



PII S0272-7358(98)00025-7

BEHAVIORAL COUPLES TREATMENT OF ALCOHOL AND DRUG USE DISORDERS: CURRENT STATUS AND INNOVATIONS

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ABSTRACT. *Research suggests that Behavioral Couples Therapy (BCT), tailored to treat alcohol problems, produces significant reduction in alcohol consumption and improvement in marital functioning. Having established basic clinical protocols for Alcohol Behavioral Couples Therapy (ABCT) and provided support for their efficacy, clinical researchers around the country continue to develop and study new applications of the basic ABCT treatment models, such as adding relapse prevention or Alcoholics Anonymous components. Recent research supporting the heterogeneity in the population of individuals with alcohol problems has prompted some researchers on ABCT to consider additional adaptations of the treatment models for specific subgroups of alcoholics, and for particular individual and couples characteristics. Adaptation of ABCT to treat new populations such as drug abusers, female alcoholics, and problem drinkers is under investigation. The current article provides an overview of theoretical and clinical aspects of ABCT, and research on efficacy of the basic model and on areas of innovation and adaptation to new populations. Directions for future research on ABCT are suggested. © 1998 Elsevier Science Ltd*

OVER THE past 25 years, models of Behavioral Couples Therapy (BCT) tailored to treat alcohol problems have been developed and tested. Alcohol Behavioral Couples Therapy (ABCT) is a collection of approaches that incorporates an intimate Significant Other into the treatment of an alcohol problem. ABCT represents an application of BCT to treatment of a specific disorder. Like BCT, ABCT is grounded in social learning theory and family systems models for conceptualizing human problems, and draws from rich empirical literatures on interactional behaviors such as communication and problem solving skills, the connections between individual psychopathology and interactional behavior, and the broader literature on social support. ABCT includes elements of behavioral self-control and skills training to facilitate abstinence and better spouse coping with drinking-related situations, and contingency management procedures, communication, and problem-solving techniques drawn from BCT to improve relationship functioning. ABCT treatments developed by different investi-

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gators vary in the degree of emphasis on these three domains (McCrady & Epstein, 1995a; O'Farrell, 1993a).

Research suggests that such treatment produces significant reduction in alcohol consumption and improvement in marital functioning (McKay, Longabaugh, Beattie, Maisto, & Noel, 1993; McCrady, Noel et al., 1986; McCrady, Noel, Stout, Abrams, & Nelson, 1991; McCrady, Stout, Noel, Abrams, Fisher, & Nelson, 1991; O'Farrell, Choquette, Cutter, Brown, & McCourt, 1993; O'Farrell, Cutter, & Floyd, 1985). Having established clinical protocols and variations of ABCT, clinical researchers continue to develop and study new applications of the basic ABCT treatment models. For instance, maintenance of change through ABCT by adding relapse prevention or Alcoholics Anonymous components is currently under investigation (McCrady, Epstein, & Hirsch, 1996; O'Farrell et al., 1993). Recent studies of heterogeneity in the population of individuals with alcohol problems have prompted some researchers on ABCT to consider additional adaptations of the treatment models (Beutler et al., 1993; McCrady & Epstein, 1995b).

Recently, ABCT has been adapted to treat drug abuse (Fals-Stewart, Birchler, & O'Farrell, 1996), and the current article will also review work done and proposed in this area. However, almost all of the work done over the past 25 years on BCT and substance use disorders has focused on alcohol. Thus, we will focus primarily on BCT with alcoholic couples (i.e., ABCT), and discuss applications of the ABCT model to other groups such as drug abusers in terms of innovations in the model.

In short, the current status of behavioral marital therapy models to treat alcoholism is in flux. It is an exciting juncture at which to pause to evaluate current techniques, applications to new populations and problems, and innovations to the basic treatment model. This article is designed to provide the reader with an overview of the basic ABCT treatment model in terms of theory, clinical techniques, and empirical support. Innovations in the model that are currently being developed, and suggestions for future work are covered.

DIAGNOSIS AND DEFINITIONS OF ALCOHOL AND DRUG USE DISORDERS

Alcohol and drug use disorders, as specified in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*; American Psychiatric Association, 1994), are broken down into two major categories, Substance Abuse, the less severe of the two, and Substance Dependence. The term *substance* refers to alcohol or 10 other classes of drugs, including amphetamines, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, PCP, and sedatives. Substance abuse is diagnosed if the individual's substance use results in failure to fulfill major role obligations at work, school, or home; is done repeatedly in situations where it is physically hazardous, or creates recurrent legal problems, or is continued despite having recurrent substance-related interpersonal or social problems. The Substance Dependence diagnosis is based on the individual's meeting at least three of seven criteria involving physical tolerance, physical withdrawal symptoms, loss of control over consumption of the substance, unsuccessful attempts to cut down, excessive time spent obtaining, using, or recovering from the substance, substitution of substance use for other important social, occupational, or recreational activities, and continued use of the substance despite knowledge of a recurring substance-related physical or psychological problem.

Because most of the research done thus far on ABCT has used the formal diagnostic approach, the terms alcohol and drug use problems, alcoholism, alcohol (substance) abuse and dependence, and substance misuse will be used interchangeably in the

current article, unless where specifically stated. Similarly, the term *alcoholic* will be used here to refer to individuals with a diagnosis of alcohol abuse or dependence.

APPLICATION OF BEHAVIORAL COUPLES THERAPY TO ALCOHOL AND DRUG USE DISORDERS: THEORETICAL FOUNDATIONS

Relationship Between Substance Use Disorders and Relationship Functioning

ABCT assumes a reciprocal relationship between substance use and relationship functioning. The model assumes that substance use behaviors impact upon the quality and nature of a couple's relationship, and that the relationship similarly impacts upon the substance use. Thus, from a systemic perspective, the two domains of function (substance use and the relationship) are interconnected rather than independent. Like BCT, ABCT emphasizes the reciprocal interactions between partners, and assumes that relationship distress and dysfunction are maintained by interactional rather than individual problems. Several lines of evidence support the view that alcohol use impacts on relationship functioning; data suggesting that relationship functioning impacts on alcohol use are much more limited.

