthens the therapeutic relationship because the couple comes to view the counselor as someone who cares about their broader life concerns, not just the patient's recovery.

DECREASING PARTNER BEHAVIORS THAT TRIGGER OR REWARD USE

Partners try many ways to cope with their loved one's substance abuse, but some of these coping behaviors can unintentionally trigger or reward substance use. Common examples are giving the user money to buy alcohol or drugs, and lying to others to protect the user. BCT helps the couple identify and stop such behaviors.

HOW BCT IMPROVES RELATIONSHIPS**Relationship Tension in Early Recovery**

Once the Recovery Contract is going smoothly, the counselor can focus on improving couple and family relationships. As noted, spouses often experience resentment about past substance abuse and fear and distrust about its return in the future. The patient often experiences guilt and a desire for recognition of current improved behavior. These differing feelings experienced by the patient and spouse often lead to an atmosphere of tension and unhappiness in couple and family relationships.

Problems caused by substance use (e.g., bills, legal charges) need to be resolved. In addition, often there is a backlog of unresolved couple and family problems. Everyday relationship problems typically pile up because the couple's anger and focus on the substance abuse prevent effective communication to resolve the problems. Often the problems are blamed on the substance abuse with the expectation that the problems would resolve with abstinence. However, a woman whose life has revolved around drinking for the past 5 years does not immediately become an attentive, caring wife and mother just because she gets sober. Similarly, a man who has been marginally employed for a number of years due to drug abuse does not become a responsible provider and father overnight just because he becomes abstinent.

Couples frequently lack the mutual positive feelings and communication skills needed to resolve these relationship problems. As a result, many marriages and families break up during the first 1 or 2 years of the patient's recovery. In other cases, couple and family conflicts trigger relapse and a return to substance abuse. Even for couples who do not have serious relationship problems, abstinence can produce temporary tension and role readjustment even as it also provides an opportunity to stabilize and enrich couple and family relationships.

Joan Jackson's pioneering work, based on interviews with women attending Al-Anon, described the stages in the adjustment of the family to the crisis of alcoholism.⁹ She described how wives took on more and more family roles as their husbands' alcoholism got worse. The wife took on the main responsibility for parenting, for financial decision making, and often for financial support of the family because the alcoholic husband could not be depended on to carry out these roles. Steinglass also has written about similar adaptations that families and spouses make to maintain (rather than dissolve) the marital and family relationship in the face of continued alcoholism.¹⁰

When the substance-abusing individual enters treatment and becomes abstinent, the couple often experiences a period of tension and role readjustment. The patient wants to regain some of the roles in the family that were lost. The spouse is reluctant to let go of the roles that have been assumed for fear that abstinence will not last and the patient will cause further problems. In BCT the focus on increasing positives reduces some of the negative feelings over possibly shifting roles. BCT work on communication helps the couple negotiate a shift in roles back to greater trust and responsibility for the patient as abstinence progresses.

BCT relationship-focused interventions have two major goals: (1) to increase positive couple and family activities in order to enhance positive feelings, goodwill, and commitment to the relationship; and (2) to teach communication skills to help the couple resolve conflicts, problems, and desires for relationship change. The general sequence in helping couples increase positive activities and improve communication is (1) therapist instruction and modeling, (2) couple practice (under the counselor's supervision), (3) homework assignment, and (4) review of homework and further practice.

Increasing Positive Activities

BCT uses a number of methods to increase positive couple and family activities. "Catch Your Partner Doing Something Nice" asks each person to notice and acknowledge one nice thing each day that their partner did. "Caring day" involves each person planning ahead to surprise

their partner with some special activity to show their caring. “Shared rewarding activities” cultivates fun, either by themselves or with their children or other couples, and can bring the couple closer together.

Improving Communication

Inadequate communication is a major problem for alcoholism and drug abuse patients and their spouses.¹¹ Once the patient is abstinent, inability to resolve conflicts and problems can cause substance abuse and relationship tensions to recur. Teaching couples how to resolve conflicts and problems can reduce family stress and decrease risk of relapse. BCT includes basic communication skills of effective listening and speaking, and use of planned communication sessions. Couples also learn more advanced skills of conflict resolution, negotiating agreements for desired changes, and problem-solving skills.

These relationship-focused procedures were based on BCT methods developed for couples without alcohol or drug problems by BCT pioneers Robert Liberman, John Gottman, Robert Weiss, Gary Birchler, and Richard Stuart.¹² O’Farrell adapted these procedures for use with alcoholic patients,¹³ Fals-Stewart applied the procedures to drug-abusing patients,¹⁴ and together we updated the procedures for use in a series of collaborative studies of BCT in alcoholism and drug abuse.¹⁵

CONTINUING RECOVERY IN BCT

Most couples who attend BCT sessions faithfully show substantial improvement. However, when the structure of the weekly BCT sessions ends, there is a natural tendency for backsliding. Therefore it is critical to help couples maintain the gains they made in BCT and prevent or minimize relapse. Near the end of weekly sessions, the BCT counselor helps the couple make (1) a Continuing Recovery Plan that specifies which aspects of BCT (e.g., trust discussion) they wish to continue, and (2) an Action Plan of steps to prevent or minimize relapse. Couple “checkup” visits every few months for an extended period can encourage continued progress. Finally, those with more severe problems may benefit from periodic couple relapse prevention sessions in the year after weekly BCT ends.

