Treating Alcohol Problems With Couple Therapy

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Couple therapy for treating alcohol use disorders (AUDs) results in less drinking and greater relationship stability and satisfaction in both men and women with AUDs. The theoretical tenets, treatment methods, and research evidence for Alcohol Behavioral Couple Therapy (ABCT) are summarized. The application of ABCT is illustrated through the treatment of a 42-year-old woman with an AUD and her 56-year-old husband. During 12 sessions over a 6-month period, the woman attained abstinence from alcohol and learned cognitive and behavioral coping skills to deal with drinking antecedents. Her husband learned to support her abstinence by stopping drinking himself, helping her cope with drinking urges, and reinforcing her successes. The couple increased positive pleasurable activities that did not involve alcohol and improved their communication skills. Challenges in the treatment included her ambivalence about abstaining, their complicated work and travel schedules, and other life stressors. J. Clin. Psychol: In Session 68:514–525, 2012.

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Most people in the United States (83%) consume alcohol at some point during their lives, and about two thirds of teenagers and adults have consumed alcohol in the past year. Most people drink without problems, but about 4% meet criteria for alcohol dependence and 4.5% meet criteria for alcohol abuse (Fenton, Aivadyan, & Hasin, in press). Larger groups of people engage in risky drinking at times, but do not meet criteria for an alcohol use disorder (AUD). However, in mental health settings, anywhere from 30%–70% of patients will have an alcohol or other substance use disorder (SUD) along with their presenting psychological disorders. Given the prevalence of alcohol problems, it is important that mental health practitioners have efficacious treatments available to them.

AUDs are best thought of as family disorders and many families are affected by AUDs. For example, 23% of Americans report that they have a first-degree relative with an alcohol problem and 38% report any blood relative with a drinking problem (Fenton et al., in press). Although the probability of getting married is about the same for those with and without AUDs, separation and divorce rates are about four times that of the general population. Physical violence is common in couples where one partner has an AUD, occurring in about two thirds of couples where either the woman or the man has an AUD. AUDs also affect the physical and psychological health of spouses and children, with spouses being more likely to be depressed or anxious or to have psychophysiological symptoms, and children being at higher risk for school problems, conduct disorder, and internalizing disorders.

Individuals' attitudes and patterns of alcohol and drug use are influenced heavily by the family. Genetic vulnerabilities to developing AUDs, family attitudes about alcohol, and family drinking patterns have a direct effect on drinking. Specific parenting behaviors and styles, parental monitoring, and family rituals also have indirect effects on adolescents' drinking. In adulthood, individual drinking patterns are influenced by the drinking of the intimate partner, and many couples align their drinking patterns so that they become more similar over time. Problems related to drinking also develop within a social network, and having a heavier drinking social network is associated with more drinking problems. Clearly there is an interaction: Heavier

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drinkers seek out and socialize with other heavy drinkers; the positive experiences in these social interactions in turn reinforce continued heavy drinking.

At the same time, the family and others in the social network are central to the initiation, resolution, and maintenance of change in AUDs. Family members often are the first to notice and comment on a loved one's behavior when drinking, suggest change, and encourage help seeking. Families also provide important support to the individual who is trying to stop drinking, and family support is often cited as one of the most important contributors to a person's successful sobriety.

We have developed and evaluated an integrated therapy for AUDs that includes both partners in the treatment and that addresses individual change in both partners as well as couple level change (McCrady & Epstein, 2009a, 2009b). We have established the efficacy of ABCT through a series of clinical trials. O'Farrell and colleagues have evaluated a similar model of couple-involved treatment, with similar positive results (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992).

Alcohol Behavioral Couple Therapy

ABCT draws upon cognitive-behavioral methods for the treatment of alcohol use disorders (Epstein & McCrady, 2009) and behavioral couple therapy (Epstein & Baucom, 2003) for the treatment of distressed relationships. Although we see AUDs as multiply determined, complex behaviors, ABCT focuses on current factors maintaining drinking. Excessive drinking is treated as an over-learned behavior.

ABCT is grounded in the assumption that drinking occurs in an interactional context, is maintained in part by interactions between the drinker and partner, and is changed most effectively by teaching each partner new individual coping skills and also changing interactions between partners. Drinkers learn skills to attain and maintain abstinence; partners learn skills to reinforce positive changes in drinkers' behavior and decrease behaviors that might cue or reinforce drinking. Changes in the couple's interactions are intended to decrease couple-level cues for drinking and increase the reinforcement value of the relationship. Throughout, ABCT maintains a dual focus on individual and interactional change. Partner behaviors and couple interactions are viewed as potential triggers for drinking. The partner's actions or the couple's interactions consequent to drinking may serve to reinforce the drinking, either by providing positive consequences for the drinking or by shielding the drinker from negative consequences of drinking that otherwise would occur. Treatment is based on the assumption that couples affected by AUDs lack the skills to deal effectively with drinking-related situations.

