



Short communication

## Effects of Parent Skills Training with Behavioral Couples Therapy for alcoholism on children: A randomized clinical pilot trial

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## ABSTRACT

This pilot study examined preliminary effects of Parent Skills Training with Behavioral Couples Therapy on children's behavioral functioning. Participants were men ( $N=30$ ) entering outpatient alcohol treatment, their female partners, and a custodial child between 8 and 12 years of age. Couples were randomly assigned to one of three equally intensive conditions: (a) Parent Skills with Behavioral Couples Therapy (PSBCT), (b) BCT (without parent training), and (c) Individual-Based Treatment (IBT; without couples-based or parent skills interventions). Parents completed measures of child externalizing and internalizing behaviors at pretreatment, posttreatment, 6- and 12-month follow up; children completed self-reports of internalizing symptoms at each assessment. Only PSBCT participants reported significant effects on all child measures throughout the 12-month follow up. PSBCT showed medium to large effects in child functioning relative to IBT, and small to medium effects relative to BCT from baseline through follow up. Effect sizes suggest clinically meaningful differences between PSBCT and both BCT and IBT that warrant further empirical evaluation of BCT with parent training for alcohol-abusing men and their partners.

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It has been widely documented that children living with an alcohol-abusing parent (COAs) are more likely than their peers to exhibit behavioral problems that encompass both internalizing and externalizing symptoms (e.g., Hussong, Wirth, Edwards, Curran, Chassin, & Zucker, 2007). Although many factors contribute to these problems, inadequate parenting has been strongly linked to increased risks for COAs (e.g., Wells, 2006). Family-based treatments that involve both an alcohol-abusing parent and his/her partner can have even stronger positive effects on COAs than individual-based approaches (Kelley & Fals-Stewart, 2002). However, because most parents who enter substance abuse treatment are reluctant to involve their children in services (Fals-Stewart, Fincham, & Kelley, 2004), interventions that do not directly involve COAs, but nonetheless improve the family environment may hold the most potential for effecting change.

A promising approach is Behavioral Couples Therapy (BCT) for substance-abusing patients and their partners, which has been shown to reduce substance use and improve family adjustment (Fals-Stewart, O'Farrell, Birchler, Cordova, & Kelley, 2005). Moreover, Kelley and Fals-Stewart (2002, 2007) found children of substance-abusing fathers and nonsubstance-abusing mothers receiving BCT displayed greater psychosocial adjustment across a 12-month follow up than children of parents in individual- or couples-based attention control treatment. Younger children showed greater improvements than adolescent siblings, suggesting preadolescence as a critical developmental period to intervene with parents.

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Although these findings are important in their own right, it is plausible that adding a parent component to BCT might further enhance benefits to children. Parent training has well-established effectiveness at improving child behavior (Serketich & Dumas, 1996). This pilot study sought to develop and test a new, hybrid treatment of parent training with BCT. We hypothesized that relative to children of parents participating in Individual-Based Treatment (IBT) or BCT, children of alcohol-abusing fathers participating in PSBCT with nonsubstance-abusing partners would demonstrate improved functioning as rated by mothers, fathers, and children. We also examined whether PSBCT would yield clinically meaningful effects compared to IBT and BCT, which would support the need for a larger randomized trial of PSBCT for alcoholic parents.

## 1. Methods

Participants were male patients entering outpatient treatment for an alcohol use disorder. Men were eligible for the study if they (a) were at least 18 years of age; (b) met *DSM-IV* criteria for alcohol abuse or dependence; (c) were married (>1 year) or cohabitating (>2 years) with a female partner at the time of admission; (d) the female partner did not meet *DSM-IV* criteria for substance abuse or dependence; and (e) had legal guardianship of at least one child 8 to 12 years old living in the home. If more than one child was eligible, one target child was randomly selected for participation. *DSM-IV* eligibility criteria were determined by the Structured Clinical Interview for *DSM-IV* (First, Spitzer, Gibbon, & Williams, 1995). Consecutively admitted males ( $n = 51$ ) who met initial eligibility screening were invited to participate in informational sessions. Of these, 15 patients or their partners (29%) met at least one exclusion criteria and 6 patients or partners (12%) declined to participate. The final sample included 30 father–mother–child triads.

### 1.1. Children's adjustment

The Internalizing and Externalizing broadband *T*-scores from the Child Behavior Checklist (CBCL; Achenbach, 1991) were used to assess parents' perceptions of children's problem behavior. The CBCL has high internal consistency, test-retest reliability, and concurrent validity with other measures of child problem behaviors. The Children's Depression Inventory (CDI; Kovacs, 1992) was used to assess children's depression. The CDI is a 27-item self-report measure with strong reliability ( $\alpha = .86$ ) and validity for children over 7 years. The Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Paget, 1983) was used as a psychometrically sound, self-report measure of worry and anxiety for children 6 to 19 years.

### 1.2. Substance use

The Timeline Followback Interview (TLFB; Sobell & Sobell, 1996) uses a calendar assessment to determine Percent Days Abstinent (PDA) from drinking and other drug use over a given time period, excluding jail or hospital stays.

Within one week of entering treatment, alcohol-abusing fathers and their partners completed self-report and clinically-structured interviews at baseline, posttreatment, 6-, and 12-month follow up. After baseline assessment, participants first were randomized to one of three equally intensive treatments: (a) PSBCT, (b) BCT, or (c) IBT, then were randomly assigned to one therapist who delivered the full course of that treatment. Master's level therapists experienced in BCT and coping skills therapy for substance abuse were trained and certified by therapy developers to deliver all treatments.

The experimental and control conditions consisted of 24 total 60-minute sessions: 12 weekly sessions of either BCT, PSBCT, or IBT, which were interleaved with 12, weekly standard care sessions of individual, cognitive-behavioral therapy for substance abuse with identified male patients. Primary elements of the treatment conditions were as follows: *Behavioral Couples Therapy (BCT)*. Both partners attended 12 manualized BCT sessions, which included collecting urine screens, reviewing the previous week's homework, improving communication and problem-solving skills, and reinforcing sobriety (O'Farrell & Fals-Stewart, 2006). No parent skills training interventions were provided. *Parent Skills Behavioral Couples Therapy (PSBCT)*. Both partners attended 12 PSBCT sessions, which included six core BCT sessions and six parent skills training sessions. The parenting component was adapted from an established treatment with documented effectiveness at improving parent and child functioning (McMahon & Forehand, 2003). *Individual-Based Therapy (IBT)*. Only male patients participated in IBT, which included 12 individual-based coping skills sessions modified from Monti, Abrams, Kadden and Cooney's (1989) cognitive-behavioral treatment for alcoholism.

### 1.3. Data analysis

Growth curve modeling was used as the primary analytic tool, estimated within a linear mixed effects model framework. Pairwise contrasts compared differences in children's adjustment between PSBCT versus (*vs.*) IBT, and PSBCT *vs.* BCT at each follow up by moving the intercept for each assessment point. Effect sizes were determined using formulae described in Xu (2003) for measuring explained variance in mixed linear models. As Table 3 notes, differences between PSBCT and IBT and BCT outcomes were interpreted using effect size  $r$  (Cohen, 1998), consistent with other pilot studies of substance abuse treatment (O'Farrell, Murphy, Alter & Fals-Stewart, 2007).

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