WHO ARE APPROPRIATE CLIENTS FOR BCT?

BCT works directly to increase relationship factors conducive to abstinence. A behavioral approach assumes that family members can reward abstinence—and that alcoholic and drug-abusing patients from happier, more cohesive relationships with better communication have a lower risk of relapse. Typically, the substance-abusing patient and the spouse are seen together in BCT for 12–20 weekly outpatient couple sessions over a 3- to 6-month period, followed by periodic maintenance contacts. BCT can be an adjunct to individual counseling or it can be the only substance abuse counseling the patient receives. To reiterate: BCT fits well with recovery-related medications and with Alcoholics Anonymous, Al-Anon, and other self-help groups. The couple starts BCT soon after the substance abuser seeks help. BCT can start

immediately after detoxification or a short-term intensive rehab program or when the substance abuser seeks outpatient counseling.

Definitely Suitable Cases

Generally, “definitely suitable” couples have been married or cohabiting for at least a year and are living together when they start BCT. Only one member of the couple has a current problem with alcoholism or drug abuse. He or she accepts at least temporary abstinence as a goal. Both partners are willing to work together to see if their substance abuse and relationship problems can be improved. Neither member of the couple has a history of a psychotic disorder. These definitely suitable cases represent the majority of couples counselors will see in a typical substance abuse treatment setting. They are the cases for which BCT has been shown to be effective in outcome studies. Other possibly suitable cases are addressed briefly next.

Cases Possibly Suitable for BCT

- *Separated couples* generally cannot be together frequently enough to provide the daily support that is critical to the success of BCT. Often the counselor can see the couple for some initial sessions to negotiate a return to living together. Once the couple has reunited, BCT proceeds as with other couples.

- *“Dual couples”*—couples in which both the male and female member have a current substance abuse problem—may benefit from BCT only under certain circumstances. If both members want to stop drinking and drugging when they first see the counselor, or if this mutual decision to seek abstinence can be attained during the first few couple sessions, then BCT generally is workable. However, when only one member of the couple wants to change, this person should get individual counseling; BCT is not advised.

- *Couples with severe emotional problems* in the substance abuser or the spouse often may not benefit from BCT. Nonetheless, our clinical experience suggests that at times BCT may be effective with such cases, when it is used along with appropriate individual therapy and psychotropic medication for the emotionally troubled person. In such cases, BCT sessions proceed slowly and are carefully tailored to the special needs of such clients.

- *Couples seen outside a substance abuse treatment setting* may present challenges for BCT. Studies showing BCT effectiveness were conducted in substance abuse treatment settings and research projects. In such settings, participants recognize the substance problem and are ready to address it, at least to some degree. In other settings, such as typical office practice of psychotherapy or marriage and family counseling, clients often are not ready to address the substance problem. Therefore, in other settings, BCT may work only if a client has, or can be helped to develop, the needed readiness for change.

Cases Definitely Not Suitable for BCT

Contraindications for BCT relate to legal and safety issues. Couples in which there is a court-issued restraining order for the spouses not to have contact with each other should not be seen together in therapy until the restraining order is lifted or modified to allow contact in counseling. Some situations present concerns for the safety of participants in BCT. If the clinical

assessment indicates that there is an active and acute risk for very severe domestic violence (i.e., could cause serious injury or be potentially life-threatening), then it is better not to use BCT. As described in more detail in Chapter 10, couples are excluded from BCT if very severe violence (defined as resulting in injury requiring medical attention or hospitalization) has occurred in the past 2 years, or if one or both members of the couple fear that taking part in couples treatment may stimulate violence. Although domestic violence is quite common among substance-abusing patients, most of this violence is not so severe that it precludes BCT. In our experience fewer than 2% of couples seeking BCT are excluded from treatment due to very severe violence or fears of couples therapy. The best plan in most cases is to address the violence in BCT sessions. Research reviewed below shows that violence is substantially reduced after BCT and virtually eliminated for patients who stay abstinent. Table 1.4 summarizes key points about who are appropriate clients for BCT.