ABCT is designed as an outpatient, stand-alone treatment for couples in which one or both partners is affected by an AUD. Both partners are present for all sessions, which are 90 minutes in length. Treatment is manual-guided and has been tested in versions ranging from 12 to 24 sessions. We reduced the length of the treatment because most change occurred in the first 12 sessions and because of the ongoing pressures from third-party payers to provide briefer treatments. Our published treatment manual and client workbook (McCrady & Epstein, 2009a, 2009b) present our current 12-session version of the treatment. The case I will present in this article was treated using the 20-session version of ABCT.

Research dating back to the early 1970s suggested that involving the spouse in treatment resulted in better outcomes for the individual with an AUD. Given that several other studies had found spouse involvement promising, our first study of ABCT examined the relative contributions to outcome of spouse presence, modifying spouse behaviors and the couple's relationship (McCrady, Noel, Stout, Abrams, & Nelson, 1991). Over the 18 months of posttreatment follow-up, we found that couples receiving the treatment focused on both individual coping and the couple's relationship had better treatment retention, marital stability and satisfaction, and better drinking outcomes than the comparison treatments that provided no intervention to improve couples' relationships.

Although our early results were promising, the majority of participants drank after treatment, and in a later clinical trial, we assessed whether adding either relapse prevention (RP) interventions or Alcoholics Anonymous (AA) and Alanon involvement would improve the outcomes

of ABCT. Participants generally showed significant decreases in the frequency of their drinking through the 18-month follow-up period (McCrady, Epstein, & Hirsch, 1999; McCrady, Epstein, & Kahler, 2004). The length of drinking episodes was shorter in the RP condition, but neither the RP nor the AA/Alanon add-ons improved overall drinking outcomes over basic ABCT.

Early research on ABCT used all or mostly male samples; more recently we have conducted studies of ABCT with women with AUDs and their male partners. In a randomized clinical trial comparing individual CBT to ABCT, we found that women who received ABCT showed greater improvements in abstinence and greater decreases in heavy drinking over time than women receiving individual treatment (McCrady, Epstein, Cook, Jensen, & Hildebrandt, 2009). These findings are very similar to findings for ABCT for men.

Our research is part of a larger body of research on conjoint treatment for persons with alcohol and other substance use disorders. Results are consistent across research groups in finding that despite some differences in the way the treatments are provided, conjoint therapies result in better drinking and drug outcomes and improved relationship functioning after treatment. O'Farrell's research also has shown that conjoint models of treatment for AUDs lead to greater decreases in intimate partner violence than individual treatment.

ABCT Treatment Goals and Elements

The principal goals of treatment are to (a) help drinkers decrease or stop drinking; (b) enhance both partners' motivation to change; (c) help the drinker develop individual behavioral, cognitive, and interpersonal coping skills to stay abstinent; (d) help the partner develop better contingent responses to drinking and abstinence, including decreasing behaviors that cue use, increasing support for positive change, and decreasing attention to negative behavior; and (e) improve the couple's relationship as an incentive to maintain change.

Stopping Drinking

Treating AUDs always requires the therapist to consider the degree to which the drinker is physiologically dependent on alcohol and to assess the potential for complicated alcohol withdrawal (see McCrady & Epstein, 2009, for guidelines for determining withdrawal risk). Clients with high levels of physiological dependence are referred for an inpatient or ambulatory detoxification. Clients with low levels of dependence are helped to set goals to step down from their current drinking level to abstinence over several weeks.

Enhancing Motivation to Change

Therapists use a motivational enhancement style, characterized by empathy, positive regard, and "rolling with resistance" (e.g., Miller & Rollnick, 2002). Several specific aspects of the treatment also address motivation to change. At the start of treatment, therapists provide feedback to the couple on the drinker's pretreatment drinking and the consequences of drinking, how the partner has coped, and strengths and concerns in the couple's relationship. Early in the treatment, the therapist and couple together complete a decisional balance related to drinking. Additionally, conducting a functional analysis highlights negative consequences from drinking in specific to manage high risk situations.

Developing Drinker Coping Skills

Functional analysis is central to ABCT. The functional analysis provides a framework for the therapist and couple to identify situations that place the client at high risk for drinking, understand cognitive and affective responses to high-risk situations, and recognize the positive and negative consequences that ensue. The therapist systematically helps the client learn to modify high-risk situations, use different cognitive and behavioral strategies to cope, learn new ways to obtain similar positive reinforcers through means other than drinking, and learn how to anticipate negative consequences of drinking in high-risk situations. Coping skills include:

self-recording of drinking and drinking urges to identify high-risk situations, completing behavior chains for specific high-risk situations, self-management planning, and cognitive and behavioral skills to manage high risk situations.

