Behavioral Couples Therapy for Alcoholism and Drug Abuse

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Learning Objectives

Participants in this CE Program will:
1. Understand clinical research findings supporting the use of behavioral couples therapy to treat alcoholism and drug abuse.
2. Learn a step-by-step model of behavioral couples therapy that promotes abstinence and teaches relationship skills.
3. Appreciate the importance of empirical research to support practice methods.
4. Examine the concept of codependency in light of empirical research.

I. OVERVIEW

The purpose of Behavioral Couples Therapy (BCT) is to build support for abstinence and to improve relationship functioning among married or cohabiting individuals seeking help for alcoholism or drug abuse. BCT sees the substance abusing patient with the spouse or live-in partner to arrange a daily “sobriety contract” in which the patient states his or her intent not to drink or use drugs and the spouse expresses support for the patient’s efforts to stay abstinent. For patients taking a recovery-related medication (e.g., disulfiram, naltrexone), daily medication ingestion witnessed and verbally reinforced by the spouse also is part of the contract. Self-help meetings and drug urine screens are part of the contract for most patients. BCT also increases positive activities and teaches communication skills.

Behavioral Couples Therapy for Alcoholism and Drug Abuse

- Purpose of BCT is to increase relationship factors conducive to abstinence
- Daily Sobriety Contract supports abstinence
- Behavioral therapy increases positive feelings, shared activities, and constructive communication
- BCT fits well with self-help groups, recovery medications and other counseling

Research shows that BCT produces greater abstinence and better relationship functioning than typical individual-based treatment and reduces social costs, domestic violence, and emotional problems of the couple’s children. Despite the strong evidence base supporting BCT, it is rarely used in substance abuse treatment programs. Low use of BCT may stem from the recency of studies on BCT, many of which were published in the past 10 years. Further, BCT clinical methods and the research supporting BCT have not been widely disseminated. This clinical guideline will acquaint substance abuse treatment program administrators and clinicians with BCT. Hopefully this will lead to increased use of BCT to the benefit of substance abusing patients and their families.

II. BACKGROUND FOR BEHAVIORAL COUPLES THERAPY

Meta-analytic reviews of randomized studies show more abstinence with family-involved treatment than with individual treatment in drug abuse and in alcoholism. Overall the effect size favoring family-involved treatments over individual-based treatments was classified as a medium-size effect. This effect size is 10 times greater than that observed for aspirin in preventing heart attacks, an effect considered important in medical research. Behavioral couples therapy (BCT) is the family therapy method with the strongest research support for its effectiveness in substance abuse.

Primary Clinical Outcomes: Abstinence and Relationship Functioning

Over 15 studies have compared substance abuse and relationship outcomes for substance abusing patients treated with BCT or individual counseling. Outcomes have been measured at 6-months follow-up in earlier studies and at 12-24 months after treatment in more recent studies. The studies show a fairly consistent pattern of more abstinence and fewer substance-related problems, happier relationships, and lower risk of couple separation and divorce for substance abusing patients who receive BCT than for patients who receive only more typical individual-based treatment. These results come from studies with mostly male alcoholic and drug abusing patients, but 2 recent studies show similar results with female alcoholic and drug abusing patients.

Studies of BCT Show

- BCT gives more abstinence, happier relationships, and fewer separations than individual (IND) Tx
- Benefit to cost ratio greater than 5:1
- Domestic violence is greatly reduced
- Children helped more by BCT than IND
- BCT also works with family members other than spouses
- BCT improves compliance with recovery medications (e.g., disulfiram, naltrexone)

Social Cost Outcomes and Benefit-to-Cost Ratio

Three studies (2 in alcoholism and 1 in drug abuse) have examined social cost outcomes after BCT. These social costs included costs for substance abuse-related health care, criminal justice system use for substance-related crimes, and income from illegal sources and public assistance. The average social costs per case decreased substantially in the 1-2 years after as compared to the year before BCT, with cost savings averaging $5,000 - $6,500 per case. Reduced social costs after BCT saved more than 5 times the cost of delivering BCT, producing a benefit-to-cost ratio greater than 5:1. Thus, for every dollar spent in delivering BCT, 5 dollars in social costs are saved. In addition, BCT was more cost-effective when compared...
with individual treatment for drug abuse and when compared with interactional couples therapy for alcoholism.