HOW TO BE AN EFFECTIVE BCT COUNSELOR

Address Substance Abuse First

Certain counselor attributes and behaviors are important for successful BCT with alcoholic and drug-abusing patients. From the outset, the counselor must structure BCT sessions so that abstinence from alcohol and illicit drugs is the first priority, before attempting to help the couple with other problems. Many of our clients have had previous unsuccessful experiences with couple and family therapists who saw the couple without dealing with the substance abuse problem. The hope that reducing relationship problems will lead to improvement in the sub-

TABLE 1.4. Suitability of Cases for BCT

Definitely suitable cases

- Married or cohabiting couples
- Reside together (i.e., not separated)
- Only one has current substance problem
- Both partners accept the need for temporary abstinence at least
- Both partners are willing to work on problems
- Neither partner has history of psychosis
- Start after detox, rehab, or no prior treatment

Possibly suitable cases

- Separated couples
- Both partners have current substance problems
- One partner has severe emotional problems
- Not in a substance abuse treatment setting

Definitely not suitable cases

- High risk of injurious/lethal violence
- Restraining order prohibiting contact

stance abuse problem rarely is fulfilled. More typically, recurrent substance-related incidents undermine whatever gains have been made in couple and family relationships.

Deal Effectively with Anger

The counselor needs to be able to tolerate and deal effectively with strong anger in early sessions and at later times of crisis. The counselor can use empathic listening to help each person feel that he or she has been heard, and the counselor can insist that only one person speak at a time. Helping the couple defuse their intense anger is very important because failure to do so often leads to a poor outcome.

Structure and Control Sessions

The counselor also needs to structure and take control of treatment sessions, especially the early assessment and therapy phase and at later times of crisis (e.g., episodes of drinking or intense family conflict). Structured therapy sessions with a directive, active counselor are more effective than is a less structured mode of therapy. Many counselors' errors involve difficulty establishing and maintaining control of the sessions and responding to the myriad forms of resistance and noncompliance presented by couples. The counselor needs to steer a middle course between lack of structure and being overly controlling and punitive in response to noncompliance. The counselor needs to clearly establish and enforce the rules of treatment and also acknowledge approximation to desired behavior despite significant shortcomings.

Empathize Readily with Both Partners

Other counselor qualities can promote successful BCT. The counselor needs to empathize with each person and not take sides, favoring one over the other on a consistent basis, or join the spouse in scapegoating the substance abuser. Using humor constructively can contribute to patients' feeling comfortable. Practical knowledge of financial and legal issues commonly faced by substance abusers and their families also can help. A further helpful stance, often used by counselors in BCT, is to act as educator or "coach" by teaching behavioral techniques to deal with substance use (e.g., monitoring urges to drink) or relationship issues (e.g., communication skills).

Do Not Impose Your Own Beliefs on Couple

Counselors also need to be aware of their own beliefs and experiences regarding relationships and recovery. If a counselor's divorce led to a happier second marriage, he or she may naturally be more inclined to see separation as a positive option for clients than would a counselor who stayed with a difficult relationship that improved over time. The important point is that counselors should try not to impose their own beliefs on patients. Patients and their partners need to make their own decisions based on their own values and experiences. Similarly, counselors who are recovering themselves might tend to think their patients should do what worked for them. Of course, just because the counselor did "90 meetings in 90 days" does not mean everyone should.

Avoid Blame and Maintain Contact

The counselor needs to take a long-term view of the course of change. Both the alcohol or drug problem and associated relationship problems may be helped substantially only by repeated efforts, including some failed attempts. Such a long-term view may help the counselor encounter relapse without becoming overly discouraged or engaging in blaming and recriminations with the substance abuser and spouse. The counselor also should maintain contact with the couple long after the problems apparently have stabilized. Leaving such contacts to the couple usually means that no follow-up contacts occur until they are back in a major crisis again.

Forge a Strong Therapeutic Relationship

A strong therapeutic relationship can keep the patient and spouse coming to therapy, especially early in treatment when risk for dropout is high. Patients and spouses are likely to continue in therapy if they consider the counselor a knowledgeable and helpful guide to the process of substance abuse and relationship recovery. As described above, counselors who develop successful relationships with their patients have the ability (1) to put “first things first” by giving priority to the substance use problem, (2) to defuse and manage anger, (3) to be fair and show evenhanded understanding of each person’s viewpoint, and (4) to steer a steady course through the confusing emotions and family conflicts encountered in substance abuse recovery. The therapeutic relationship is strengthened when the counselor takes an active role to help clients deal with the everyday problems that arise between sessions in coping with recovery, relapse, and relationships. Finally, whenever possible, it helps to have clients leave therapy sessions on a positive note, feeling as good as, or better than, when they arrived. This improvement will make them want to return for the next session and promote continued treatment.

Background and Training Needed

Ideally a counselor conducting BCT with substance abuse patients would have a master’s degree or higher in psychology, social work, or counseling. Training should include courses on the nature and treatment of both substance abuse and marital and family problems, and supervised clinical experiences providing individual, couple, and family counseling for patients with alcohol and drug problems. Counselors also need training in basic cognitive-behavioral methods for treating substance abuse.