Alcoholic couples report substantial levels of marital dissatisfaction, although if the male is alcoholic he is less likely to perceive problems than his wife. Even in nonclinical samples heavier alcohol use is associated with greater marital dissatisfaction (Leonard & Senchak, 1993). Alcoholic husbands are similar to husbands in other maritally conflicted relationships in avoiding responsibility for problems in the relationship (O'Farrell & Birchler, 1987). Results from clinical and nonclinical samples reveal a close relationship between heavy drinking and relationship violence. Alcoholic couples have high rates of relationship violence, irrespective of the gender of the alcoholic partner (Rotunda, 1995), and communication patterns of maritally aggressive alcoholic couples are characterized by high rates of aversive-defensive behaviors and negative reciprocity (Murphy & O'Farrell, 1997). Similar data from nonclinical samples suggest a relationship between heavier alcohol consumption and marital violence (Leonard & Senchak, 1993). Women with alcohol problems and marital distress expect alcohol to increase conflict engagement in the relationship, and such expectations are correlated with high rates of verbal and physical aggression (Kelly & Halford, 1994). Sexual dysfunction and dissatisfaction are also common in alcoholic relationships. Male alcoholics and their partners have less sexual satisfaction, less frequent intercourse, and more disagreements about sex than nonconflicted couples (O'Farrell, Choquette, & Birchler, 1991). In general, their sexual problems are similar to couples with other types of marital conflict but impotence is a more common problem with alcoholic men (O'Farrell, Choquette, Cutter, & Birchler, 1997). Noel, McCrady, Stout, and Nelson (1991) found that frequency of sexual relationships decreased as the severity of women's alcohol problems increased. No such relationship was found for male alcoholics and their wives. Married women with drinking problems report that relationship problems influence their drinking, stating that they drink to continue to function in the relationship, to be more assertive, and to deal with sexual "demands" from their partners (Lammers, Schippers, & van der Staak, 1995).

There is substantial evidence that the spouses and children of male alcoholics experience psychological distress, health problems, and behavioral problems. Wives of actively drinking male alcoholics have elevated levels of depression, anxiety and psychosomatic complaints, and utilize more medical resources (Moos, Finney, & Gamble, 1982; Moos & Moos, 1984). Even in samples of older problem drinkers, spouses have

poorer health and social functioning, and use more cognitive avoidance strategies than spouses of older, nonproblem drinkers (Brennan, Moos, & Kelly, 1994). The interrelationships between individual psychopathology, marital problems, and drinking may vary, depending on the drinking pattern of the alcoholic: some data suggest that heavier drinking is inversely correlated with individual and marital distress for wives of men who are steady drinkers (Jacob, Dunn, & Leonard, 1983). For men who drink outside their homes, however, drinking reliably predicts decreases in marital satisfaction (Dunn, Jacob, Hummon, & Seilhamer, 1987).

Alcohol consumption and communication are also closely linked. Hersen, Miller, and Eisler (1973) reported that wives of alcoholics looked at their husbands more when discussing an alcohol-related than a non-alcohol-related topic. Alcoholics become more negative toward their wives when drinking (Jacob & Krahn, 1988), and husbands' problem-solving increases when drinking (Jacob & Leonard, 1988). The research suggests differences in the interrelationships between drinking and communication, depending on the drinker's usual pattern of drinking. For example, women whose husbands drink in an episodic style tend to use less negative communication behaviors when their husbands drink, whereas women whose husbands' drinking is steadier tend to increase their negativity when he is drinking (Jacob & Leonard, 1988). More sophisticated sequential analyses of marital interactions comparing alcoholic, depressed, and nondistressed men and their wives suggest that alcoholic husbands tend to reciprocate their wives' positive or problem-solving behavior more than depressed men. The wives of alcoholic men, compared to depressed men, however, react very negatively to their husbands' negative behavior, try to encourage problem-solving, but are somewhat skeptical when their husbands emit positive behaviors (Jacob & Leonard, 1992).

The relationships between relationship functioning and drinking outcomes are complex. In late life problem drinkers, those whose drinking problems remit tend to have less spousal support for their drinking (Schutte, Brennan, & Moos, 1994), and greater spouse stress is associated with poorer outcomes (Brennan, Moos, & Mertens, 1994). Support for abstinence from the spouse or other members of an alcoholic's social support system appears to interact with the degree to which the alcoholic is socially invested in that support system in predicting outcome, so that those who are highly invested in their social network and receive good support from that network after treatment will have better outcomes (e.g., Longabaugh, Beattie, Noel, Stout, & Malloy, 1993).

Finally, there is evidence that alcoholics perceive marital problems to be a significant precipitant of relapses posttreatment, but that marital and family problems also serve as an important stimulus for trying to resume abstinence after a relapse (Maisto, McKay, & O'Farrell, 1995).

In summary, multiple sources of data from clinical and community samples suggest that heavier drinking is often associated with negative functioning for the nonalcoholic spouse and for the marital relationship. Under some circumstances, however, heavier drinking may be associated with enhanced relationship functioning. Evidence that marital problems precede heavy alcohol use is limited, but it appears that marital problems may serve as a precipitant of relapse after treatment.

Functional Analytic Approach

The literature reviewed in the previous section illustrates the unique ways that substance use and relationship functioning generally are intertwined. To analyze a specific case, ABCT uses a functional analytic approach to understand the specific patterns of

antecedents, cognitive and affective mediators, behavioral excesses and deficits, and consequences that connect substance use and relationship functioning for each couple.

Cognitive-behavioral models assume that substance use occurs in response to *antecedent stimuli or cues*. These stimuli or cues precede the substance use, and their presence increases the probability that substance use will occur. External antecedents may relate to the individual, familial, or other social systems. Familial antecedents might include family members' attempts to control the use, or negative interactions around specific problems resulting from the use, such as problems in communication, sexual functioning, or finances.

Aspects of the environment become cues for substance use through repeated sequences of events that include the antecedent stimulus, substance use, the occurrence of stimuli that *reinforce* use, and the lack of occurrence of *punishing* stimuli. The spouse and other family members may unwittingly supply positive consequences for use, for instance, by taking care of the intoxicated family member, pampering him or her when sick from use, or may protect the user from naturally occurring negative consequences, for instance, by calling in sick when the user cannot go to work. For certain couples, drinking or substance use may be associated with an increase in positive interactions.

The relationship between an antecedent stimulus and substance use is believed to be mediated by *organismic* events, including thoughts, feelings, and physiological reactions. Substance abusers may have a variety of positive expectancies about the reinforcing consequences of substance use, including the impact of use on the relationship, or may use in response to negative affect or physiological cues such as decreasing blood alcohol level. Substance abusers may also have cognitive and affective reactions to interpersonal situations such as an argument with a spouse, and may drink in response.

The repertoire of behavioral *responses* available to the substance user and to the couple or family is important. Alcoholic families often have *skills deficits*. Couples may have difficulty coping with alcohol- or drug-related situations, expressing affect, disagreeing, making requests for change, listening to and understanding the partner's communication, providing positive support, or solving problems productively as a couple. Spouses may lack coping skills to respond effectively to the substance user and to use situations, and may have difficulty balancing attention to their own needs, the responsibilities they may have to maintaining the integrity and functioning of their families, and the stresses presented by the alcoholic's or drug user's behavior.

