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▶ A randomized trial of individual and couple behavioral alcohol treatment for women.

McCrady B.S., Epstein E.E., Cook S. et al. Request reprint

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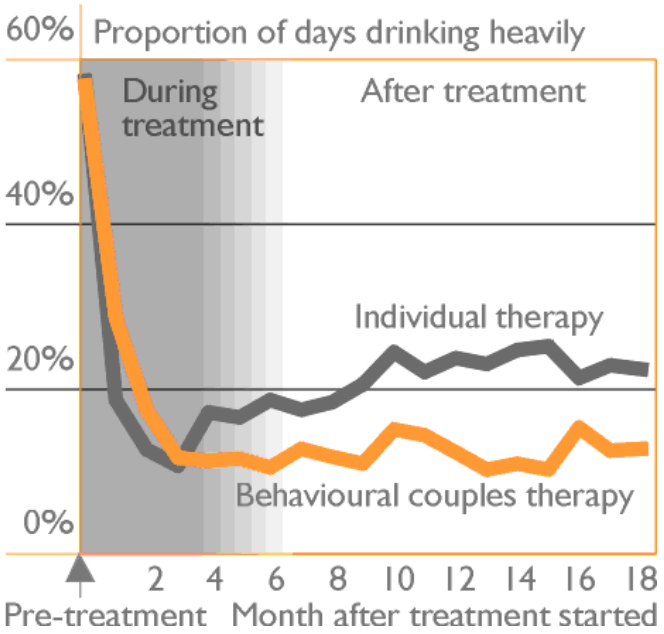
Alcohol dependent women experienced more lasting improvements when couples-based therapy embedded therapeutic processes in a lasting relationship with a willing husband or partner, extending an impressive research portfolio for the therapy.

Abstract Behavioural couples 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. 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. A major limitation on applicability has been that the partner of the problem substance user must not themselves have a substance use problem. In respect at least of drinking, the featured study tried dispensing with this requirement. It sought to further broaden applicability by combining couples therapy with components aimed at the individual patient so the combination could be deployed as a standalone approach rather than (as typical in previous studies) supplementing other therapies.

Through adverts and referrals from local alcohol treatment services, contact was made with 351 women who seemed potentially eligible for the study. Apart from alcohol abuse or dependence, the main requirements were that the women were in a committed relationship with a male partner who met criteria intended to exclude men who might respond aggressively to involvement in therapy, and that neither were physically dependent on drugs other than alcohol. A further requirement that the man was willing to participate in research and treatment meant (it was known or presumed) that a third of the women could not join the study. In the end 109 joined, of whom 102 participated in at least one treatment session and formed the sample from whom outcomes were

recorded. All but three were diagnosed as dependent on alcohol. Typically they were white women in their mid-40s who were working and/or looking after the home. At entry to the study they admitted drinking heavily on nearly 60% of days in the past three months. Their partners were on average much less frequent drinkers, less likely to be heavy drinkers, and generally in full-time employment.

At random the women were allocated to one of two abstinence-oriented cognitive–behavioural therapies intended to be delivered over 20 sessions for up to six months. The first was an individual approach involving only the woman and featuring typical cognitive–behavioural components. The second involved both partners. Couples sessions were extended from an hour to 90 minutes to incorporate the individual components of the first therapy plus interventions intended to teach the man to support abstinence, decrease attention to drinking, and improve the relationship through enhanced reciprocity, communication and problem-solving. The men were free (but not required) to use the therapy's interventions to change their own drinking, and if asked for, treatment referrals were offered. On average more individual therapy sessions were attended (15 versus 12) and more women completed the course (44% versus 24%). However, longer sessions meant that in total more hours were spent in the couples therapy.



Treatment progress was tracked every three months for a year and a half, mainly by interviewing each partner separately and selecting the 'worst' report on the woman's drinking over the past three months. In the year after treatment ended, women who had been in couples therapy were slightly (but the advantage was statistically significant) better able to sustain the rapid improvements in proportion of days abstinent and days of heavy drinking seen in the first months of treatment. On average they ended up not drinking on 75% of days compared to 63% after individual therapy, and drank heavily on just 13% of days compared to 22% ▶ *chart*.

A composite measure combined the degree to which before treatment each woman was satisfied with their relationship, it was not characterised by aggression, and the woman's drinking was not triggered by relationship issues. After treatment had ended, only women in (according to this measure) relatively healthy relationships benefited more from couples therapy in terms of reducing the proportion of days they drank heavily. Women in unhealthy relationships did just as well in individual therapy. Women whose

own psychological health was relatively poor when treatment started also benefited most clearly from the couples therapy.