Clearly this level of training is an ideal that often is not a practical reality. Most graduate programs and internships do not provide training in substance abuse or in family problems of substance abuse patients. Many counselors in substance abuse settings learn on the job. In our projects, experienced substance abuse counselors have become proficient in BCT. In fact, we trained bachelor’s level counselors to deliver BCT,¹⁶ but they received intensive, ongoing supervision in BCT that is not available in most settings. On the other hand, we have noticed that a couple or family therapist with little substance abuse experience may have some difficulty learning BCT. Such therapists often do not give the necessary priority to the substance abuse problem and the substance-focused parts of BCT.

Table 1.5 summarizes key counselor attributes and behaviors that are important for successful BCT.

TABLE 1.5. How To Be An Effective BCT Counselor

-
- Address substance abuse problem first.
 - Tolerate and defuse strong anger.
 - Structure and control sessions.
 - Empathize readily with both partners.
 - Do not impose your own beliefs.
 - Use positive approach with humor.
 - Know common legal and money problems.
 - Avoid blame and hopelessness.
 - Maintain long-term contact with couples.
 - Forge a strong therapeutic relationship.
-

EFFECTIVENESS OF BCT

Randomized studies show that family-involved treatment in alcoholism and drug abuse results in more abstinence than does individual treatment.¹⁷ BCT is the family therapy method with the strongest research support for its effectiveness in treating substance abuse among adults.¹⁸ BCT produces greater abstinence and better relationship functioning than typical individual-based treatment and reduces social costs, domestic violence, and the emotional problems of couples' children.

Primary Clinical Outcomes: Abstinence and Relationship Functioning

Studies comparing substance abuse and relationship outcomes for substance-abusing patients treated with BCT or individual counseling show a fairly consistent pattern of results. Substance-abusing patients who receive BCT have more abstinence and fewer substance-related problems, happier relationships, and lower risk of couple separation and divorce than those who receive only typical individual-based treatment. These results come from studies with mostly male alcoholic¹⁹ and drug-abusing²⁰ patients. Two studies (one in alcoholism and one in drug abuse) show the same pattern of results with female patients.²¹ Drug abuse patients for which BCT had better outcomes than individual treatment include heterogeneous samples (mostly cocaine and heroin), methadone maintenance patients, and heroin patients taking naltrexone. These BCT studies have included diverse patient populations, with: (1) income levels ranging from public assistance to solidly middle class, (2) minority group representation from almost none to over half African American, and (3) gay and lesbian patients and their same-sex partners.²²

Reduced Social Costs

The social costs of substance abuse include treatment, substance-related crimes, and public assistance. Studies have examined whether BCT reduced these costs. In three studies (two in alcoholism and one in drug abuse),²³ the average social costs per case decreased substantially in the 1–2 years after, as compared to the year before, BCT. Cost savings averaged \$5,000–\$6,500 per case. The costs saved by BCT was more than five times the cost of delivering it, producing

a benefit-to-cost ratio greater than 5:1. For every dollar spent in delivering BCT, \$5 in social costs are saved. In addition, BCT was more cost-effective when compared with individual treatment for drug abuse and when compared with interactional couples therapy for alcoholism.

Reduced Domestic Violence

Two studies reported that male-to-female partner violence was significantly reduced in the first and second year after BCT, and it was nearly eliminated with abstinence.²⁴ In two other studies, BCT reduced partner violence and couple conflicts better than individual treatment.²⁵ These results suggest that couples learn to handle their conflicts with less hostility and aggression in BCT.

Impact of BCT on the Children of Couples

Kelley and Fals-Stewart²⁶ conducted two studies (one in alcoholism, one in drug abuse) to find out whether BCT for a substance-abusing parent also has beneficial effects for the children in the family. Results were the same for children of male alcoholic and male drug-abusing fathers. BCT improved children's functioning in the year after the parents' treatment more than did individual-based treatment or couple psychoeducation. Only BCT couples showed reduction in the number of children with clinically significant impairment.

Increased Compliance with Recovery-Related Medication

BCT has been used to increase compliance with recovery-related medications. Male BCT patients stopping opioid use had better naltrexone (Trexan) compliance compared with their individually treated counterparts. The better compliance led to greater abstinence and fewer substance-related problems.²⁷ Another study found that BCT produced better compliance with HIV medications among HIV-positive drug abusers in an outpatient treatment program than did treatment as usual.²⁸ BCT also has improved compliance of alcoholic patients with disulfiram (Antabuse)²⁹ and with naltrexone (ReVia).³⁰

Evidence Supports Wider Use of BCT

Table 1.6 summarizes key points about the effectiveness of BCT, an approach that needs wider application by counselors so that patients and their families can benefit from this evidence-based method of treating alcoholism and drug abuse. A major obstacle to this wider application has been that, until now, there has been no guide showing how to implement BCT.