Developing Partner Coping Skills

Partner behaviors are considered at each step in the functional analysis and specific interventions focus on partner coping. The therapist helps the partner identify actions that may serve as triggers for drinking. These may include behaviors intended to influence the drinker to change (such as nagging), attempts to control the drinking or the drinker's behavior (such as restricting access to money), or the partner's own drinking. The therapist works with the couple to help the partner develop alternative behaviors that are less likely to serve as cues for drinking. The therapist also helps the partner learn to provide positive reinforcement for positive behavior changes related to drinking, decrease reinforcers for drinking, and allow negative consequences to occur should the drinker drink.

Improving the Couple's Relationship

The goal of reciprocity enhancement is to increase positive exchanges between the partners so that they experience more pleasure in being with each other, and so that the positive aspects of the relationship may serve as an incentive for abstinence. Couples are helped to identify positive behaviors from their partner and give each other feedback about these positive actions. Later interventions focus on the development of shared enjoyable activities. Communication and problem-solving skills are taught by helping couples identify positive and negative aspects of their communication and then practicing more constructive communication skills. Problem-solving skills are introduced toward the end of treatment.

Case Illustration

Presenting Problem and Client Description

Terri was a 42-year-old woman in her second marriage who sought treatment for her drinking problem in one of our clinical trials for women with AUDs. Treatment included two assessment sessions with Terri and her husband, Steve, which totaled about 4 hours, and 12 sessions of treatment over 6 months.

Terri had a master's degree in business administration and worked as an international management consultant; her annual income was about $175,000 per year. Her job required her to travel about 2 weeks per month. She devoted at least 60 hours a week to her job, and said that she had no friends. Her only social outlet was her involvement with church. She came from a large family and had five older brothers. Her father had died of cirrhosis of the liver when Terri was in college; her mother was suffering from advanced Parkinson's disease. Steve was 55 years old; this was his third marriage. Steve had two teen-aged daughters from his first marriage. He also was college educated and had a small construction company. His annual income was about $100,000/year.

Terri started drinking in high school, and by her senior year she started cutting school on occasion to go drinking with her friends. She drank and drove frequently, although she had never been arrested or charged with driving while intoxicated. By her senior year of college, she was drinking heavily Thursdays through Sundays, describing herself as a "party girl," and had frequent arguments with her parents about her drinking. She continued to miss school, and said that she "lost more than one boyfriend because I could drink more than they did." She also had experimented with cocaine during college, but had stopped using by her senior year of college. She said she could drink large amounts of alcohol from the first time she drank, but began to experience the physiological of tolerance and withdrawal in her early 30s. She made several unsuccessful attempts to stop drinking on her own, which led her to decision to seek treatment. She met criteria for Alcohol Dependence with Physiological Dependence.

We assessed her drinking pattern in the past 90 days using the TimeLine FollowBack Interview (Sobell & Sobell, 1996), which we administered to Terri with Steve present to provide additional information about Terri's drinking as needed. They reported that Terri had drunk on about half (48) of the past 90 days. She had two different drinking patterns: She typically drank 1-2 glasses wine a day during the week, and she and Steve shared three liters of wine each day on the weekends over about a 3-hour period in the evenings. We estimated that she drank about 10 standard drinks per day on the weekends, with a resultant blood alcohol level of about .30.

Negative consequences of her drinking were assessed through a clinical interview and with the unpublished Rutgers Consequences of Use (RCU). Major consequences of concern to Terri included: acting in an embarrassing manner at work, weight gain, decreased energy, and concerns about her health. On the RCU, she noted other concerns as well: arguments and other problems in her relationship with Steve, feeling guilty about her drinking, a lack of other hobbies or interests, being concerned that she was not following through on responsibilities at home, and missing work. She also reported physical consequences of her drinking, such as having blackouts and hangovers, getting sick, and feeling that her thinking was fuzzy. Although Terri had tried to stop drinking on her own, this was her first attempt at alcohol treatment. She was on Paxil for anxiety, prescribed by her general practitioner. Because she was seeking help for her drinking problem, I did not assess her for a possible anxiety disorder, and anxiety issues did not arise in the treatment.

Steve also was a regular drinker, and his drinking pattern was similar to Terri's. On the RCU he also reported that he and Terri had been arguing, that he experienced blackouts, hangovers, and withdrawal symptoms, and that he got irritable and verbally violent at times when drinking. Steve clearly had an alcohol problem as well, but the couple was presenting with primary concerns about Terri's drinking rather than Steve's. Because they were presenting for treatment in a clinical trial for women with AUDs, I thought it was appropriate to focus on Terri's drinking. In my clinical experience outside of clinical trials, I have treated a number of couples with similar presentations and found that the spouse who is not identified as the patient often makes substantial changes in his or her drinking even when not the main focus of the treatment. Steve coped with Terri's drinking by taking care of her when she had been drinking, by trying to support her efforts toward abstinence by complimenting her and spending time with her when she was not drinking, and by expressing his affection toward her.