APPLICATION OF BEHAVIORAL COUPLES THERAPY TO ALCOHOL AND DRUG USE DISORDERS: COUPLES THERAPY MODEL

Overview

The full ABCT model includes several treatment elements, including individual skills building for both partners, contingency management procedures, and relationship enhancement. Different models emphasize different elements of the treatment. The ABCT model implies that interventions at multiple levels may be necessary—with the individual, the spouse, the relationship as a unit, the family, and the other social systems in which the drinker or substance user is involved. Implicit in the model is the need for detailed assessment to determine the primary factors contributing to the maintenance of the substance use, the skills and deficits of the individual and the couple, and the sources of motivation to change. Both McCrady and O'Farrell and

their colleagues have had long-term research programs on ABCT. Before discussing the general model, some comments about the differences between their approaches is appropriate. McCrady's treatment protocol is designed as a stand-alone treatment, and therefore incorporates interventions to facilitate attainment of sobriety as well as changes in relationship functioning. The treatment protocol is delivered in conjoint format with individual couples. O'Farrell's treatment protocol is designed for use in conjunction with or subsequent to treatment focused on cessation of drinking. The treatment, therefore, does not include specific sobriety-related interventions. O'Farrell, however, routinely establishes disulfiram (Antabuse) contracts between drinkers and their spouses at the beginning of treatment. His treatment is delivered in a group rather than an individual setting.

At the individual level, the treatment helps the client assess potential and actual reinforcers for continued use and for decreased use or abstinence, as well as assessing negative consequences of use and abstinence. Assessment of the relative strength of incentives for continuing to use or changing use provides an incentive framework for the rest of the therapy. Teaching individual coping skills to deal with substance-related situations is a second important individual intervention. Skills include self-management planning, stimulus control, drink or drug refusal, and self-monitoring of use and urges to use. Behavioral and cognitive coping skills, individually tailored to the types of situations that are the most common antecedents to use ("high risk situations"), are a third type of individually focused intervention, and include assertiveness, cognitive restructuring, relaxation, lifestyle balance, recreational activities, and the like.

Another important factor at the individual level is comorbid psychopathology of either partner, and its effect on delivery of ABCT. Comorbid antisocial personality disorder rates among male alcoholics range from 23% (Morgenstern, Langenbucher, Labouvie, & Miller, 1994) to 53% (Ross, Glaser, & Germanson, 1988). For mood disorders, Ross et al. (1988) cited rates of 23% and 60% for depressive and anxiety disorders respectively in men, and 35% and 67%, respectively, for women. Because ABCT takes an individualized approach in terms of extensive assessment of the drinking problem and related psychiatric disturbances, and in terms of functional analysis of factors related to the drinking, the clinician is able to consider the effects and treatment of comorbid psychopathology in patients. Often, Axis I and Axis II disorders complicate delivery of ABCT (e.g., see McCrady & Epstein, 1995a, 1996). Either partner may be referred out for psychotropic medication, or for adjunct treatments such as specialized treatment for panic attacks. Research is beginning to directly address the contribution of various comorbid psychological problems to ABCT (see section in this article on Couples-Treatment Matching).

A second set of interventions revolves around the coping behaviors of the partner. The partner's own motivation for entering and continuing in treatment, and the partner's perceptions of the positive and negative consequences of changes in substance use and the marital relationship are important factors contributing to the partner's willingness to engage in new behaviors and be an active participant in the therapy. The model also suggests that the spouse learn a variety of coping skills to deal with substance use and abstinence. An individualized assessment of spouse behaviors that may either cue substance use or maintain it is essential. Spouse coping skills might include learning new ways to discuss drinking or drug use and situations associated with use, learning new responses to the partner's substance use and behavior when using, or individual skills to enhance his or her own individual functioning.

The third treatment component is a focus on the interactions between the two partners, around both substance use and other issues. Substance-focused couples interven-

tions use substance-related topics as a vehicle to introduce communication and problem solving skills. Such topics as how the couple could manage in a situation where alcohol or drugs are present, whether or not they will keep alcohol or drugs in the house, how the partner could assist the user in dealing with impulses to use, or what the couple will tell family and friends about the treatment are all relevant topics that the couple must face. By using such topics as vehicles for discussion, the couple is taught basic communication skills.

Behavioral contracting may be used to facilitate abstinence. Such contracts are used to establish a contingent relationship between sobriety-related behavior and a desired spouse behavior. Contracting has been used to enhance compliance with aftercare attendance, and to enhance compliance with the use of disulfiram (Antabuse).

Behavioral contracting in the form of Antabuse (disulfiram) contracting is common in most current variations of ABCT, and in fact is integral to the ABCT couples group program called the Counseling for Alcoholics' Marriages (CALM) Project, developed by O'Farrell and his colleagues (O'Farrell, 1993a). Antabuse *contracting* (O'Farrell & Bayog, 1986) is based on the notion that though Antabuse, a medication that is to be taken daily and produces nausea when alcohol is ingested, can be an effective deterrent to drinking, it often does not work because patients discontinue self-administration of the drug. The Antabuse contract, which is negotiated during the course of BCT, is designed to maintain Antabuse ingestion and decrease alcohol-related arguments between spouses. The alcoholic agrees to take Antabuse each day while the spouse watches and records the ingestion on a calendar. Each spouse agrees to thank the other each day, and the spouse also promises to not to mention past or future drinking. The contract is agreed to for a particular period of time, and is introduced as a method for repairing damaged trust.

Additionally, research suggests that many of these couples need to learn general communication and problem-solving skills to decrease marital conflicts that may cue further use and to increase the rate of positive exchanges. When appropriate, the treatment also incorporates general reciprocity enhancement interventions to increase the overall reward value of the relationship.

The fourth set of interventions focuses on other social systems in which the drinker/drug user and partner are currently or potentially involved. Clients are helped to identify interpersonal situations and persons who are associated with heavy use, and are also helped to identify potential social situations and people who would be supportive of abstinence. Social skills such as refusing drinks or drugs or general assertiveness may be taught. Additionally, some clients are encouraged to become involved with self-help groups.

Finally, the model includes techniques to increase generalization to the natural environment and maintenance of new behaviors. Homework assignments, teaching clients how to anticipate high-risk situations, and planned follow-up treatment sessions all are designed to contribute to maintenance of change.

ABCT has also been adapted to a unilateral model that incorporates many of the principles of ABCT, but is delivered only to the nonalcoholic spouse when the drinker is unwilling to seek treatment (e.g., Thomas & Ager, 1993). Unilateral approaches teach the spouse coping skills to respond differently to alcohol-related situations, and teach communication and problem-solving skills as well.