PREVIEW OF THIS BOOK

This book is written as a clinical guide for counselors who want to use BCT with patients seeking outpatient treatment for alcoholism or drug abuse. It also is a resource for marriage and family counselors who treat couples with substance abuse problems. Chapters 2–8 describe how to implement the BCT program outlined in Table 1.3. First, the counselor engages the

TABLE 1.6. What Studies of BCT Show

-
- BCT produces more abstinence, happier relationships, and fewer separations than individual treatment.
 - Benefit-to-cost ratio for BCT is greater than 5 to 1.
 - Domestic violence is greatly reduced after BCT.
 - BCT helps a couple's children more than individual treatment for the substance-abusing parent.
 - BCT improves compliance with recovery medications (e.g., disulfiram, naltrexone).
 - Evidence supports wider use of BCT.
-

patient and spouse for initial couple sessions in which the counselor assesses substance abuse and relationship functioning and gains commitment to starting BCT (as shown in Chapter 2). BCT begins with the Recovery Contract and other substance-focused interventions that continue throughout the therapy to promote abstinence (as shown in Chapters 3 and 4). The next step in BCT is to add relationship-focused interventions to increase positive activities (Chapter 5) and improve communication (Chapters 6 and 7). Finally, when the couple has progressed and it is time to stop weekly BCT sessions, the counselor helps them plan for continuing recovery to prevent or minimize relapse (as shown in Chapter 8). Chapters 2–8 cover BCT with what we call *definitely suitable cases*: married or cohabiting couples with one substance-abusing member and without very severe violence or psychosis. As noted, such cases constitute the majority of couples counselors will see and those for which BCT has been shown effective.

Chapters 9–11 cover challenges and enhancements to BCT. Chapter 9 shows how to use BCT with potentially suitable couples who are separated or where both members have a current substance problem. Chapter 10 takes a detailed look at partner violence among couples treated in BCT. Earlier chapters give the standard BCT approach to partner violence: Assess violence history, exclude the very small number of couples with histories of very severe violence, monitor commitment to nonviolence, teach communication and conflict resolution skills, and coach nonusing spouses on how to stay safe if relapse occurs. Chapter 10 provides an in-depth rationale for using BCT with couples who have experienced violence and gives extended case examples. Chapter 10 also recaps solutions to common challenges in BCT (e.g., noncompliance with homework). (Another good place to look for answers to BCT challenges are the frequently asked questions at the end of each chapter.) Chapter 11 shows how we enhanced BCT outcomes by adding parent training and an HIV-risk reduction module, and by expanding BCT to family members other than a spouse. Although these enhancements have not been fully researched, we included them because they appear promising.

The closing chapter considers practical issues in implementing BCT in day-to-day practice in substance abuse treatment centers and other settings. It has suggestions for counselors who want to get started with BCT and for those who want to establish an ongoing BCT program. For example, we suggest that counselors start using BCT with couples who are likely to benefit (i.e., definitely suitable couples) to build their skill and confidence in BCT before moving on to more difficult situations. Chapter 12 also considers the various formats in which BCT has been delivered. Most often we have used BCT with one couple at a time, but we also have used a BCT couples group format. Typically BCT has ranged from 12 weekly sessions to a flexi-

ble length program of 20 sessions or more. We have used BCT in many different community-based substance abuse treatment programs, where BCT was combined with individual-based treatment for the patient that included 12-step, cognitive-behavioral, or treatment as usual provided in individual or group counseling.

This book describes a set of BCT procedures that counselors can use flexibly with their patients, basing the timing of interventions on their judgement of patients' needs. Counselors also may find helpful a session-by-session treatment manual they can follow. Appendix A contains a 12-session BCT treatment manual. Each session includes a therapist checklist and an outline. Once familiar with BCT, a counselor can use the checklist to guide his or her implementation of the session. Appendix B contains posters that we often use to convey key points to couples receiving BCT. These posters can be enlarged and kept in the counselor's office for use in BCT sessions. Appendix C contains BCT-related forms that can be copied by counselors for use with their own couples.

Sequence of Interventions in BCT

Table 1.7 shows how the therapeutic tasks and interventions of BCT unfold over the sequence of couple sessions. The table shows a 12-session weekly format of core BCT sessions preceded by initial couple engagement sessions and followed by elective periodic maintenance sessions. Sessions are also broken into "early," "middle," and "later" phases of BCT for flexible expansion to BCT formats with more than 12 sessions. As shown in the table, assessment and commitment interventions that begin before BCT may continue for the first few core BCT sessions in some cases. The sequence of interventions in the core BCT sessions is described as follows.

RECOVERY CONTRACT

The couple starts doing the daily trust discussion in the first BCT session and continues this practice through all sessions. Depending on the couple's needs and willingness, other components (i.e., 12-step meetings, drug screens, medication) may be part of the Recovery Contract. If so, these other components usually start in the first few BCT sessions and continue to the end of the therapy.

OTHER SUPPORT FOR ABSTINENCE

Review of substance use and urges is part of every session. Other components (i.e., decreasing substance exposure, stressful problems, enabling) are first addressed in early sessions if needed by the couple. Most couples need some attention given to stressful problems and substance exposure. Whether these other components are continued in subsequent sessions is based on the particular needs of the couple.

