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Review Article

Substance Use and Relationship Functioning: A Parallel Process

Abstract

The present paper addresses some of the current literature surrounding Behavioral Couples Therapy (BCT) as it pertains to couples dealing with substance use. Previous research consistently reveals that BCT is an effective means for increasing dyadic functioning while simultaneously decreasing substance use in individuals. Probing further, researchers have found that there is increased relationship dissatisfaction in couples with only one substance abusing partner as opposed to those where either both or neither of the partners uses substances, which is suggestive of mediating and/or moderating variables. However, little is known as to what these variables may be, or why these effects occur. As such, the National Institute on Alcohol Abuse and Alcoholism has sought to identify the "Mechanisms of Action of Behavioral Treatments for Alcoholism" which would further aid in the generalizability and dissemination of empirically-supported treatments into clinical practice. The present manuscript is in accordance with this viewpoint, and highlights the importance for further research.

Introduction

It is no longer debated that substance abuse treatments are, to varying degrees, effective [1]. Yet, there is a paucity of research examining the active ingredients of these treatments [2]. Unfortunately, most clinical investigations examining the effectiveness of a treatment do not include an actual test of the theory underlying the treatment's effectiveness [2]. Over the past two decades, as a result of the dearth of literature in this area [3], posted a program announcement (PA) seeking applications to identify "Mechanisms of Action of Behavioral Treatments for Alcoholism." Simply stated, based on numerous effectiveness and efficacy trials, there was recognition among investigators that the need to determine which model worked best (i.e., "racehorse studies) was no longer the central question; instead, behavioral scientists should shift their focus to the active components and mechanisms of action believed to be responsible for change. In particular, in an effort to increase the generalizability and dissemination of empirically-supported treatments into clinical practice, the objective of this announcement was to identify the active ingredients of effective treatments. Consequently, until such ingredients are identified, dissemination of research findings into clinical practice will be limited. However, if the active ingredients of treatments can be identified, they can be incorporated into new treatments or added to others, with the ultimate goal of increasing their overall effectiveness [2].

Behavioral Couples Therapy (BCT) has consistently been shown to produce superior dyadic functioning among distressed couples compared to no-treatment or nonspecific control conditions [4], and is equal to or more effective than other therapies for reducing relationship distress [5,6,7]. In fact, several variants of the standard BCT treatment have been developed using the machinery of BCT to specifically target secondary outcome domains (e.g., parent skills training, intimate partner violence). In an effort to increase dissemination possibilities, the standard 12-session BCT conjoint delivery method has been adapted to provide the treatment in multi-couple group format (Group BCT [GBCT]) and a 6-session brief version (Abbreviated BCT [ABCT]). Preliminary research is currently being conducted to examine the effect of adding such circumscribed interventions to the standard BCT intervention package.

Despite multiple efficacy studies, to date we know very little about how any evidence-based treatment for substance dependence achieves its curative effects [2]. Longabaugh and his colleagues argued that, "future research should be directed toward further understanding the purported mechanisms of action, particularly to identify the key treatment elements so that a simplified ABCT (Alcohol Behavioral Couples Therapy) model can be developed" (p. 240) [8]. Addressed the latter aspect of Longabaugh's statement; their research revealed that behavioral couples therapy for alcohol use disorders (ABCT) was an effective means for increasing participants' percentage of days abstinent (PDA), and decreasing their days of heavy drinking (PHD). Yet, this study did not directly address mechanisms of action of ABCT, which further drives the point that more research is needed in this area.

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The association between dyadic adjustment and alcoholism

Of the few investigations examining the relationship functioning of alcohol-abusing couples, all have found them to be significantly distressed. Several early descriptive studies characterized alcoholic partners in intimate relationships as dependent, passive-aggressive, and as having difficulties maintaining long-term intimate relationships [9,10]. Findings from other investigations suggest an association between dyadic adjustment and substance use. For example, in a survey of 450 patients who had completed treatment, results indicated that the most frequently cited reason for relapse among married or cohabiting patients was conflict with their partners [11].

In the first large-scale investigation (N = 287) exploring the interrelationship of drug abuse and relationship functioning [5], examined the dyadic adjustment and substance use of couples with a drug-abusing husband, couples with a drug-abusing wife, and couples in which both partners abused drugs. Results indicated that couples in which one or both partners used drugs reported moderate to severe relationship distress across multiple measures of dyadic adjustment. In addition, findings also revealed that relationship distress was associated with increased drug use among couples with one drug-abusing partner. Further, during the 12-month follow-up phase after treatment completion, among couples with one drug-abusing partner, a greater percentage of days abstinent was associated with higher levels of reported dyadic adjustment. The relationship of dyadic adjustment and drug use among couples in which both partners abused drugs was moderated by the time partners spent together using substances such that increased time these partners used drugs together was related to increased relationship satisfaction [12].