RESEARCH ON ABCT: EARLY STUDIES

Two reviews of the literature published between 1970 and 1988 provided comprehensive summaries of research on the effectiveness of couples and family therapy for alco-

hol abuse/dependence (McCrady, 1989; Steinglass, 1976). These early studies focused on four major questions: (1) the relative effectiveness of individual versus spouse involved treatment, (2) the effectiveness of specific interventions to change contingencies for abstinence-related behaviors, (3) the effectiveness of treatments for the spouse when the drinker was unwilling to participate in treatment (unilateral therapies), and (4) the effectiveness of behavioral versus nonbehavioral models of couples therapy. Research conducted subsequent to these reviews provides further evidence related to these questions, and has also examined a fifth question: the necessary and sufficient elements of ABCT.

Studies of Individual Versus Spouse-Involved Treatment

Early work on spouse-involved approaches to alcohol treatment included both conjoint treatment and separate but concurrent treatment for drinkers and their spouses. Early models were eclectic, and included educational elements, communication skills training, analysis of interactional behavior, and disease model treatment elements. Thus, the early work provides a context for later ABCT studies, but does not provide an unambiguous evaluation of ABCT versus individual therapy. The results, however, of both nonrandomized and randomized clinical trials were consistent. Two nonrandomized trials reported better drinking outcomes for clients whose spouses participated in treatment than those who did not (Ewing, Long, & Wenzel, 1961; Smith, 1969). Three subsequent randomized clinical trials reported better drinking outcomes for the spouse-involved condition (Cadogan, 1973; Corder, Corder, & Laidlaw, 1972; McCrady, Paolino, Longabaugh, & Rossi, 1979). One study specifically compared behavioral couples therapy to other behavioral treatments, and found that outcomes tended to favor the conjoint condition, although no statistical tests were reported (Hedberg & Campbell, 1974).

Spouse-Involved Contingency Management Studies

Early behavioral contracting studies demonstrated that behavioral contracts involving spouses and other family members led to greater compliance with aftercare attendance (Ahles et al., 1983; Ossip-Klein et al., 1984). Spouse/family-involved contingency management procedures have also been used to enhance use of disulfiram, and data suggest better compliance with spouse-involvement (Azrin, Sisson, Meyers, & Godley, 1982; Keane, Foy, Nunn, & Rychtarik, 1984).

Unilateral Treatment Methods

The ABCT model can also be used even if the drinker is unwilling to be involved in therapy. The functional analytic framework can be used to identify spouse-related antecedents and consequences of drinking. Spouses then can be taught to respond differently to drinking and abstinence, and can learn new communication and coping skills. Two early applications of this unilateral framework found that drinkers were more likely to become involved in treatment if their spouses or other family members participated in unilateral therapy than in the comparison treatment condition (Sisson & Azrin, 1986; Thomas, Santa, Bronson, & Oyserman, 1987). A later evaluation of a unilateral approach found similar results (Thomas & Ager, 1993).

Behavioral Versus Other Treatment Models

Few studies have compared ABCT to other conjoint models. O'Farrell et al. (1985) reported posttreatment results of a comparison of ABCT, interactional couples group therapy, and a no-couples treatment control. They found that couples in both conjoint therapy conditions showed significantly greater improvements in marital satisfaction and communication than the no-couples control group, and that alcoholics in the ABCT condition drank less than other subjects. Longer term outcome data on the relative effectiveness of ABCT compared to interactionally focused couples treatment (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992) suggested that ABCT was not associated with better long-term drinking outcomes, but did result in greater marital satisfaction for wives who had reported less extreme marital distress prior to treatment. McCrady (1989) concluded:

Overall, behavioral approaches to couples-involved alcoholism treatment appear to show some promise. Three distinct approaches have been employed. Spouse-oriented treatment, while conceptually well developed, has yielded little objective outcome data thus far. Treatment that uses the spouse as an adjunct to treatment, primarily as a monitor and support for taking disulfiram, has shown promise, as short-term treatment outcome data are encouraging. However, longer term outcome studies of this modality are still lacking. When behavioral approaches to marital therapy with alcoholic couples are compared to interactionally oriented treatment, behavioral approaches appear to yield better short-term outcomes, but longer-term outcome data are not yet available. Behavioral approaches appear to have their primary impact during the posttreatment maintenance phase, and seem to be associated with helping couples to cope more effectively with relapse episodes, and perhaps maintain positive motivation to continue to work toward long-term abstinence. (pp. 174–175)

Since McCrady's (1989) review, longer term outcome data have been reported on the relative effectiveness of ABCT compared to interactionally focused couples treatment (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992). Results suggested that ABCT was not associated with better long-term drinking outcomes, but did result in greater marital satisfaction for wives who had reported less extreme marital distress prior to treatment.

Other, smaller scale studies have been done. Bowers and Al-Redha (1990) reported better drinking outcomes for alcoholics receiving couples than standard group therapy. In contrast to these positive findings, Monti and his colleagues (Monti et al., 1990) found, compared to behavioral mood management training, that communication skills training improved alcoholism treatment outcomes whether or not family members were present.

Active Elements in ABCT

Two studies have examined the necessary and sufficient conditions for ABCT. Zweben, Pearlman, and Li (1988), comparing brief advice and conjoint therapy, reported no differences in drinking outcomes, although those receiving conjoint therapy reported more satisfaction with the treatment. McCrady and her colleagues (McCrady, Stout, Noel, Abrams, & Nelson, 1991) examined the relative importance of spouse involvement, teaching of spouse coping skills, and relationship enhancement. They reported that the relationship enhancement elements were associated with better marital functioning, and were also associated with a pattern of improved drinking over time. Monti

et al.'s (1990) findings (reviewed above) also point to the central role of communication skills training.

CONTEMPORARY RESEARCH ON ABCT: INNOVATIONS, EVIDENCE, AND FUTURE DIRECTIONS

Several innovations to the basic ABCT model, currently or recently studied, include (1) incorporation of other treatment techniques such as relapse prevention components and 12-step involvement; (2) growing awareness of the need to address heterogeneity among alcoholic couples; (3) research on cost-effectiveness of ABCT; (4) increasing focus on functioning of spouses of alcoholics; and (5) adaptation of the ABCT model to treat specific populations, such as female alcoholics, problem drinkers at risk for developing alcohol dependence, and drug abusers. This section will briefly review the status of these innovations, with most emphasis on adaptation of ABCT to new populations, particularly drug abusers.