Terri and Steve had been married for 3 years. Even though they argued often when they were drinking, they both reported a very high level of marital satisfaction on the Dyadic Adjustment Scale (DAS; Spanier, 1976). Terri's DAS was 124; Steve's was even higher at 133 (DAS scores below 100 suggest a distressed relationship). On the DAS they reported that they used a mutual approach to decision making. She was "extremely happy"; he rated their relationship as "perfect." Both partners identified few areas of substantial concern. Steve was more concerned about household chores than Terri, and reported that he would like more frequent sexual relations. She also reported a desire for more frequent sexual relations and wanted them to spend more time with her relatives.

To identify specific antecedents to drinking, Terri recorded drinking and drinking urges throughout treatment. In addition, she completed the Drinking Patterns Questionnaire (DPQ: Menges, McCrady, Epstein, & Beem, 2008), a self-report questionnaire listing a variety of potential drinking antecedents. Steve also filled out the same measure to report his view of Terri's drinking. She said specific environments were the most important antecedents to her drinking, including drinking at home, after work, at supper, during the evening, at bedtime, with her husband, while smoking, while talking, while partying, when others drank, on Fridays/Saturdays, and during the winter. Steve also noted that Terri drank at restaurants, while entertaining, and at dinner. Work provided the second most important set of antecedents to drinking, and included drinking after work to relieve job pressure and with business associates at meetings. Marital antecedents (ranked #3) included Steve's drinking, having a good time together, and celebrating. Other antecedents included drinking when others were drinking, when others would buy her drinks or offer her drinks, and when she felt guilty about not paying enough attention to her mother or thought about her father's early death.

Case Formulation

Terri had a positive family history of alcoholism and developed a drinking problem early, suggesting that she may have been genetically vulnerable to alcohol dependence. Her social environment in high school and college reinforced her heavier drinking pattern and her husband reinforced her current drinking. They had clearly established a "drinking partnership" in which alcohol was integral to the fabric of their relationship.

Terri's work environment provided multiple cues for drinking and her frequent travel made it difficult for her to establish a regular schedule that could support abstinence-based activities. Her drinking had a strong habitual component and had generalized to multiple environments. In addition to social reinforcement for her drinking, Terri's drinking was maintained by several individual factors, including anxiety relief, relaxation from work pressures, and temporary relief from her high personal standards. Alcohol also provided temporary relief from her concerns about her mother's advancing illness and guilty feelings about not spending as much time with her mother as she thought she should. Her high level of physiological dependence and her positive family history suggested that abstinence was the most appropriate goal for her drinking.

Terri had several important strengths that she brought to the treatment: her intelligence, stable job, and good income; a strong and positive relationship with her husband, who was willing to support her efforts to change; and their strong religious faith.

Course of Treatment

Session 1 (Week 1). Terri came in saying that she had been trying to drink less since her initial evaluation. After providing the rationale for treatment, I gave the couple feedback about Terri's drinking, Steve's role in her drinking, and strengths and problems in their relationship. Despite their high scores on the DAS, Terri said that she was unhappy in her relationship with Steve, noting in particular that their ability to communicate had eroded. Steve stated that although he knew he also needed to stop drinking, he did not want to discuss his drinking yet. I introduced self-recording, asking her to record her drinking, drinking urges, and marital satisfaction (on a 1–7 scale, where 7 was high satisfaction) on a daily basis, and to note when she had her menstrual period. I asked him to record a daily estimate of her drinking as none, light, moderate, or heavy; his estimate of the intensity of her urges to drink; and a daily marital satisfaction rating. At the end of the session, we discussed situations that were coming up during the week that might be particularly high-risk for her to drink. She was feeling guilty about her mother and was concerned about having strong urges to drink after visiting with her. Steve thought that her mother was manipulative of Terri because of her illness, and thought that she "shouldn't" feel guilty.

Session 2 (Week 2). Terri drank less on the weekend, but still drank on Friday and Saturday evening (6 and 7.5 glasses of wine, respectively). I began graphs of her drinking, drinking urges, and their relationship satisfaction (see Figure 1). Each week, I updated the graphs and showed them to the couple. The visual representation provided feedback to them on change that might not have been as apparent simply from a verbal discussion and review of their weekly self-recording. Their relationship satisfaction ratings remained very high throughout treatment and thus are not shown in the figure. We spent a fair amount of time reviewing high-risk situations for her to drink (as described above). We also talked more about her "anxiety attacks" and use of Paxil. She said she was ambivalent about taking medication and that she did not get her prescription refilled consistently. However, she also reported intense anxiety symptoms when she was off her medication for a few days. Terri also reported that about twice a year she'd experience a few days of "intense" depression and low energy, but without suicidal thoughts or hopelessness.