INCREASING POSITIVE ACTIVITIES

"Catch Your Partner Doing Something Nice" may start as early as the first BCT session. Other components (shared rewarding activities and caring days) are phased in during the early sessions. Starting with the middle sessions and continuing to the end of BCT, the couple picks at least one of the three assignments to carry out each week.

TABLE 1.7. Sequence of Therapeutic Tasks and Sessions in BCT for Alcoholism and Drug Abuse

Therapeutic tasks	Before core BCT sessions	Core BCT sessions												After core BCT sessions			
		Early sessions			Middle sessions				Later sessions								
		1	2	3	4	5	6	7	8	9	10	11	12				
Initial couple sessions																	
1. Engagement	X																
2. Initial interview	X																
3. Assessment for BCT	X	(X)	(X)														
4. Gaining commitment and starting BCT	X	(X)															
Supporting abstinence																	
• Recovery Contract																	
1. Daily Trust Discussion		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	C
2. Self-help involvement		(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	C
3. Urine drug screens		(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	C
4. Medication to aid recovery		(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	(X)1	C
• Other Support for Abstinence																	
1. Review substance use or urges to use		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	C
2. Decrease exposure to alcohol and drugs				X	X	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	C
3. Address stressful life problems			X	X	X	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	C
4. Decrease behaviors that reward use				(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	(X)	C
Improving the relationship																	
• Increasing Positive Activities																	
1. “Catch Your Partner Doing Something Nice” (and tell him or her)		X	X	X	X	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	C
2. Shared Rewarding Activities			X	X	X	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	C
3. Caring Days			X	X	X	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	(X)2	C

(continued)

TABLE 1.7. (continued)

Therapeutic tasks	Before core BCT sessions		Core BCT sessions										After core BCT sessions				
			Early sessions			Middle sessions				Later sessions							
	1	2	3	4	5	6	7	8	9	10	11	12					
• Improving Communication																	
1. Communication sessions				X	X	X	X	X	X	X	X	X	X	X	X	X	C
2. Listening skills					X	X	X	X	X	X	X	X	X	X	X	X	C
3. Expressing feelings directly						X	X	X	X	X	X	X	X	X	X	X	C
4. Negotiating for requests								X	X	(X)	(X)	(X)	(X)	(X)	(X)	(X)	C
5. Conflict resolution									X	X	(X)	(X)	(X)	(X)	(X)	(X)	C
6. Problem solving										X	X	(X)	(X)	(X)	(X)	(X)	C
Continuing Recovery																	
1. Continuing Recovery Plan														X	X	X	C
2. Action Plan to prevent or minimize relapse															X	X	C
3. Checkup visits for continuing contact																	(X)
4. Relapse prevention sessions																	(X)
5. Couple and family issues in long-term recovery																	(X)

Note. X = This task is part of this session for all or nearly all couples; (X) = this task *may be* part of this session, depending on the couple's needs and choices and the counselor's recommendation; 1 = if part of couple's treatment, this task is part of all BCT sessions; 2 = couple picks at least one of the three positive activities to do for this session; C = partners may choose to continue this procedure after weekly core BCT sessions end, as part of their own self-directed Continuing Recovery Plan or as part of additional checkup visits or relapse prevention sessions conducted by the counselor.

IMPROVING COMMUNICATION

Basic skills of effective listening and speaking and use of planned communication sessions are introduced starting at the end of the early sessions. These basic skills are part of all subsequent sessions because they are used in all the more advanced communication skills (i.e., negotiating requests, resolving conflicts, problem solving). Each of these more advanced skills is introduced for two sessions starting toward the end of the middle sessions, and may be continued in later sessions, depending on the particular needs of the couple.

CONTINUING RECOVERY

In the last three BCT sessions, couples focus on their Continuing Recovery Plan of activities to continue after BCT and their Action Plan to prevent or minimize relapse. Finally, depending on the couple's needs and willingness, the counselor may schedule additional checkup visits or relapse prevention sessions after the weekly core BCT sessions end.

A Note on Terminology

As we end this introductory chapter, a note on the terminology used throughout the book may be helpful. We use the term “substance-abusing patient” or just “patient” to indicate generically the alcoholic or drug-abusing member of a couple. Similarly, we use the term “substance abuse” generically to refer to problems with either alcohol or drugs or both. If a specific substance (e.g., alcohol, cocaine) is at issue, it is referred to specifically. We use the term “spouse” or “partner” interchangeably to indicate the non-substance-abusing spouse or unmarried live-in partner who is in a couple relationship with the patient. These terms refer to couples in which only one member has a current substance problem (the majority of the couples described in this book). When we refer to couples in which both members have a substance problem, this is indicated. Each case example we present in this book is a composite case with individual identities disguised to protect the privacy and anonymity of the couples with whom we have worked. Finally, starting with frequently asked questions below and continuing throughout the book, we address our comments in the form of a dialogue with you, the reader, our colleague and potential BCT counselor.