Incorporation of Other Treatment Techniques

Addition of Relapse Prevention. The addition of Relapse Prevention (Marlatt & Gordon, 1985) sessions and techniques to the basic ABCT model has been tested by O'Farrell and his colleagues (O'Farrell, 1993b; O'Farrell et al., 1993), and by McCrady and her colleagues (McCrady & Epstein, 1993). Both these research groups established the clinical efficacy of variants of the basic ABCT model, and then turned to study ways to enhance maintenance of long term gains of the couples treatment. Relapse prevention (RP) techniques such as focusing on high risk situations, using urge imagery and metaphor, enhancing motivation through alcohol autobiography and decisional matrix, dealing with warning signs and relapse issues directly, writing relapse contracts, and scheduling RP booster sessions to follow treatment, are all incorporated into the couples sessions format.

O'Farrell et al. (1993) found that alcoholics randomly assigned to receive 15 couples RP sessions over the 12 months following 5 months of weekly participation in an outpatient BCT couples group program, had more days abstinent and fewer light and heavy drinking days, better maintained improvements in the relationship, and used behaviors targeted by BCT more than couples who participated in the 5 months of couples group BCT but did not receive RP booster sessions. After the RP sessions were completed, couples who received that treatment continued to have superior drinking outcomes for the next 6 months, and better marital functioning for the next 12 months (O'Farrell, Choquette, Cutter, Brown, & McCourt, 1995).

Addition of 12-Step involvement. McCrady et al. (1996) in a randomized clinical trial, studied the efficacy of adding 12-Step involvement, or AA/Alanon components to the ABCT treatment, versus a basic ABCT condition, and a third condition, ABCT plus Relapse Prevention. Initial, within treatment results revealed three patterns of involvement with AA: positive affiliators whose AA attendance increased during treatment, negative AA affiliators whose AA attendance decreased during treatment, and nonaffiliators who showed an inconsistent pattern of attendance. Posttreatment data suggest no differences among the three conditions on drinking (McCrady et al., 1996). Positive affiliators during treatment were more likely to be abstinent over the first 6 months of follow-up than negative affiliators or nonaffiliators. Overall, AA attendance tended to be correlated with better drinking outcomes, but the correlation was nonsignificant.

Six-month follow-up data suggest that subjects in the ABCT + RP treatment condition had shorter drinking episodes if they drank (McCrary & Epstein, 1993).

“Couples-Treatment Matching”: Heterogeneity Among Alcoholic Couples and Implications for ABCT

The majority of research done thus far on ABCT used samples of alcoholic couples who were legally married, white, primarily middle or upper middle class, with no other psychopathology, and with husbands who have the alcohol problem (McCrary et al., 1986; O’Farrell, 1989; O’Farrell et al., 1993). The ABCT model developed over the last 25 years on rather homogeneous samples predated the more recent literature on heterogeneity among alcoholics, which shows high rates of comorbidity with other drug use disorders and psychopathology. Some research has been done over the last 15 years addressing heterogeneity and marital interaction among alcoholic couples (Dunn et al., 1987; Ichiyama, Zucker, Fitzgerald, & Dreves, 1994; Jacob et al., 1983; Jacob & Leonard, 1988). This research suggests that various typologies of alcoholics based on steady versus episodic drinking pattern, primary site of drinking (in-home versus out-of-home), and Antisocial Personality (ASP) may impact on the degree of relationship distress, effect of drinking on the relationship, and communication patterns of alcoholic couples. Only recently, however, has the notion of heterogeneity among alcoholics and alcoholic couples been directly related to development of ABCT (Beutler et al., 1993; McCrary & Epstein, 1995b). The ultimate goal of such studies would be to develop variants of ABCT specifically tailored to well-defined, easily assessed subtypes of alcoholic couples, to maximize treatment effectiveness and efficiency. Examples of recent attention to aspects of heterogeneity are listed below.

Early versus late onset alcoholism. In our own lab we recently completed a study (Epstein, McCrary, & Hirsch, 1997) comparing Early versus Late Onset alcoholic males and their spouses in terms of baseline marital functioning and within treatment change in marital satisfaction over time, in the context of a randomized clinical trial of three variants of ABCT. At baseline, early onset couples were more maritally unstable and the females in these couples were more distressed. During treatment, Early Onset couples reported higher daily marital satisfaction than Late Onset couples. Regardless of age of onset, males reported higher marital satisfaction than their spouses during treatment but their satisfaction did not increase during treatment. Female partners’ marital satisfaction increased during treatment. Female partners of Late Onset males reported particularly low marital satisfaction during treatment. Dividing the sample according to the early/late onset typology yielded different predictors of marital satisfaction for males and females within each subtype. For female partners of Early Onset alcoholics, psychological distress unrelated to her partner’s drinking severity was most associated with her own marital satisfaction, while marital adjustment of female partners of Late Onset alcoholics was most associated with the male’s level of perceptual accuracy regarding her needs. This pattern was reversed for the males; marital adjustment of Early Onset alcoholics was most associated with his partner’s perceptual accuracy of his needs, while marital functioning of Late Onset alcoholics was best accounted for by his own psychological distress. This study provides evidence that the marital functioning of male alcoholics and their female partners may vary according to the Early versus Late Onset alcoholism subtype of the male. In future research, other variables might be explored—such as age of onset in association with a criminal lifestyle, other drug use, lifestyle instability, or socioeconomic status. In

addition, other current alcohol subtyping schemas such as Type A/B (Babor et al., 1992) might be studied in relation to marital functioning.

Internalizing versus externalizing alcoholics. Recently, Beutler et al. (1993) described research designed to link alcoholic subtypes based on internalizing versus externalizing coping style with differential treatment outcomes of systemic versus cognitive-behavioral marital therapy. They equate the externalizing subtype with Type 2, Type B alcoholics, ASPs, and Jacob and Leonard's episodic drinkers. The internalizing subtype is identified as similar to Type 1, Type A alcoholics, non-ASP, and Jacob and Leonard's steady drinkers. This is a promising line of research, however, the overlap among various typologies needs to be established empirically before assuming that there are only two subtypes.

Relationship enhancement ABCT and treatment matching. Longabaugh and his colleagues have studied factors associated with differential response to individual or relationship-involved alcoholism treatment. In the first of a series of studies, McKay et al. (1993) reported that relationship enhancement conjoint treatment was less effective if patients were low in personal autonomy, but led to better outcomes for patients higher in personal autonomy, relative to individually focused treatment. A second factor studied by this group was the interaction between a diagnosis of Antisocial Personality Disorder (ASP) and treatment condition. Longabaugh et al. (1994) reported that subjects with ASP drank the least after individually-focused treatment, and the most after relationally focused treatment. Finally, the group examined the interrelationships between type of treatment, patient's investment in their social network, and the degree of social support that network provided (Longabaugh, Wirtz, Beattie, Noel, & Stout, 1995). They found that, for patients who had either low social support *or* low investment in their social network, extended relationship enhancement therapy was more effective than comparison treatments. However, relationship enhancement therapy was *less* effective than comparison conditions if patients were both low in social support *and* low in social investment prior to treatment. In essence, the results suggest that ABCT is most appropriate either when the social network is already supportive, or when the patient cares about the social network.