In this session, I introduced functional analysis to the couple. We worked through two behavior chains, one related to work and one related to visits to her mother, to show them the functional and temporal relations among environmental triggers, cognitive appraisals, drinking, and positive and negative consequences. They both grasped the concepts easily, and I asked her

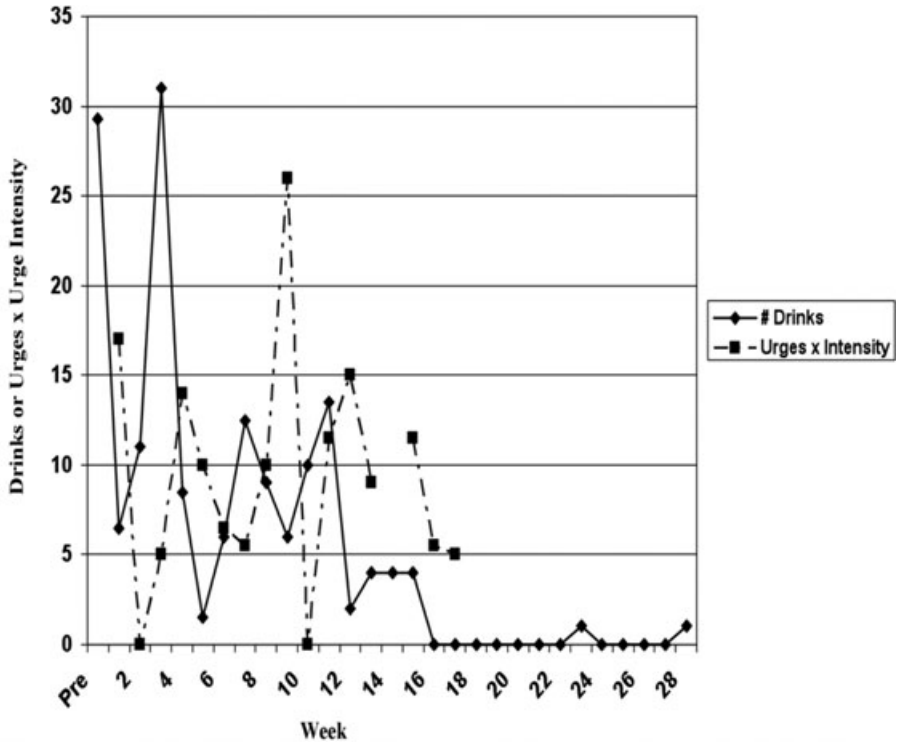

Figure 1. Terri's weekly drinking and drinking urges during treatment.

to work two more behavior chains on her own for other situations. At the end of the session, we discussed an upcoming high-risk situation—a business reception—and how to avoid drinking there. We identified simple strategies, such as getting a nonalcoholic beverage as soon as she got there, spending more time with light than heavy drinkers, and perhaps leaving early if necessary.

Terri and Steve also noted an upcoming trip to the Caribbean, which was prepaid and all-inclusive, including alcohol. Both of them said that they intended to drink during the trip. I raised the possibility of using the trip as a way to enjoy each other without alcohol, but they were not moved by my suggestion.

Session 3 (Week 4). Steve was held up at a business meeting so Terri came to the session alone. However, our research trial required that both partners attend each session, so she and I talked for 10-15 minutes and then rescheduled.

When Terri and Steve came in a week later, Terri had been in Spain for 4 days for business, and the couple had been in the Caribbean for their extended weekend vacation. Terri reported that she had been trying to limit her drinking, but she was still drinking a lot, as was Steve. They said that the drinks at the resort were watered down, so they drank their usual number of drinks but believed that they had effectively drunk less than was typical for them. Terri and Steve continued to be ambivalent about making any substantial changes in their drinking, and we started to work on a decisional balance sheet as a way to enhance their motivation. Although we were focusing on Terri's drinking, Steve was an active participant in this part of the session and mentioned pros and cons of drinking that were personally relevant to him. Terri listed many reasons not to drink, similar to the negative consequences she had reported at intake, and she saw significant benefits of abstinence. A major reason for her to continue to drink, however, was her feeling of being "terrified" of how she'd feel if she weren't drinking. I talked with them about behavioral sampling, suggesting that she'd know better how she felt when abstinent if she tried. Because she said that she did want to stop drinking, and Steve supported that desire, we

worked on a schedule to help her reduce her drinking by about 10% every 2 days to work down to abstinence.

Terri and Steve also talked about Terri's high expectations for herself. She felt that she should "always" be a good daughter, sister, aunt, wife, professional, etc. Steve challenged her "shoulds," saying that she "shouldn't" let people bother her so much.