FREQUENTLY ASKED QUESTIONS

- *Question 1:* You advocate starting BCT right after the patient leaves detox, during the early recovery period. I thought you were not supposed to do couple or family counseling until the substance-abusing patient has had at least a year of abstinence. The patient needs to focus on him- or herself. Couples therapy may lead to relapse because it distracts the patient from the priority of staying abstinent, or it stirs up negative emotions that the patient isn't ready to deal with.

- *Answer:* This was a popular belief for many years. However, as described above, studies do not support this belief. After more than 30 years of research on couples therapy during the early recovery period, outcome data show that patients who get BCT are *less likely* to relapse than patients who get only individual substance abuse counseling. As you will see in later chapters, BCT helps the patient stay focused on abstinence, and it helps the couple deal construc-

tively with strong anger and resentments without breaking up—or the patient breaking out. The belief that couples counseling should be delayed may come from advice in AA that it is unwise to make major changes in the first year of abstinence. This advice, which is particularly strong against starting a new relationship or ending an existing one, seems like pretty good advice for many people. The early recovery period is a good time to “take it easy” and not make impulsive choices on major life decisions. However, extending this advice to prohibit couple and family counseling seems like an overgeneralization.

- *Question 2:* If a substance-abusing patient has serious relationship problems that interfere with his or her recovery, BCT might make sense. But you seem to be advocating BCT for nearly all patients with a spouse or live-in partner. If relationship problems or issues are not interfering with the patient’s recovery, why should the patient get BCT? How would BCT help such patients?

- *Answer:* When we started in the field over 25 years ago, we assumed that all, or nearly all, alcoholism and drug abuse patients had serious relationship problems and could benefit from therapy to address these problems. Two things have changed over the years. First, although studies show that most substance abuse patients do have relationship problems, the problem severity varies considerably; some have very serious problems, whereas others score in the nonproblem range on relationship adjustment measures.³¹ Second, we have changed our focus from one of couples therapy to alleviate relationship distress to one of BCT with the dual goals of helping the patient stay abstinent and helping the couple get along better. Even patients without serious relationship problems can benefit from BCT to help them stay abstinent. BCT should not be reserved for substance abuse patients who have serious relationship problems secondary to, preceding, or coexisting with the substance abuse problem. Couples with less serious problems often are better able to work together to help the patient stay abstinent and to enrich their relationship, which has been strained by substance-related stressors. Further, even when couple factors do not play an important role in triggering or maintaining the substance abuse, involving the spouse in BCT may help the patient stay abstinent while learning how to deal with triggers for substance use that are outside the relationship. In addition, BCT can help support healthier activities (e.g., involvement with children and spouse) that are incompatible with substance abuse.

- *Question 3:* You said that BCT can be an adjunct to individual counseling, or it can be the only substance abuse counseling the patient receives. When can BCT be the only counseling the patient receives?

- *Answer:* Our answer is based solely on clinical experience because research has not examined this question. BCT is frequently delivered as part of a comprehensive treatment package that includes individual and group therapy for the identified substance-abusing patient. However, some patients can benefit from BCT without other ongoing counseling. Patients with less severe problems may benefit from BCT alone. Patients who have a strong commitment to a 12-step self-help program and make this part of their BCT Recovery Contract may not need individual counseling. Alcoholic patients who take Antabuse or opioid-dependent patients who take naltrexone often do well with BCT alone, because they tend to stay on these medications as part of the BCT daily Recovery Contract. Patients who have had prior successful treatment, accept they have an addiction, and know what they need to do to stay abstinent (but need support to do it) benefit from the structure of BCT and the monitoring of the Recovery Contract. Patients who are likely to need both BCT and individual counseling include those with more severe substance

abuse problems, those with comorbid psychiatric problems, and those who are new to substance abuse treatment or very ambivalent about abstinence.