Increasing Focus on Specific Content Areas Relevant to ABCT

ABCT does not assume that the same problem areas should be addressed for all couples, because the content of therapy should vary by couple and be individually determined by a functional analysis of problems, reciprocal interactions particular to each couple, and the like. However, the content areas of marital aggression and sexual functioning have been identified as particularly relevant to the marital functioning of alcoholic couples, because both aggression and sexual functioning are directly affected by alcohol consumption. So, for instance, Murphy and O'Farrell (1994, 1997) recently published research indicating that maritally aggressive alcoholics have several characteristics different than nonmaritally aggressive alcoholics, and that husband to wife communications of maritally aggressive alcoholic couples are more problematic (during a sober state laboratory setting) than nonmaritally aggressive alcoholic couples. Exploration of marital aggression among alcoholic couples is important and has implications for enhancing clinical work with alcoholic couples.

Sexual functioning of alcoholic couples has also been studied recently. Male alcohol-

ics suffer more sexual dysfunctions than nonalcoholic men (O'Farrell, 1990), and reduced sexual satisfaction has been found in alcoholic couples (Wiseman, 1985). O'Farrell et al. (1991) reported that both alcoholic and nonalcoholic couples who were conflicted, differed from nonconflicted couples in terms of lowered quality of the sexual relationship, but did not differ from each other. In a study designed to overcome methodological flaws of previous research, O'Farrell et al. (1997) examined the contribution of alcoholism and marital conflict to sexual satisfaction and dysfunction of male alcoholic marriages versus nonalcoholic maritally conflicted and nonconflicted couples. Findings indicated that marital conflict and physical effects of chronic alcohol misuse jointly were most associated with sexual problems, especially among older alcoholics. Further research in these areas may indicate incorporation of specific modules to treat marital aggression and sexual difficulties into ABCT programs.

Research on Cost-Benefit and Cost-Effectiveness of ABCT

O'Farrell et al. (1996) recently published a study on cost-benefit and cost-effectiveness of an outpatient couples program at a Veterans Affairs Medical Center, comparing their standard ABCT program with and without 15 additional couples RP sessions in the subsequent 12 months. Cost-benefit analyses showed that the ABCT program resulted in decreased health care and legal cost after treatment compared to pretreatment costs, positive cost offsets, and health and legal cost savings that exceeded the costs of delivering the ABCT treatment. Cost-effectiveness analyses demonstrated that ABCT only was more cost-effective in producing abstinence than was ABCT plus RP because ABCT only was cheaper, and that ABCT only and ABCT plus RP were equally cost effective when marital outcomes were taken into account. This is the first published study to explicitly examine added benefits of ABCT in terms of economic advantages in addition to clinical outcomes. Further work examining cost-benefit ratios of variations of ABCT is warranted.

Focus on Spouse Coping and Functioning

Some researchers are focusing more explicitly on the coping of spouses of alcoholics from a behavioral perspective. For instance, McCrady, Miller, Epstein, and Van Horn (1993) reported on psychometric work on a modified version of the Spouse Behavior Questionnaire (SBQ; James & Goldman, 1971). McCrady et al. (1993) recently identified an underlying four factor structure of the SBQ, including: Confrontation and Control, Avoidance of Confrontation, Detachment, and Positive Consequences of Sobriety. McCrady, Kahler, and Epstein (1995) recently examined patterns of functioning of wives of alcoholics in ABCT treatment. The data suggested that spouses' marital functioning was influenced by the severity of their partner's drinking, the overall quality of their marital relationship, the presence of domestic violence, and the types of strategies they used to cope with the drinking. Spouse coping is relevant to ABCT, because increased knowledge of how spouses cope with their partner's drinking will enhance our ability to further develop effective components of ABCT.

Adaptation of ABCT to Specific Populations

Adaptation of ABCT for female alcoholics and nonalcoholic male partners. Almost all research on spouse-involved treatment has used samples of males with alcohol abuse/dependence and their female partners. The few studies that included female alcoholics (e.g., Longabaugh et al., 1995; McCrady et al., 1986) had too few females to com-

pare the effectiveness of the treatment for males versus females. The literature on women and alcohol suggests that it would inappropriate to generalize results of previous research to couples with female alcoholic partners, since women with alcohol problems differ from men on several individual and relational dimensions (Blume, 1986; Braiker, 1984; Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995; Helzer & Pryzbeck, 1988; Lammers et al., 1995; Mays, Beckman, Oranchak, & Harper, 1994; McCrady, 1988; Schneider, Kviz, Isola, & Filstead, 1995; Wilcox & Yates, 1993).

Research on adaptation of ABCT for females with alcohol abuse/dependence and their partners has recently begun in our lab, through a federally funded randomized clinical trial of ABCT versus individual cognitive behavioral treatment for female alcoholics and their male partners. As this study unfolds, more information will accrue on the effectiveness of ABCT and relationship characteristics of couples where the female is alcoholic.

ABCT for problem drinkers. Currently in progress is a randomized clinical trial (Walitzer, Dermen, Connors, & Leonard, 1996) called the Couples' Drinking Reduction Program, which is designed to test spouse involvement and ABCT in a moderation program for heavy drinkers who are not severely dependent on alcohol. Male and female married or cohabitating problem drinkers are randomly assigned to one of three conditions. In one condition, the problem drinker only attends 10 sessions focusing on drinking moderation and health education. In condition two, clients and spouses together attend 10 sessions focusing drinking moderation and spouse support techniques sessions. In the third condition, clients and spouses together attend 10 sessions focusing on drinking moderation, spouse support techniques, and relationship issues, using ABCT techniques. This new application of ABCT is based on a secondary prevention treatment approach for heavy and problem drinkers, and combines ABCT with behavioral self-control strategies for a moderation goal.

Adapting ABCT to treat drug abusers. Estimates of lifetime drug use disorders comorbid with alcohol dependence are as high as 80% (Carroll, 1986; Ross et al., 1988). However, most studies testing marital therapy for alcohol problems explicitly have excluded subjects with a current drug dependence, and none have treated nonalcohol drug problems. Given the close nosological and epidemiological association between alcohol problems and drug misuse, it seems reasonable to apply treatment methods shown useful for alcohol problems to treat drug abuse.