Session 4 (Week 5). Terri drank heavily for the 3 days of the weekend (7.5 to 9 drinks per day) including on Monday, which was a federal holiday. Steve was upset by her intoxicated behavior and said that he realized that he also had to stop drinking for her to stop. Terri was upset throughout the session, feeling overwhelmed at the prospect of not drinking but also feeling even more that she needed to stop.

During the session, we reviewed the behavior chains she had completed and began to move toward self-management for environmental triggers for her drinking. As a first step, we created a list of her most important high-risk drinking situations, which were as follows: Friday nights after work, Steve's having a drink, dining in a restaurant, attending work/social functions, entertaining at home, Saturday nights, job stress, socializing with friends, having alcohol in the house, being offered a drink, holidays, trying to live up to her own standards ("shoulds"), dinner time, sitting at the kitchen table for dinner and afterwards, sitting in their sunroom, celebrating special events, feeling like she deserved a reward, when she and Steve were not "healthy" in their relationship, and when she felt the need to "come down." We worked on a specific self-management plan around drinking at home, and after discussing several options, Terri and Steve decided together to keep wine out of their house. They worked well together in discussing and coming up with a plan that they agreed upon.

At the end of the session, I again asked her about upcoming high-risk situations. She was planning to go out of town to visit family and anticipated drinking situations throughout the visit because the family members she was visiting all were heavy drinkers. We discussed some options, including telling her family that she had decided to stop drinking, or telling them that she was on medication and could not drink, or giving some other excuse. Steve was impatient in this discussion, and confronted her about "dancing around" the issue. She did not come up with a plan that she felt comfortable with, and ended the session by saying, "I'll be okay."

Session 5 (Week 6). Terri cut down dramatically on her drinking the previous week. She drank on only 2 days, consuming a total of eight drinks. Steve did not drink at all. They attributed the change to their decision to keep alcohol out of the house and she emphasized the importance of Steve's not drinking. They both said they enjoyed each other during the week, and found communication easier without drinking. During the session we continued to focus on self-management planning, discussing ways that they could socialize without alcohol, and how they would handle dining out. We also talked about ways to manage urges to drink and practiced thinking about negative consequences of drinking as a strategy.

In addition, I introduced the concept of Steve's providing positive reinforcement for Terri's sobriety. As first, he was somewhat uncomfortable with the idea, saying that he wanted to make her happy whether or not she was drinking. However, she resonated with the idea of his giving her extra support for not drinking, saying that she'd like him to give her positive feedback by saying things such as, "I'm proud of what you're doing." We did a brief role-play and I asked him to try this out during the week. Toward the end of the session, Terri returned to the discussion of her "overachieving" style and her constant internal drive to do more and be more successful. She said that she felt unable to relax or achieve any kind of balance in her life and wanted to continue to discuss this issue in future sessions.

Session 6 (Week 8). Terri was returning from Portugal the day of our scheduled session. Steve called to say they would have to reschedule the session because her plane had been delayed.

When the couple came in the next week, they reported that they had had a very good 2 weeks. She had 1.5 glasses of wine on one occasion and six 4-ounce glasses of wine on a second occasion. I graphed her reported drinking and urges since our last session and she protested that she was not getting "credit" for her success because some points on the graph covered 2 weeks

rather than 1. Given that she was eager to get positive feedback about changes she was making, I agreed to redo all their graphs in 7-day chunks, regardless of when we held our treatment sessions.

Terri had been using several strategies to deal with urges, particularly focusing on negative consequences of drinking. The couple also had been spending more time with nondrinking friends/acquaintances (primarily through their church) and she had been using other self-management strategies, including keeping alcohol out of the house. Terri also had been telling Steve when she was having urges to drink and he had been very helpful, mostly by telling her about positive changes he had seen in her since she had almost stopped drinking. We discussed additional ways that Steve could be supportive, such as making herbal tea for her after dinner, or giving her a foot massage. Finally, we spent time on a self-management plan for an upcoming visit with heavy drinking friends from high school.

Session 7 (Week 10). Once again, the couple had to reschedule their session, this time because Steve had an unexpected business meeting.

The couple came in a week later. Terri had continued to drink intermittently. I was increasingly concerned about her inability to abstain, even though she was making good progress in decreasing her drinking. I asked Terri if she still saw abstinence as her ultimate goal, and when she said "yes," I asked when she thought she'd be ready to stop completely. Her answer was, "Not yet, but I'm getting closer." We spent the balance of the session talking about alternatives to drinking and I helped the couple talk about ways to share positive times together. We identified several things that were appealing to them, including lighting fragrant candles and soaking in the hot tub and entertaining people from their church.