The authors concluded that their results were consistent with other studies supporting the relatively greater efficacy of couple rather than individual treatment when both partners are prepared to participate. Together with these studies, the featured study suggests that couples therapy is effective for women of varied backgrounds and ages either as a standalone treatment or a supplementary therapy, may not require the accompanying partner to be free of drinking problems, and remains effective (perhaps particularly so) when the female partner starts treatment in relatively poor psychological health.

FINDINGS In research terms behavioural couples therapy is one of the best-established psychosocial substance misuse therapies, though generally as an adjunct to other approaches. Among women, two previous studies dealing respectively with drinking and drug/alcohol problems, had demonstrated its superiority to treatments not involving family-based therapy. A recent meta-analysis synthesising results from relevant studies found that for the minority of patients for whom it feasible, acceptable and safe, the therapy reduces substance use relative to (mainly) individual therapies, and is more likely to improve the quality of family relationships. Immediate improvements in relationships seem to pave the way for later relative gains in substance use outcomes. Though these outcomes were not included in the meta-analysis, studies have also shown that the therapy outperforms individual-based treatments in respect of child adjustment, cost-effectiveness, and reduced interpersonal violence. Behavioural couples therapy was one of only two psychosocial therapies recommended by Britain's National Institute for Health and Clinical Excellence (NICE) for problems related to illicit drug use. Experts reached a similar conclusion after reviewing the alcohol treatment literature for England's National Treatment Agency for Substance Misuse (NTA).

Both NICE and the review for the NTA noted the therapy's limited applicability: normally 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. Particularly when they engage women in the treatment of male substance users, care is also needed to exclude the risk that such therapies might perpetuate or aggravate victimisation by abusive partners. The featured study dispensed with the need for cohabitation and for the partner to be free of drinking problems, but in practice these extensions applied to very few couples. As such the study can only be considered a very partial test of whether relaxing these requirements makes any difference to the therapy's effectiveness. It seems likely that the requirement that the man be willing and able to help in the therapy will always tend to exclude those with serious substance use problems or whose relationship is such that they do not share a home with the woman. Despite the systematic selection of promising and willing couples, a few women who dropped out of treatment were uncomfortable at the presence of their partner in sessions, and the logistics of getting both along to therapy were at times difficult, perhaps partly accounting for poorer retention in the couples therapy. However, the viability and value of combining individual and couples therapy components does seem to have been demonstrated, widening the potential applicability of the approach.

Another 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 substance misuse professionals have been trained in family approaches. A census of UK alcohol treatment agencies conducted in 1996 made no mention of family therapy at all. More recent guidance 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.

When competent therapists are available, and the patient is in a committed relationship of the kind which makes involving the partner feasible, acceptable and safe, behavioural couples therapy seems preferable to non-family therapies, and the benefits are more likely to extend to the whole family. Such advantages may not be apparent to treatment staff; in this and previous studies (1 2) of female patients, improvements *during* treatment have generally been the same whether or not couples therapy was employed. This may be partly because much of the initial gains are to do with having made the decision and taken steps to enter treatment, rather than treatment itself. However, once treatment ends, embedding therapeutic processes in a lasting relationship seems to mean that the gains are better sustained. Where couples therapy is not possible, it should not be forgotten that individual therapies focused on the (in these studies, male) drinker also substantially benefit not just the patient, but their partners and children.

The featured study's strengths include excellent follow-up rates and sophisticated statistical analyses. Of the methodological issues affecting confidence in its findings or their wider applicability, a major one is that most patients did not seek treatment in the normal way, but instead responded to the study's ads. Their motivations may have been to do with joining (with accompanying financial compensation) a study rather than simply seeking help. Some other issues are dealt with below.

Participants were relatively affluent compared to other caseloads. Research assistants who gathered the outcome data knew which treatment patients had been assigned to, opening up the possibility that somehow they favoured one of the treatments. So too does the fact that it seems the authors of the study themselves developed this version of the couples intervention. This also applies to most other studies of behavioural couples therapy, and studies *not* conducted by the developers usually produced the least convincing results. In substance misuse and in other sectors, research conducted by teams linked in some way to the intervention they are testing has been found (1 2 3) to produce more positive findings than fully independent research. The applicability of an intervention is severely limited if effectiveness depends on the involvement of the developers.

Six couples randomly allocated to couples therapy never participated in a single session versus just one allocated to individual therapy. These seven were left out of the analysis, compromising the equivalence of the two caseloads. Though few, at the (perhaps unlikely) extremes, very bad drinking outcomes among these women would have almost eliminated the couples therapy's advantage in curbing the proportion of heavy drinking days by the end of the follow-up. The study did not report how the quality of the relationships between the partners developed in response to the therapies. What is known is that six of the 52 couples in individual therapy (12%) and 10 of the 50 in the couples therapy (20%) separated during the follow-up period.

Thanks for their comments on this entry in draft to Barbara McCrady of the Center on Alcoholism, Substance Abuse, and Addictions at the University of New Mexico. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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