The ABCT model, which was developed on less recent, less multiproblematic cohorts of alcoholics, does not translate seamlessly into treatments for current drug dependent populations, and thus must be modified to deal with characteristics of primary drug dependent samples. These drug dependent samples generally have more severe problems, in multiple life areas (legal, occupational, financial, etc.), polysubstance abuse, comorbid psychiatric disorders, and poor education (Moras, 1993).

Additionally, other factors must be considered that may require modification of the theoretical and clinical aspects of the ABCT model applied to drug abuse. For instance, the social context of illicit drug acquisition and use is different than that of alcohol, which is a legal substance and easily available in liquor stores and bars. Thus, potential negative consequences of use may be more serious than for spouses of alcoholics. Spouses and children of drug abusers are put at much higher risk by the user's involvement in illegal activities necessary to obtain and use drugs, including the user's loss of employment, danger in dealing with other drug users and dealers, higher risk for AIDS, and incarceration. This may result in even more secretive behavior by the

abuser, more damage to the marital relationship and trust of the nonusing spouse, and less willingness of the spouse to tolerate involvement with a partner who uses drugs. The couple's lifestyle may be more drastically affected by cessation of drug use than by alcohol misuse, if the drug abuser has either been spending a great deal of money to obtain drugs, or, alternately, if the user has been earning money dealing drugs. Discriminative stimuli for drug use may be more distinctive and salient than for alcohol use, including drug paraphernalia such as cocaine vials, syringes, and the like. Because certain drugs have a higher reinforcement value than alcohol, high salience reinforcers for abstinence must be considered.

Clinically, there might be less relevance for the spouse's role in drug refusal, and less involvement in general in the system of antecedents and consequences of drug use. The nonusing spouse may be more angry and fearful, and less committed to the relationship than a spouse of an alcoholic partner. Marital and cohabitating relationships of drug abusers may be different than those of alcoholics, in terms of stability, commitment, and behavioral and verbal interaction. There may be more assortative mating among drug abusers, thereby complicating the application of ABCT. Additionally, clinical work must attend to problems in many life areas (legal, financial, etc.).

Researchers will need to study these above-mentioned factors in adapting and testing ABCT models with drug abusers, and there is thus far little empirical work done in these areas. Research on BCT for drug abusers is beginning, and recent studies provide evidence that relationship distress among married or cohabiting drug abusers is high (Fals-Stewart & Birchler, 1994; Fals-Stewart, Birchler, & O'Farrell, 1996; Fals-Stewart, O'Farrell, & Birchler, 1995).

Fals-Stewart et al. (1996) recently reported the first study on BCT for drug abusers, a randomized trial of 12 weekly outpatient behavioral couples treatment sessions versus no-couples-treatment for 80 male, primarily court-referred drug abusers and their partners. The 12-week course of couples versus no couples treatment was adjunctive to an intensive course of approximately 30 group and individual treatment sessions, for a total of 42 outpatient sessions over 24 weeks of treatment. Couples were followed up at 3, 6, 9, and 12 months posttreatment. In this well-designed study, Fals-Stewart et al. found that couples who received Behavioral Couples Therapy (BCT) had better relationship outcomes during the first 3–6 months of follow-up, though the gains dissipated thereafter. Husbands who received BCT reported fewer drug use days, longer periods of abstinence, fewer drug-related arrests and hospitalizations during the 12-month follow-up period than the husbands in the adjunctive individual therapy condition.

The Fals-Stewart study is the first to expressly study the effect of cognitive-behavioral couples treatment for drug abusers in a randomized clinical trial; results indicate that this approach to the treatment of married or cohabiting drug abusers is promising. Several factors limit the generalizability of the findings. First, 85% of the sample was mandated for treatment by the criminal justice system, so efficacy for noncoerced populations was not addressed. Second, the treatment was intensive (46 treatment sessions over 24 weeks), which may limit clinical utility of the study, given high rates of attrition from drug abuse treatment. Third, the couples treatment was not a stand-alone treatment model, but served as an adjunct to an intensive course of both individual and group therapy. Fourth, more than a quarter of the sample used medication (naltrexone or disulfiram) as an adjunct to behavioral treatment. Fifth, the spouse-involvement component did not explicitly integrate spouse-assisted recovery and marital therapy, as have previous models of behavioral treatment for alcoholism. The Fals-Stewart et al. (1996) study, however, is methodologically sound and carefully executed,

and indicates that partner involvement in treatment of drug abuse problem is a promising approach to enhance positive treatment outcome.

Fals-Stewart and his colleagues (Fals-Stewart, O'Farrell, Finneran, & Birchler, 1996) have also reported some within-treatment benefits for BCT with patients on methadone maintenance, but the differences were not maintained after the primary treatment was completed.

Future Directions

Applications of ABCT for couples with two abusing partners. The conjoint model can be modified to allow treatment of both spouses. This might entail a longer therapy protocol since cognitive-behavioral skills would be covered for both spouses' drinking or drug use patterns. Also, other issues might need to be addressed, such as possible differences in level of motivation for sobriety and subsequent differences in level of support for the other spouse, and difficulty in both giving and receiving support from the spouse while trying to curb one's own abusive drinking or drug use.

Integration of ABCT with BCT for depressive disorders. There is a high rate of comorbidity of alcoholism and depression; Ross et al. (1988) found depressive disorders among 23% of a male inpatient alcoholic sample, and among 35% of female inpatient alcoholic sample. Models and clinical trials of marital treatment for depression have been reported in recent years (see Gotlib & Beach, 1995; Jacobson, Dobson, Fruzetti, Schmalings, & Salusky, 1991; O'Leary & Beach, 1990). Given the high rates of comorbidity of depressive disorders with alcohol problems, and the fact that behavioral couples treatment models are in place for both alcohol and depressive problems, it would make sense to develop a BCT-based treatment for couples in which these disorders co-occur. Such adjuncts might be added to the ABCT protocol after the drinker has been sober for a number of weeks, to allow for evaluation of non-alcohol-related depressive disorder in the drinker, and to determine if the partner's depression is alleviated when the drinker becomes sober and the relationship becomes more functional. In other words, careful diagnosis of the depression is important, and the immediate effects of alcohol must be considered. Once it is determined that treatment of depression is necessary for either partner, BCT techniques can be implemented as part of the ABCT package.

Integration of acceptance-based therapies with ABCT. Acceptance-based therapies have received growing attention recently (Hayes et al., 1996; Strosahl, 1996; Wilson & Hayes, 1996) and have been applied to cognitive-behavioral treatment for a range of problems including substance abuse and marital issues. Integrative Behavioral Couple Therapy (IBCT; Christensen, Jacobson, & Babcock, 1995) represents a shift in BCT, which traditionally has emphasized behavioral change, to incorporate the notion of acceptance of the partner's behavior. The notion of acceptance in couples therapy may be particularly relevant to ABCT, because spouses of alcoholics typically have accrued resentment, often over years, towards the alcoholics' chronic alcohol consumption and related negative consequences. Through ABCT, the drinking may stop, but the spouse might still harbor resentment toward the sober alcoholic. The resentment in many cases may be so intense that it can undermine the treatment and contribute to relapse. Use of acceptance-based therapy techniques such as those established in IBCT might work well in ABCT to deal more systematically with emotional problems related to spousal drinking.