Session 8 (Week 11). Although Terri continued to drink, she reported that she was trying hard to use the abstinence strategies she was learning in treatment. The couple had been spending enjoyable time together. They had talked about having church friends over but Terri said that she would find that difficult. She felt that she was not a worthy member of her church because of her drinking and having people to their home would heighten her feeling of not belonging. We spent some time talking about cognitive strategies to address her high level of self-criticism. The balance of the session focused on drink refusal skills, first doing role-plays with Terri alone, and then with Terri and Steve together to develop ways that he could help her in drinking situations.

Session 9 (Week 12). Terri reported having four glasses of wine during the week (two on Friday and two on Saturday) and Steve also reported drinking on the same days. When asked, they said they had not given up on their plan to not keep alcohol in the house but that Steve had stopped to buy a couple of bottles of wine on his way home from work on Friday. Terri reported no urges to drink on any other days. We talked about Steve's decision to stop for wine and he said that he just "felt like drinking" and thought since Terri had been doing better, it "wouldn't hurt." Terri gave Steve feedback about her disappointment with his getting wine and asked that he not do so without calling her first.

We spent much of session on the topic of assertiveness. Terri described herself as holding in her feelings related to her family while Steve was overly blunt. He agreed with this characterization. We then discussed how Terri could be more assertive with her siblings, who she felt were not paying enough attention to their mother, and how Terri could be assertive in specific situations with her stepdaughters and with Steve. The assertiveness discussion led naturally into a more general discussion about communication between them. Although they saw themselves as positive, supportive, and loving in their communication with each other, they felt they were not skilled at discussing areas of disagreement. Steve described himself as impatient with "long conversations about feelings" and Terri expressed a desire for him to listen to and acknowledge her feelings, particularly when she was sharing her anxiety about his children.

In the last part of the session, we tried to build on the earlier positive, shared activities by planning a *love day,* in which each of them would do a number of small, loving things for the other throughout the day. At the end of the session, the couple noted that they had another

vacation planned and they expected they would drink more. We again talked about ways to keep drinking low during the trip. Terri decided to set a quit date for 3 weeks thence. She had a long-awaited job promotion that was going to be effective at that point and Steve's younger daughter was going to be moving in with them. Terri thought these two events would provide a good point for change.

Session 10 (Week 14). We had a short session because Steve was caught in a traffic jam, making them late. The couple had been on vacation for the past week and Terri reported that she drank on three occasions in the past 2 weeks (two, two, and four drinks). They had visited her brother at the start of the vacation. Terri said he was an active alcoholic and that he was drinking heavily and behaving in ways that they found distressing (he was belligerent and berating toward his wife and drank to the point of passing out). She spoke with him about his drinking and gave him feedback about his behavior; he agreed to go to a detoxification program. Although she found the situation with her brother upsetting, it also motivated her to make a decision to stop drinking, at least for the next 30 days. Much of the rest of session focused on reviewing their homework from the previous session. Terri had been trying assertiveness skills in work situations and found them helpful. Both members of the couple had implemented the love day and were positive about it. I then briefly introduced problem-solving skills before we had to end the session.

Session 11 (Week 15). Steve again was a bit late because of his work schedule. Terri reported that she did not drink at all during the week, and had just two urges. She said she was successful because she had "made up her mind," and then used several strategies to support her decision. Although Terri and Steve said they were happy that Terri had successfully stopped drinking, they were tired and tense during the session. Terri said that she was concerned about having Steve's daughter come to live with them and how this change would affect their lives and their relationship. We focused on communication skills for the rest of the session and I encouraged them to hear and validate the other's concerns around the daughter. However, they found it difficult to hear each other and to identify specific concerns that they could address collaboratively.

Session 12 (Week 26). The couple did not arrive for their scheduled session. Ten minutes into the scheduled session time Terri called and said she had forgotten to check her calendar, and that she was at work and Steve was away. We rescheduled for next the week.

The next week, Terri called to say they couldn't make their appointment because Steve was away. We again rescheduled for the following week.

The next week, Terri again called to say they couldn't make appointment because Steve was away. We then rescheduled for the next week. During our conversation, she noted that she now had been abstinent for a month.

The next week, I called to reconfirm appointment. Steve called back to say that Terri was at an offsite meeting and would be away the next week.

We finally met $2\frac{1}{2}$ months after the previous appointment. Terri had been virtually abstinent since last session: She drank a half a beer on one occasion and one glass of wine on another occasion. Factors that she said helped her included daily prayer, bible study class, Steve's abstinence, keeping busy at high-risk times, going to bed early, traveling for work, socializing less with drinking friends, and spending time with her mother.

Steve's younger daughter had moved in and they were finding the adjustment difficult, especially Terri, who tried to impose her high standards on the stepdaughter in terms of how she dressed, how she kept her room, her schoolwork, and her friends. Steve felt that Terri was placing him in the middle between her and his daughter and was upset with Terri. To deal with these tensions, Steve and Terri had been trying to make time to talk and be together as a couple. Although they felt that they were still finding their way, they were trying to use the communication skills we had discussed in sessions and said that not drinking made it much easier for both of them to maintain their calm.