**Domestic Violence Outcomes**

A recent study examined male-to-female partner violence before and after BCT for 303 married or cohabiting male alcoholic patients. There was also a demographically matched comparison sample of couples without alcohol problems. In the year before BCT, 60% of alcoholic patients had been violent toward their female partner, five times the comparison sample rate of 12%. In the year after BCT, violence decreased significantly to 24% of the alcoholic sample but remained higher than the comparison group. Among remitted alcoholics after BCT, violence prevalence of 12% was identical to the comparison sample and less than half the rate among relapsed patients (30%). Results for the second year after BCT were similar to the first year. An earlier study found nearly identical results. Thus, these 2 studies showed that male-to-female violence was significantly reduced in the first and second year after BCT and that it was nearly eliminated with abstinence.

Two recent studies showed that BCT reduced partner violence and couple conflicts better than individual treatment. Among male drug abusing patients, while nearly half of the couples reported male-to-female violence in the year before treatment, the number reporting violence in the year after treatment was significantly lower for BCT (17%) than for individual treatment (42%). Among male alcoholic patients, those who participated in BCT reported less frequent use of maladaptive responses to conflict (e.g., yelling, name-calling, threatening to hit, hitting) during treatment than those who received individual treatment. These results suggest that in BCT couples do learn to handle their conflicts with less hostility and aggression.

**Impact of BCT on the Children of Couples Undergoing BCT**

Kelley and Fals-Stewart conducted 2 studies (1 in alcoholism, 1 in drug abuse) to find out whether BCT for a substance abusing parent, with its demonstrated reductions in domestic violence and reduced risk for family breakup, also has beneficial effects for the children in the family. Results were the same for children of male alcoholic and male drug abusing fathers. BCT improved children’s functioning in the year after the parents’ treatment more than did individual-based treatment or couple psychoeducation. Only BCT showed reduction in the number of children with clinically significant impairment.

**Integrating BCT with Recovery Related Medication**

BCT has been used to increase compliance with a recovery-related medication. Fals-Stewart and O’Farrell compared BCT with individual treatment for male opioid patients taking naltrexone. BCT patients, compared with their individually treated counterparts, had better naltrexone compliance, greater abstinence, and fewer substance-related problems. Fals-Stewart, O’Farrell and Martin found that BCT produced better compliance with HIV medications among HIV-positive drug abusers in an outpatient drug abuse treatment program that did treatment as usual. BCT also has improved compliance with pharmacotherapy in studies of disulfiram for alcoholic patients and in an ongoing pilot study of naltrexone with alcoholics.

**BCT with Family Members Other than Spouses**

Most BCT studies have examined traditional couples. However, some recent studies have expanded BCT to include family members other than spouses. These studies have targeted increased medication compliance as just described. For example, in the study of BCT and naltrexone with opioid patients, family members taking part were spouses (49%), parents (36%), and siblings (15%). In the study of BCT and HIV medications among HIV-positive drug abusers, significant others who took part were: a parent or sibling (67%), a same-sex (12%) or opposite-sex (9%) partner, or a roommate (12%).

### Suitable Cases for BCT

- Married or cohabiting couples
- Reside together or reconcile
- Not psychotic past 90 days
- Not high risk of injurious/lethal violence
- Start after detox, rehab, or no prior Tx

**Needed Research**

In terms of future directions, we do need more research on BCT, to replicate and extend the most recent advances, especially for women patients and broader family constellations. Research on BCT for couples in which both the male and female member have a current substance use problem is particularly needed because prior or BCT studies have not addressed this difficult clinical challenge. Even more than additional research, we need technology transfer so that patients and their families can benefit from what we have already learned about BCT for alcoholism and drug abuse.

