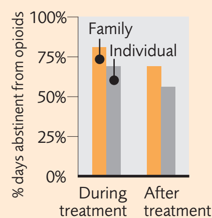
FEATURE NUGGET

10.2 Working with couples helps client and family

Findings The latest in what experts have called an "impressive" series of studies on behavioural couples therapy found that the benefits extend to naltrexone treatment of opiate dependence.

The approach differs from other family therapies in its focus on changing behaviour so that the couple respond positively to each other and in particular so that every day the substance misuser's partner rewards abstinence-promoting behaviours. Where one of these behaviours is taking medication, the partner observes and praises its consumption. After positive findings with disulfiram treatment of alcoholism, US researchers decided to see if this approach would improve the generally poor compliance with naltrexone (opiate-blocking) treatment of opiate addiction.

459 men seeking treatment for opiate dependence at two US outpatient clinics who were living with a non-addicted lover or relative were invited to enter the study. 124 agreed; most of the remainder refusing because they did not want to take naltrexone. Treatment involved daily naltrexone and 24 weeks of group and individual cognitive-behavioural counselling. For a randomly selected half, in the first 16 weeks one of the two weekly individual sessions was replaced by behavioural family counselling of patient and partner. Researchers attempted to interview both for up to a year after the scheduled end of therapy. At the last follow-up, nearly 90% of patients were re-interviewed. Compared to the control group, patients allocated to family counselling attended more therapy sessions and took naltrexone on 29% more days. During and after treatment, they also spent roughly an extra 10% of days free of opiates and about the same free of other drugs including alcohol, and attained longer periods of continuous abstinence. By the end they had also improved more on measures of family and social functioning and of legal and drug-related problems. Whether their counselling partner was a lover or a parent (the most common categories) or other member of the family made no difference to the outcomes.



In context Using family therapy to involve partners in naltrexone treatment extends extra benefits to the family and provides (for both patient and clinic) a more convenient way to improve treatment compliance than contingency techniques which use material rewards. In this study the experience and competence of the counsellors and the total scheduled counselling time were equalised, leaving the presence or absence of family counselling as the main difference between the two groups. Though family counselling did improve naltrexone compliance, this did not account for the lasting benefits after treatment, suggesting that family counselling directly contributed to sustained remission. Why a family intervention worked in this study but not in others may be due to the directness of the behavioural approach which mandates daily reinforcement of abstinence-fostering behaviour. Also, because they seemed more prepared to try naltrexone, participants tended to be relatively young men with relatively short (about six years) histories of opiate use.

Other studies of the approach have tested it as a supplement to drug and non-drug based treatments and as a treatment in its own right ◤ *Additional reading*. Benefits for clients and their families (including children) have been found for men or women using cocaine, opiates, or alcohol, male methadone patients, and patients in disulfiram treatment for alcohol dependence. These studies also showed that among drug abusers (as opposed to alcoholics) it can be difficult to find suitable candidates because often their partners are also misusing substances.

A recent comparison of the research support for different alcohol treatments placed behavioural marital therapy towards the top of the list. Several other strongly supported approaches are not competing options but incorporate elements of (community reinforcement) or could be enhanced by (naltrexone, acamprosate) marital therapy.

Practice implications Behavioural couples therapy is applicable only to clients/patients with an intact live-in relationship with a non-dependent relative or partner. This will be the case for many (especially male) drinkers but usually not for long-term dependent users of cocaine or heroin. Among those who are eligible, studies indicate that most patients and their partners will engage with the therapy and that it will make a worthwhile contribution to reducing substance misuse problems and enhancing family harmony.

However, involvement of the patient's family in therapy is rare and does not usually follow behavioural principles, though these have the greatest research backing. The key task for commissioners and managers is to identify and overcome barriers to implementing such approaches. Time is one issue. The studies outlined above were careful to equalise the time commitment between couples therapy and comparison therapies, but nevertheless the commitment is considerable. One way forward would be to incorporate elements of the therapy into existing practice rather than to go for an all or nothing transformation. Also, an abbreviated version of the approach is currently being tested. Few professionals have been trained in these approaches and the dominant paradigm sees addiction as a disorder of the individual and treats it accordingly. As a result, drug workers do not prioritise the need for training in family or couples work. Current national occupational standards for drug and alcohol work do not explicitly incorporate competency in family/couples work. Further progress nationally may require this to be changed. Locally, services which wish to pioneer this approach can obtain the US manual (◤ *Contacts*) and adapt it to their needs.

LINKS Nugget 7.8 • *Take the network into treatment*, issue 10

Featured studies Fals-Stewart W. *et al.* "Behavioral family counseling and naltrexone for male opioid-dependent patients." *Journal of Consulting and Clinical Psychology*: 2003, 71(3), p. 432–442. Copies: apply DrugScope.

Additional reading O'Farrell T.J. *et al.* "Behavioral couples therapy for alcoholism and drug abuse." *Journal of Substance Abuse Treatment*: 2000, 18, p. 51–54. Copies: apply DrugScope.

Contacts William Fals-Stewart, Research Institute on Addictions, State University of New York at Buffalo, 1021 Main Street, Buffalo, New York 14203-1016, USA, wstewart@ria.buffalo.edu, www.ria.buffalo.edu/BFSweb/index.htm.

NUGGETTE

Convergent clues to how to match clients to therapeutic styles have emerged from research at a Philadelphia counselling service whose clients were typically poor, black, single unemployed cocaine users, and from an offshoot of Project MATCH involving mainly white, employed, dependent drinkers.

The Philadelphia report is a later analysis of a study previously featured in FINDINGS ◤ *Links*. Based on 80 patients randomly allocated to two styles of therapy, this had found that neither better overall but that some types of people did better in one than the other. Specifically, clients high in 'learnt helplessness' (feeling unable to control one's everyday life) did much better in structured therapy where the counsellor took the lead and focused on behaviour rather than emotions. Clients who felt more in control did better in a less structured therapy where the therapist facilitated self exploration and focused on feelings. With now 120 patients randomised, the new report confirms this finding for during-treatment measures including patient and therapist ratings of benefit, attendance, and number of drug-free urines, and finds that the matching effect persisted to six months after treatment on measures of drug, family, social and psychiatric problems.[1] Pre-treatment levels of depression (another relevant variable – more depressed clients did best in the more structured therapy) did not account for the findings: when depression was statistically 'evened out', learned helplessness was still just as or even more important.

For depression, corresponding findings emerged from a clinic which provided MATCH's three therapies as aftercare.[2] Over the first year after these ended patients with clinically elevated depressive symptoms drank or drank heavily on fewer days when the therapist avoided focusing on painful emotional material, on more when the therapist did the reverse.

LINKS Nuggets 9.3 7.4 *Project MATCH: unseen colossus*, issue 1

1 Thornton C.C. *et al.* "High- and low-structure treatments for substance dependence: role of learned helplessness." *American Journal of Drug and Alcohol Abuse*: 2003, 29(3), p. 567–584.
2 Karno M.P. *et al.* "Patient depressive symptoms and therapist focus on emotional material: a new look at Project MATCH." *Journal of Studies on Alcohol*: 2003, 64(5), p. 607–615.