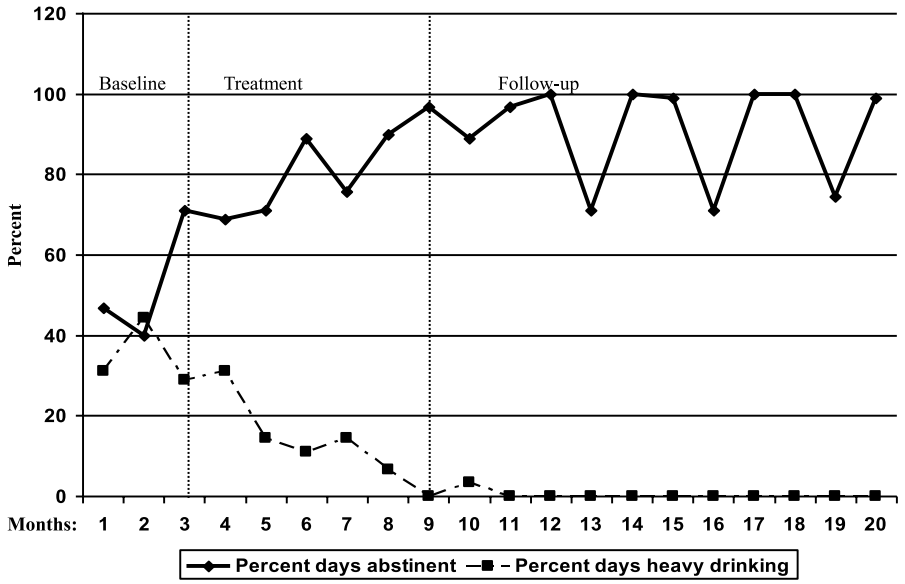

Figure 2. Terri's monthly drinking.

Because Terri and Steve were part of a research study, there was a 6-month limit on the treatment, and this session had to be their last. We spent the last part of the session discussing relapse prevention, including warning signs, what they could do if warning signs for a relapse were coming up, and how they could cope if a relapse occurred. We concluded with a review of their progress through treatment. They both were pleased with the changes in their drinking and felt that their relationship was stronger. They both, however, expressed uncertainty about their commitment to longer term abstinence.

Outcome and Prognosis

We followed Terri and Steve's progress for a year after treatment. The couple stayed together and reported that they felt more comfortable with and happier with each other. At 12 months posttreatment, Terri's DAS had increased to 140; Steve's DAS was essentially unchanged at 130. Figure 2 shows Terri's posttreatment abstinence and heavy drinking (defined as more than 3 drinks/day). Terri was abstinent most of the time during the year after treatment, and although she drank occasionally, she never drank heavily.

Given that we tracked the couple's progress for a year after treatment, their prognosis seemed good. I capitalized on the strengths they brought to treatment, particularly their commitment to each other, and tried to give Terri sufficient space to find her way to making a decision to change. She developed individual behavioral and cognitive coping skills to maintain abstinence, Steve made a commitment to abstinence and learned ways to support Terri's abstinence, and the couple developed better communication skills to deal with problems in their relationship.

Clinical Practices and Summary

This case illustrates several aspects of couple-involved treatment for AUDs. First, the treatment had a dual focus on drinking and the relationship. For this couple, in particular, drinking was multiply determined by Terri's familial vulnerability, her current situation, and her coping skills. By involving Steve in the treatment, I could change the social environment that reinforced her drinking at the same time that I focused on her individual motivation and coping skills for change. The improvements in the couple's relationship should, in the long run, provide additional incentives for maintaining the changes they initiated during treatment.

Although ABCT is a structured and directive treatment, the therapist respects the clients' autonomy and need for self-determination. The optimal stance is one of collaboration in exploring their goals and means to achieve them. This stance was most challenged by Terri's ambivalence about abstinence. In several sessions, I simply asked if she was ready to change, and when she'd say, "not quite yet," we would talk about what would help her "get there." The fortuitous interaction with her brother was not something I orchestrated, but it did provide a deeper motivation when she saw how devastating drinking could be and how strongly alcoholism was manifested in her own family.

The couple did not complete the full 20-session ABCT in use at that time. The number of sessions they attended was typical for ABCT; we found that only about one quarter of couples actually attended the full 20 sessions. This observation was one reason why we reduced the total length of the treatment to 12 sessions. My sense was that they both thought that successfully achieving abstinence represented a good stopping point for treatment. Additionally, their life circumstances had become more complicated with the addition of Steve's daughter to their household, and because they did not see a need for treatment to help them stay abstinent, treatment became a lower priority. I would have liked additional sessions to reinforce their abstinence and communication skills, but was glad to at least have a final session to consolidate and reinforce key points.

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