III. CLINICAL GUIDELINE FOR BEHAVIORAL COUPLES THERAPY

BCT works directly to increase relationship factors conducive to abstinence. A behavioral approach assumes that family members can reward abstinence -- and that alcoholic and drug abusing patients from happier, more cohesive relationships with better communication have a lower risk of relapse. The substance abusing patient and the spouse are seen together in BCT, typically for 12-20 weekly outpatient couple sessions over a 3-6 month period. BCT can be an adjunct to individual counseling or it can be the only substance abuse counseling the patient receives. Generally couples are married or cohabiting for at least a year, without current psychosis, and one member of the couple has a current problem with alcoholism and/or drug abuse. The couple starts BCT soon after the substance abuser seeks help. BCT can start immediately after detoxification or a short-term intensive rehab program or when the substance abuser seeks outpatient counseling. The remainder of this guideline is written in the form of instructions to a counselor who wants to use BCT.

To engage the spouse and the patient together in BCT, first get the substance abusing patient’s permission to contact the spouse. Then talk directly to the spouse to invite him or her for an initial BCT couple session. The initial BCT session involves assessing substance abuse and relationship functioning and gaining commitment to starting BCT. You start first with substance-focused interventions that continue throughout BCT to promote abstinence. When abstinence and attendance at BCT sessions have stabilized for a month or so, you add relationship-focused interventions to in-

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creases positive activities and teach communication. These specific BCT interventions are described in detail next.

**Substance-Focused Interventions in BCT: Daily Sobriety Contract**

You can arrange what we call a daily Sobriety Contract or Recovery Contract. The first part of the contract is the “sobriety trust discussion.” In it, the patient states his or her intent not to drink or use drugs that day (in the tradition of one day at a time) and the spouse expresses support for the patient’s efforts to stay abstinent. For patients taking a recovery-related medication (e.g., disulfiram, naltrexone), daily medication ingestion witnessed and verbally reinforced by the spouse also is part of the contract. The spouse records the performance of the daily contract on a calendar you give him or her. Both partners agree not to discuss past drinking or fears about future drinking at home to prevent substance-related conflicts which can trigger relapse, reserving these discussions for the therapy sessions. At the start of each BCT session, review the Sobriety Contract calendar to see how well each spouse has done their part. Have the couple practice their trust discussion (and medication taking if applicable) in each session to highlight its importance and to let you see how they do it. Twelve-step or other self-help meetings are a routine part of BCT for all patients who are willing. Urine drug screens taken at each BCT session are included in BCT for all patients with a current drug problem. If the Sobriety Contract includes 12-step meetings or urine drug screens, these are also marked on the calendar and reviewed. The calendar provides an ongoing record of progress that you reward verbally at each session.

**Sobriety Contract**

<table>
<thead>
<tr>
<th>• Daily Sobriety Trust Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Alcohol/drug abuser states intention to stay abstinent that day</td>
</tr>
<tr>
<td>• Spouse thanks alcohol/drug abuser for efforts to stay abstinent</td>
</tr>
<tr>
<td>• Medication to aid recovery</td>
</tr>
<tr>
<td>• Self-help involvement</td>
</tr>
<tr>
<td>• Weekly drug urine screens</td>
</tr>
<tr>
<td>• Calendar to record progress</td>
</tr>
</tbody>
</table>

**Sobriety Contract Case Example #1.** Mary was a 34-year old teacher’s aide in an elementary school who had a serious drinking problem and also smoked marijuana daily. She was admitted to a detoxification unit at a community hospital after being caught drinking at work and being suspended from her job. Her husband Jack worked in a local warehouse and was a light drinker with no drug involvement. Mary and Jack had been married 8 years, and Jack was considering leaving the marriage, when the staff at the detoxification unit referred them to the behavioral couples therapy program.