SUMMARY

- The 12-step Al-Anon family disease approach is the most widely used approach for dealing with family issues in recovery. It emphasizes separate individual programs for the patient and the spouse. Al-Anon helps reduce family members' emotional distress, but it does not deal directly with relationship issues. So BCT may have a role to play in recovery programs.
- This chapter introduced you to behavioral couples therapy (BCT), in which a substance-abusing patient and his or her spouse work together each day to support abstinence and improve their relationship. BCT promotes abstinence with a "Recovery Contract" that involves both members of the couple in a daily ritual to reward abstinence. BCT improves the relationship by implementing techniques that increase positive activities and improve communication.
- Couples are "definitely suitable" for BCT if (1) they are married or living together, (2) one member has a current substance problem and accepts the need for at least temporary abstinence, (3) both are willing to work together for improvement, and (4) there is no acute risk of very severe partner violence or a history of psychosis. "Possibly suitable" cases already mentioned are considered further in Chapters 9 and 10.
- Successful BCT counselors have the ability (1) to put "first things first" by giving priority to the substance use problem, (2) to defuse and manage anger, (3) to be fair and show evenhanded understanding of each person's viewpoint, and (4) to steer a steady course through the confusing emotions and family conflicts encountered in substance abuse recovery.
- Research has shown that BCT produces greater abstinence and better relationship functioning than more typical individual-based treatment, and it reduces social costs, domestic violence, and emotional problems of couples' children.
- Although some believe that 6–12 months of abstinence are needed before couples counseling is advised, we advocate starting BCT when the patient leaves detox. Concerns that couples therapy may lead to relapse by distracting patients from the priority of staying abstinent or stirring up negative emotions have not been borne out. Over 30 years of research show that patients who get BCT in the early recovery period are *less likely* to relapse than patients who get only individual counseling.
- BCT has dual goals of helping the patient stay abstinent and the couple get along better. Even patients without serious relationship problems can benefit from BCT to help them stay abstinent. Therefore, BCT should be provided for all couples, not just those who have serious relationship problems.
- BCT is frequently part of a comprehensive treatment program that includes individual and group therapy for the substance-abusing patient. However, some patients can benefit from BCT without other ongoing counseling if they have less severe problems, a strong commitment to AA or NA, take recovery medication, have had prior successful treatment, and accept they have an addiction.
- Starting in the next chapter, this book provides "how to" instructions to counselors who want to use BCT with patients seeking outpatient treatment for alcoholism or drug abuse.

NOTES

1. For more information on the family disease approach, see (a) program information from Al-Anon (e.g., Al-Anon Family Groups, 1981), (b) Nowinski's (1999) therapist manual for Al-Anon facilitation, (c) Laudergeran and Williams (1993) on the family psychoeducational program at Hazelden, (d) Dittrich (1993) on group therapy for wives of alcoholic men, and (e) O'Farrell and Fals-Stewart (2003).
2. A therapist manual for Al-Anon facilitation therapy is available (Nowinski, 1999).
3. O'Farrell and Fals-Stewart (2003).
4. Miller (1976); Miller and Hersen (1975).
5. Maisto, McKay, and O'Farrell (1995); Maisto, O'Farrell, Connors, McKay, and Pelcovits (1988).
6. Azrin (1976).
7. For a review of the use of BCT to increase compliance with disulfiram, see O'Farrell, Allen, and Litten (1995).
8. Personal communication, May 18, 1984.
9. Jackson (1955).
10. Steinglass, Bennett, Wolin, and Reiss (1987).
11. O'Farrell and Birchler (1987).
12. Gottman, Notarius, Gonso, and Markman (1976); Liberman, Wheeler, DeVisser, Keuhnel, and Keuhnel (1980); Stuart (1980); Weiss, Birchler, and Vincent (1974).
13. O'Farrell and Cutter (1984a).
14. Fals-Stewart, Birchler, and O'Farrell (1996).
15. O'Farrell and Fals-Stewart (2000).
16. Fals-Stewart and Birchler (2002).
17. O'Farrell and Fals-Stewart (2001); Stanton and Shadish (1997).
18. Epstein and McCrady (1998).
19. Azrin, Sisson, Meyers, and Godley (1982); Bowers and Al-Redha, (1990); Chick et al. (1992); Fals-Stewart, Klosterman, Yates, O'Farrell, and Birchler (2005); Fals-Stewart and O'Farrell (2002); Hedberg and Campbell (1974); Kelley and Fals-Stewart (2002); McCrady, Stout, Noel, Abrams, and Nelson (1991); O'Farrell, Cutter, Choquette, Floyd, and Bayog (1992).
20. Fals-Stewart et al. (1996); Fals-Stewart and O'Farrell (2003); Fals-Stewart, O'Farrell, and Birchler (2001a, 2001b); Kelley and Fals-Stewart (2002).
21. Fals-Stewart, Birchler, and Kelley (in press); Winters, Fals-Stewart, O'Farrell, Birchler, and Kelley (2002).
22. Hequembourg, Hoebbel, Fals-Stewart, O'Farrell, and Birchler (2004).
23. Fals-Stewart, O'Farrell, and Birchler (1997); O'Farrell, Choquette, Cutter, Brown, et al. (1996); O'Farrell, Choquette, Cutter, Floyd, et al. (1996).
24. O'Farrell and Murphy (1995); O'Farrell, Murphy, Stephan, Fals-Stewart, and Murphy (2004).
25. Birchler and Fals-Stewart (2001); Fals-Stewart, Kashdan, O'Farrell, and Birchler (2002).
26. Kelley and Fals-Stewart (2002).
27. Fals-Stewart and O'Farrell (2003).
28. Fals-Stewart, O'Farrell, and Martin (2002).
29. Azrin et al. (1982); Chick et al. (1992); O'Farrell et al. (1992).
30. Fals-Stewart and O'Farrell (2002).
31. Fals-Stewart, Birchler, and O'Farrell (1999); O'Farrell and Birchler (1987).