Obviously, the excessive drinking is not acceptable, given the myriad of negative consequences—health, legal, emotional, interpersonal—that drinking imparts. Thus, the notion of acceptance and tolerance-building of particular behaviors might be introduced into the ABCT protocol after the drinker has been sober for a number of weeks. This would allow for the relationship to begin adjusting to the sobriety, and for the therapist and couple to note which negative behaviors and interactions were primarily alcohol-related, and which are likely to continue to create conflict. Then, using standard acceptance and tolerance-building techniques, the therapist can work on helping the couple reduce conflict and increase supportive behaviors.

Integration of ABCT with psychopharmacological approaches to treat alcoholism. Several medications have been tested and found to be promising for treatment of alcoholism. Naltrexone, for instance, an opioid antagonist, has been associated with higher rates of abstinence, fewer drinking days and relapses to heavy drinking, and lowered craving for alcohol (Litten & Fertig, 1996; O'Malley et al., 1992; Volpicelli, Alterman, Haya-shida, & O'Brien, 1992), and has been approved by the FDA as a treatment of alcoholism. Another medication currently thought to be promising is acamprosate, which has been approved for treatment of alcoholism in seven European countries (Litten & Fertig, 1996). Acamprosate appears to increase rates of abstinence, and help prevent relapse even after psychopharmacologic treatment is terminated (Sass, 1996).

Patient compliance with medication based treatment needs to be further studied, since patients who discontinue ingestion of prescribed medication may not benefit. Integration of medication based treatment with established ABCT approaches such as behavioral contracting would be a promising direction for research on the integration of psychosocial and pharmacologic treatment.

Dissemination of ABCT to the mental health delivery system and to the public. ABCT models have been shown through randomized clinical trials to be effective in decreasing alcohol misuse and enhancing marital functioning among couples who participate in such treatment. The model has been applied with successful results to drug abusing individuals and their spouses. However, delivery of ABCT has thus far been limited to a relatively small number of clinics that conduct efficacy studies, despite a large number of descriptive and "how to" chapters' having been published in recent years in books geared toward a professional audience (McCrary, 1990, 1993; McCrary & Epstein, 1995a, 1996; Noel & McCrary, 1993; O'Farrell, 1986, 1989, 1993a, 1993b).

Dissemination of empirically supported marital treatment models for substance use would be a fruitful area of focus in the coming years. It is currently unclear if such treatment technology can successfully be transferred to and delivered by clinicians in the wider treatment community. This is an area where further research is indicated. In addition, developing and testing self-help models of ABCT would be useful. Workbooks might be created and made available directly to the consumer, so that the couples can learn about techniques such as functional analysis and spouse-related triggers, urge discussions, and the like and improve their ability to work together towards abstinence of the drinking partner.

SUMMARY

Strengths and Weaknesses of ABCT

ABCT has a well-articulated theoretical model that links drinking or drug use with relationship functioning. A substantial body of data supports the underlying model.

Several conclusions can be drawn about the effectiveness of treatments based on the ABCT model: (1) Randomized clinical trials suggest that different types of spouse-involved therapy generally, and ABCT in particular appear to be more effective than treatments that do not include the spouse, both for alcohol and drug use disorders, (2) using the spouse to apply positive contingencies for sobriety-related behaviors (aftercare attendance or use of disulfiram) leads to more positive outcomes, (3) unilateral formats of ABCT are associated with an increased probability that the drinker will become involved with treatment, (4) evidence does not exist to support the long-term superiority of behavioral over other interactional models of couples therapy for alcoholism, (5) evidence suggests that a specific focus on relationship functioning may enhance long-term drinking outcomes, and clearly enhances long-term marital stability and satisfaction, (6) evidence is equivocal about the necessary length or intensity of treatment, with one study suggesting that brief and extended interventions yield comparable results, (7) the addition of relapse prevention treatment elements enhances drinking outcomes, (8) the addition of 12-step facilitation to ABCT does not appear to enhance drinking outcomes, (9) certain individual patient characteristics appear to interact with ABCT to yield more or less positive outcomes. Available evidence suggests that those with Antisocial Personality Disorder, or low personal autonomy respond more poorly to ABCT than to individually focused treatment. Data also suggest better outcomes with ABCT than individually focused treatment for those with low social support for abstinence, or low investment in their social network, but that individually focused treatments are more effective for individuals high or low on both of these dimensions. (10) Cost studies suggest a positive benefit to cost ratio for ABCT. (11) Clinical materials and treatment manuals are available.

Despite the strong empirical support for ABCT, there are limitations to the research. To date, the strongest applications of ABCT have been to alcohol abuse/dependent populations. Although some promising research with individuals abusing other substances is now appearing, the body of research continues to be limited. Most studies have used fairly homogeneous populations, limited in comorbidity, and predominantly male (McCrady & Epstein, 1995b). Little research has examined the necessary or sufficient components of ABCT. Analyses testing the linkages between hypothesized mediators of change and outcomes are rare. Little attention has been given to contraindications for ABCT. Severity of substance dependence, extent of relationship distress, degree of commitment to the relationship, and presence of and extent of domestic violence are all variables that warrant investigation.

Current Status and Future Directions

ABCT is best understood as a group of interventions that involve the spouse or intimate partner in the treatment process. Treatments range in complexity from simple contingency contracts to treatments that fully address both substance use and relationship functioning. At this point in the 20-year history of development of ABCT, clinical researchers have carefully established the feasibility and efficacy of ABCT. They have described the population of male alcoholic marriages fairly well. In the last 5 years or so, these researchers have moved forward to expand the basic, established ABCT model to incorporate techniques, concepts, and content areas from the substance abuse and marital therapy fields. They have also begun to modify the basic model to treat new, more heterogeneous samples such as female alcoholics, problem drinkers, and drug abusers. The current article has outlined the basic ABCT model, and described research testing various innovations over the past few years.

The efficacy, and ease of adaptation and expansion make the future of ABCT quite promising. Several lines of future directions were outlined in this article; we hope that 20 years from now, a review will be written to reflect as much progress in these directions as has been made thus far in developing, testing, and expanding the basic ABCT model.

Acknowledgment—This study was funded by NIAAA Grants R01AA07070 and R29AA09894 to the authors.

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