The therapist developed a contract in which Mary agreed to a daily “trust discussion” in which she stated to Jack her intent to stay “clean and sober” for the next 24 hours and Jack thanked her for her commitment to sobriety. The couple practiced this ritual in the therapist’s office until it felt comfortable, and then also performed the discussion at each weekly therapy session on Wednesday evening. They did this part of the contract nearly every day, missing only on an occasional Saturday because their schedule was different that day and sometimes they forgot. Mary agreed to at least two AA meetings each week and actually attended 3 meetings per week for the first two months. Jack was pleased to see Mary going to AA and not drinking. However, he was upset that weekly drug urine screens were positive for marijuana for the first few weeks, taking this as evidence that his wife was still smoking marijuana even though she denied it. The therapist explained that marijuana could stay in the system for some time particularly in someone who had been a daily pot smoker. The therapist suggested Jack go to Al-Anon to help him deal with his distress over his wife’s suspected drug use. After a few weeks, the drug screens were negative for marijuana and stayed that way lending further credence to Mary’s daily statement of intent. Jack found Al-Anon helpful and the couple added to their contract that one night a week they would go together to a local church where Mary could attend an AA meeting and Jack could go to an Al-Anon meeting.

**Sobriety Contract with a Recovery Medication**

A medication to aid recovery is often part of BCT. Medications include Naltrexone for heroin-addicted or alcoholic patients and Antabuse (disulfiram) for alcoholic patients. Antabuse is a drug that produces extreme nausea and sickness when the person taking it drinks. As such it is an option for drinkers with a goal of abstinence. Traditional Antabuse therapy often is not effective because the drinker stops taking it. The Antabuse Contract, also part of the Community Reinforcement Approach, significantly improves compliance in taking the medication and increases abstinence rates. In the Antabuse Contract, the drinker agrees to take Antabuse each day while the spouse observes. The spouse, in turn, agrees to positively reinforce the drinker for taking the Antabuse, to record the observation on a calendar you provide them, and not to mention past drinking or any fears about future drinking. Each spouse should view the agreement as a cooperative method for rebuilding lost trust and not as a coercive checking-up operation. Before negotiating such a contract, make sure that the drinker is willing and medically cleared to take Antabuse and that both the drinker and spouse have been fully informed and educated about the effects of the drug. This is done by the prescribing physician but double check their level of understanding about it.

**Sobriety Contract Case Example #2.** The next case is Bill Jones, a 42-year old truck driver with a chronic alcoholism problem, and his wife Nancy who drank only occasionally. The staff at the detoxification unit also referred this couple to our program. Daily Antabuse observed and reinforced by the wife was part of their contract in addition to the daily trust discussion in which Bill stated his intent to stay sober. Drug urine screens were not part of the contract because Bill did not have a problem with any substance other than alcohol. The therapist thought each member of the couple was a good candidate to benefit from 12-step meetings, but Bill refused AA and Nancy was reluctant to attend Al-Anon. Thus, 12-step meetings were not part of their contract. During the first 2 weeks of trying out the contract, the couple were inconsistent in performing the contract due to logistical problems and to their continued anger and distrust with each other -- a common problem. The therapist worked with the couple to overcome these problems and the couple eventually did the contract consistently each day and felt it helped them. After 6 months Bill stopped taking Antabuse, but the daily trust discussion was continued for an
additional 6 months and this proved a satisfactory arrangement for both Bill and Nancy.

**Other Support for Abstinence**

Reviewing urges to drink or use drugs experienced in the past week is part of each BCT session. This includes thoughts and temptations that are less intense than an urge or a craving. Discussing situations, thoughts and feeling associated with urges helps identify potential triggers or cues for alcohol or drug use. It can help alert you to the possible risk of a relapse. It also identifies successful coping strategies (e.g., distraction, calling a sponsor) the patient used to resist an urge and builds confidence for the future.

