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Journal of Substance Abuse Treatment 20 (2001) 277–283

JOURNAL OF SUBSTANCE ABUSE TREATMENT

Featured article

A national survey of the use of couples therapy in substance abuse treatment

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Received 9 November 2000; received in revised form 5 January 2001; accepted 20 January 2001

Abstract

Although results from multiple studies conducted over the last two decades indicate that Behavioral Couples Therapy (BCT) is an effective treatment for married or cohabiting alcohol- and drug-abusing patients, both in terms of reduced substance use and improved relationship satisfaction, it is unclear whether BCT or other types of couples-based interventions are used in community-based substance abuse treatment programs. In the present study, program administrators (e.g., executive directors, clinical directors, staff physicians) from 398 randomly selected community-based outpatient substance abuse treatment programs in the U.S. were interviewed regarding use of different family- and couples-based therapies in their programs. According to the program administrators, 27% of the programs provided some type of couples-based treatment. However, less than 5% of the agencies used behaviorally oriented couples therapy and none used BCT specifically. Recommendations for researchers and clinicians to increase the use of BCT in community-based treatment programs are provided.

Keywords: Couples treatment; Behavior therapy; National survey

1. Introduction

More than 25 years ago, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) described couples and family therapy for alcohol-dependent patients as "one of the most outstanding current advances in the area of the psychotherapy of alcoholism" and called for controlled clinical trials to evaluate the effectiveness of this class of interventions (Keller, 1974, p. 161). Of the many forms of family-based therapies, one that held particular promise was Behavioral Couples Therapy (BCT), which has been shown to produce superior dyadic functioning among distressed couples compared to no-treatment or nonspecific control conditions (Hahlweg & Markman, 1988) and to be equally or more effective than other therapies in terms of reducing relationship distress (Gurman, Kniskern, & Pinsof, 1986).

Since the time the NIAAA called for empirical examinations of family-based treatments for alcoholism, BCT has been evaluated rigorously in several controlled clinical trials. Results from these studies provide very strong empirical support for BCT's effectiveness with substance-abusing patients and their intimate partners (for a review, see Epstein & McCrady, 1998). More specifically, multiple studies indicate that BCT is associated with positive outcomes for alcoholic couples, both in terms of reduced drinking and improved relationship adjustment (e.g., McCrady, Stout, Noel, Abrams, & Nelson, 1991; O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992). In addition, BCT has been shown to be more cost-beneficial and cost-effective than more traditional individual-based treatments, such as individual and group counseling (O'Farrell et al., 1996). In a recent critique of 41 different treatments for alcoholism, Moyers and Hester (1999) cited BCT as one of only 16 therapies, and the only family-based intervention, to have strong empirical evidence of effectiveness. In contrast, these authors also reported that nonbehavioral marital therapies had insufficient evidence of their effectiveness.

As with alcoholic dyads, many of the relationships of couples in which one or both partners primarily ingest psychoactive substances other than alcohol are also dis-

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0740-5472/01/$ – see front matter
PII: S0740-5472(01)00165-9

tressed (Fals-Stewart, Birchler, & O'Farrell, 1999). In several recent investigations, substance-abusing male patients and their intimate female partners who received BCT in outpatient settings reported fewer days of drug use, longer periods of abstinence, fewer drug-related arrests, fewer drug-related hospitalizations, and higher relationship satisfaction through 12-month follow-up than patients receiving individual-based treatment such as group and individual counseling (e.g., Fals-Stewart, Birchler, & O'Farrell, 1996). Very similar findings also have been found with married or cohabiting substance-abusing female patients (Winters & Fals-Stewart, 2000) and male methadone maintenance patients (Fals-Stewart, O'Farrell, & Birchler, in press). Several overviews and detailed therapist manuals are available that describe the use of BCT with substance-abusing patients and their partners (e.g., McCrady, 1982; O'Farrell, 1986; O'Farrell & Cowles, 1989; Wakefield, Williams, Yost, & Patterson, 1996).

Based on the large and growing body of research indicating that family-based treatments are among the most effective interventions for patients with alcohol and other drug problems, substance abuse treatment programs can no longer justify providing little or no spouse or family involvement. In fact, the Joint Commission on Accreditation of Health Care Organizations standards now requires that, when available, a family member must be included in at least the assessment process for substance-abusing patients seeking help. Given the well-established effectiveness of BCT for alcohol- and drug-abusing patients across multiple studies, it would seem reasonable for treatment providers to offer this type of treatment to married or cohabiting substance-abusing patients.

However, it remains unclear if substance abuse treatment programs routinely provide couples therapy of any type, behaviorally oriented couples therapy, or BCT in particular. Further, for programs that do not offer conjoint treatment, knowing the reasons why could provide BCT investigators and other proponents of this intervention with insights into ways to make it more attractive and perhaps more widely used in the substance abuse treatment community. Thus, the purpose of the present investigation was to conduct a survey of outpatient treatment programs in the U.S. and to determine (a) if administrators and treatment providers were aware of BCT and the evidence for its effectiveness, (b) if treatment programs use BCT or other family- or couples-based interventions with married or cohabiting substance-abusing patients and their partners, and (c) for those programs that do not use BCT, the reasons for not using this intervention with appropriate patients.

2. Method

2.1. Participants

A random sample of alcohol and drug abuse treatment programs was selected from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Directory of Drug Abuse and Alcoholism Treatment and Prevention Programs. All outpatient programs in the U.S. that were described in the SAMHSA directory as treating adults were eligible for selection. Of the 8,742 programs identified in the search, 800 programs (7%) were randomly selected for the survey. Of these, 569 programs (71%) reported that they treated married or cohabiting alcohol- or drug-dependent patients who would be eligible for couples treatment. Of the 569 program administrators contacted, 398 (70%) agreed to complete the telephone survey. One representative from each program was interviewed. Survey participants either were program executive directors ($n = 124$, 31%), clinical program directors ($n = 204$, 51%) or staff physicians ($n = 70$, 18%).

Although not by design, at least one program from each state was included. All programs provided some type of outpatient service; responses from interviewees indicated that 269 of these programs (68%) also provided intensive outpatient care. In terms of populations served, interviewees from 196 programs (49%) reported that their programs primarily treated alcohol-dependent patients, 97 (24%) reported that their programs primarily treated patients who abused psychoactive substances other than alcohol, and the remaining programs ($n = 105$, 26%) regularly treated both types of patient populations.

2.2. Procedure

Potential survey participants were contacted by telephone and asked about their willingness to participate in a telephone interview concerning current use of family- and couples-based treatments for substance-abusing patients who receive services in their programs. For those who agreed to participate, interviewees were told that they would be asked a series of questions about the type of family services they provide in their programs. Contacts were then mailed an advanced copy of the questions to be asked to allow them to find out answers to the questions (if necessary) from line staff and clinical supervisors before the telephone interview. Two weeks after the questionnaire was mailed, interviewees were again contacted by telephone and interviewed.

After the initial interview, a two-page primer describing BCT for substance-abusing patients and their partners was sent to interviewees via U.S. mail, which they were asked to read. The primer described the basic interventions used as part of BCT and a typical course of treatment, and provided an overview of empirical findings. A telephone call was then made to these interviewees 2 weeks after sending the BCT description to solicit further information about whether they would use BCT with their patients as described in the primer. If their programs would not be willing to provide BCT to eligible patients, the reasons were solicited. Furthermore, contacts were asked to delineate under what conditions their programs might be willing to use BCT and what modifica-