Study also supported the notion that partners were more dissatisfied in marriages where only one member drank heavily or used drugs, particularly in newlywed couples. Furthermore, the researchers found that there was no significant difference in marital quality reports between marriages where either both or no members drank heavily or used drugs, suggesting that there are other mediating variables at bay. Another longitudinal study conducted by [13], examined marital satisfaction in couples with discrepant drinking patterns. Interestingly, but perhaps unsurprisingly, they found that marital satisfaction could be predicted by husbands' and wives' heavy drinking. More specifically, discrepancies in drinking patterns were predictive of temporal decreased marital satisfaction, proposing that couples with these configurations are at an increased risk for diminished marital functioning.

Theoretical rationale for use of couples therapy to treat alcohol use disorders

The interrelationship between alcoholism and relationship functioning is complicated and appears to be bidirectional. Couples in which one of the partners abuses alcohol typically report significant relationship problems; these couples are often characterized by high levels of relationship dissatisfaction, instability, and a desire for substantial change in many aspects of the relationship [6]. In addition, spouses' alcohol use is often correlated with reduced marital satisfaction [14]. Taken as a whole, relationship distress is associated with increased problematic drinking patterns and serves a trigger for relapse among alcoholics and drug abusers after treatment [11]. Simply stated, the interrelationship between problematic substance use and relationship dysfunction might be best described as a "vicious cycle", and suggests that distressed couples engage in interactions that are driven by punishment rather than mutual positive reinforcement of desired behaviors [15,16].

Given the strong relationship between drinking and family interaction, it seems that individual-based treatment may not be optimally effective. Yet, the standard format for substance abuse treatment is individual-based therapy. In contrast, BCT has two primary objectives:

1) Reduce or eliminate alcohol use and strengthen the relationship to positively support the clients' efforts to change.

2) Alter dyadic and family interaction patterns to promote a family environment that is more conducive to long-term stable abstinence; in other words, replace the vicious cycle with a more virtuous one in which the strength of the relationship is harnessed to support the client's recovery efforts.

BCT also is based on three major assumptions:

1) Distressed couples have low rates of rewarding interactions and high rates of punishing interactions.

2) Distressed couples' interactions are characterized by negative rather than positive reciprocity.

3) Distressed couples have deficits in communication and problem solving.

Based on these assumptions, BCT includes activities aimed at increasing the number of positive interactions and frequency of positive reciprocity, and improve both communication and problem-solving skills [17].

Over the last few decades, BCT has been rigorously evaluated in several controlled clinical trials. Results from these studies provide very strong empirical support for BCT's effectiveness with substance- abusing patients and their intimate partners [18]. More specifically, multiple studies indicate BCT is associated with positive outcomes for alcoholic couples, both in terms of reduced drinking and improved relationship adjustment [19-22]. Importantly, BCT has been shown to be more cost-beneficial and cost-effective than more traditional individual-based treatments, such as individual and group counseling [23]. In a critique of 41 different treatments for alcoholism [24], cited BCT as one of only sixteen therapies, and the only family- or couples-based intervention, to have strong empirical evidence of effectiveness.

BCT methods used to address alcoholism

A primary goal of BCT is to build support from within the dyadic system for abstinence by treating the client with his

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or her intimate partner. Together, the therapist and couple develop a Recovery Contract in which the partners agree to engage in a daily ritual called the Trust Discussion. In this brief verbal exchange, the client states his or her *intent* not to drink that day (in the tradition of "one day at a time" from Alcoholics Anonymous). In turn, the nonsubstance-abusing partner verbally expresses positive support for the client's efforts to remain abstinent. In addition to participating in the daily Trust Discussion, the partner may witness and verbally reinforce the daily ingestion of abstinence-related medications (e.g., naltrexone, disulfiram). The couple is asked to record on a Recovery Calendar (which is provided by the therapist) each time they've completed the discussion and bring it to each session for the therapist to review compliance and address any possible barriers.

It's important to note, given the instability and propensity for relapse, the client is not promising to remain substance free, but rather stating his or her intent. Given the purpose of the Trust Discussion is to rebuild trust, clients are encouraged to be honest in this exchange. Thus, if a client has drank or used substances, he or she is encouraged to be honest about the incident or not engage in the trust discussion; lying is counterproductive and undermines the process.

A central tenant of the Recovery Contract is the agreement between partners to not discuss the past. Clients are advised to not discuss drinking or fears of future alcohol use when at home, and to save such discussions for therapy sessions. This agreement is designed to reduce the likelihood of alcohol-related conflicts occurring between sessions, which could serve as a trigger for a lapse or relapse. In addition, the Recovery Contract require partners' regular participation at self-help meetings (e.g., Alcoholics Anonymous, Al-Anon); completion of these activities are also marked on the Recovery calendar each week.

In the beginning of each BCT session, after setting the agenda for material to be covered, the therapist reviews the Recovery Calendar to determine overall compliance with the agreed-upon activities. The calendar not only provides a daily record of progress (which is rewarded verbally by the therapist at each session), but it also provides a visual (and temporal) record of any problems with adherence which can be addressed in couples' sessions. Moreover, the partners are asked to perform behaviors that are components of their Recovery Contract (e.g., Trust Discussion) in each scheduled BCT session. The purpose of this in-session practice is to highlight the importance of the Recovery Contract and to allow the therapist to observe the partners' behaviors providing corrective feedback as needed which is critical since incorrect performance of the trust discussion may lead to one or both partners not wanting to engage in the activity. The BCT therapist reviews compliance and asks the partners to perform the Trust Discussion just like it's done at home. In those situations in which corrective feedback is warranted, the therapist typically compliments the couple on their effort, offers feedback, and asks them to rehearse until it is satisfactorily completed. Once the couple has successfully performed the discussion, the therapist advises the couple that they are to do it the exact same way at home each day.

Couples-based relapse prevention and planning

Relapse prevention transpires during BCT's final phases. Toward the end of BCT, the partners attempt to encourage stable abstinence via the development of a written plan (i.e., Continuing Recovery Plan), which addresses things like the timeframe for continuation of a daily Trust Discussion and/or attending self-help support meetings. It also lists contingency plans in the event that a lapse or relapse occurs. An important part of creating the Continuing Recovery Plan for many couples is the negotiation of the post treatment duration of the agreed-to activities which can be challenging for many couples. While the identified patient typically wants a life that does not involve the structured exercises and homework that are part of BCT, the partner tends to be hesitant and suspicious about progress made in treatment (i.e., relationship improvement, abstinence) and as a result, requests the continuation of certain activities (e.g., self-help meeting attendance, Trust Discussions) [17]. For example, those couples in which the client is taking an abstinence-related medication (e.g., Antabuse) may want to eventually forgo the daily Trust Discussion with the observation of medication taking. In this situation, partners negotiate an acceptable timeframe and jointly develop means to aid in the long-term gradual reduction of the frequency of the activity until it is eliminated (e.g., for the first month, daily Trust Discussion with observed medication-taking, as was done during active treatment; for the second month, the Trust Discussion is performed three times per week with observed medication taking; for the third month, the Trust Discussion is performed once per week with observed medication taking, and so forth). Additionally, in an effort to shift the treatment from an acute experience to a longer-term model of care, the therapist and couple may develop a follow-up plan for "booster sessions" to review progress and discuss any potential issues or concerns that have arisen since the last meeting. The timing and frequency of these sessions is usually based on the clients level of functioning at the end of treatment.

Recommendations for future BCT study

Important gaps in the BCT research, some of which have been recognized for many years while others have only recently been identified, are only now ready to be addressed. Investigations in the following two areas seem most pressing: (a) examination of mechanisms of action underlying the effects of BCT; and (b) dissemination of BCT to community-based treatment programs. Multiple studies reveal that BCT is a comparatively effective intervention for married or cohabiting alcoholic patients with various sociodemographic characteristics (e.g., male and female alcohol-abusing patients) and in different treatment contexts (e.g., outpatient treatment, inpatient treatment). Although the results of randomized clinical trials demonstrate the effectiveness of BCT, no studies to date have empirically established specifically *how* it works. More precisely, the mechanisms of action that produce the observed outcomes have not been empirically tested. As

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described earlier, the general theoretical rationale for the effects of BCT on alcoholism has been that certain dyadic interactions reinforce continued drinking or relapse and that relationship distress, in general, is a trigger for alcohol use. In turn, the BCT intervention package that has evolved from this rationale involves (a) teaching and promoting methods to reinforce abstinence from within the dyad (e.g., engaging in the Recovery Contract); (b) developing continuing recovery plans, including action plans (i.e., specific abstinence-supporting options and a plan of action when faced with high-risk situations) and Continuing Recovery Inventories, which are used to determine what skills the couple will continue to use and incorporate in their lives once treatment is over; and (c) improving communication skills to address problems and conflict appropriately when it arises and encouraging participation in relationship enhancement exercises (e.g., Shared Rewarding Activities) to increase dyadic adjustment.

However, it is not clear which of these three aspects of the BCT intervention results in the observed improvements. Thus, it is important for future studies to formally test the theoretical mechanisms thought to underlie the observed BCT effects [25]. Recently argued that the study of mechanisms of action is, at this point, more important than efficacy testing of competing approaches. In discussing future directions of this programmatic line of research [17], noted. "BCT investigators will continue to modify, refine, and re-evaluate the intervention to make what is already a very effective intervention even more so" (p.252). Second, from a clinical vantage point, a fundamental goal continues to be a transfer of this well-established treatment technology to standard alcoholism treatment providers to, in turn, make BCT more available to alcoholic couples who are likely to benefit from participating in the program.

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