**Other Support for Abstinence**
- **Reviewing urges to drink or use drugs**
  - Helps identify substance use triggers
  - Resisting urges builds confidence
- **Crisis intervention for substance use**
  - Get substance use stopped quickly
  - Use as a learning experience

Crisis intervention for substance use is an important part of BCT. Drinking or drug use episodes occur during BCT as with any other treatment. BCT works best if you intervene before the substance use goes on for too long a period. In an early BCT session, negotiate an agreement that either member of the couple should call you if substance use occurs or if they fear it is imminent. Once substance use has occurred, try to get it stopped and to see the couple as soon as possible to use the relapse as a learning experience. At the couple session, you must be extremely active in defusing hostile or depressive reactions to the substance use. Stress that drinking or drug use does not constitute total failure, that inconsistent progress is the rule rather than the exception. Help the couple decide what they need to do to feel sure that the substance use is over and will not continue in the coming week (e.g., restarting recovery medication, going to AA and Al-Anon together, reinstituting a daily Sobriety Contract, entering a detoxification unit). Finally, try to help the couple identify what trigger led up to the relapse and generate alternative solutions other than substance use for similar future situations.

**Relationship-Focused Interventions in BCT**

Once the Sobriety Contract is going smoothly, the substance abuser has been abstinent and the couple has been keeping scheduled appointments for a month or so, you can start to focus on improving couple and family relationships. Family members often experience resentment about past substance abuse and fear and distrust about the possible return of substance abuse in the future. The substance abuser often experiences guilt and a desire for recognition of current improved behavior. These feelings experienced by the substance abuser and the family often lead to an atmosphere of tension and unhappiness in couple and family relationships. There are problems caused by substance use (e.g., bills, legal charges, embarrassing incidents) that still need to be resolved. There is often a backlog of other unresolved couple and family problems that the substance use obscured. The couple frequently lacks the mutual positive feelings and communication skills needed to resolve these problems. As a result, many marriages and families are dissolved during the first 1 or 2 years of the substance abuser’s recovery. In other cases, couple and family conflicts trigger relapse and a return to substance abuse. Even in cases where the substance abuser has a basically sound marriage and family life when he or she is not abusing substances, the initiation of abstinence can produce temporary tension and role readjustment and provide the opportunity for stabilizing and enriching couple and family relationships. For these reasons, many alcohol abusers can benefit from assistance to improve their couple and family relationships.

Two major goals of interventions focused on the drinker’s couple/family relationship are (a) to increase positive feeling, goodwill, and commitment to the relationship; and (b) to teach communication skills to resolve conflicts, problems, and desires for change. The general sequence in teaching couples and families skills to increase positive activities and improve communication is (a) therapist instruction and modeling, (b) the couple practicing under your supervision, (c) assignment for homework, and (d) review of homework with further practice.

**Increasing Positive Activities**

Catch Your Partner Doing Something Nice. A series of procedures can increase a couple’s awareness of benefits from the relationship and the frequency with which spouses notice, acknowledge, and initiate pleasing or caring behaviors on a daily basis. Tell the couple that caring behaviors are “behaviors showing that you care for the other person,” and assign homework called “Catch Your Partner Doing Something Nice” to assist couples in noticing daily caring behaviors. This requires each spouse to record one caring behavior performed by the partner each day on sheets you provide them. The couple reads the caring behaviors recorded during the previous week at the subsequent session. Then you model acknowledging caring behaviors (“I liked it when you _______. It made me feel ______________”), noting the importance of eye contact; a smile; a sincere, pleasant tone of voice; and only positive feelings. Each spouse then practices acknowledging caring behaviors from his or her daily list for the previous week.

**Increasing Positive Activities**
- Catch Your Partner Doing Something Nice
- Caring Day Assignment
- Shared Rewarding Activities

### **Catch Your Partner Doing Something Nice**

<table>
<thead>
<tr>
<th>Name: Mike</th>
<th>Partner’s Name: Nancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAY</strong></td>
<td><strong>DATE</strong></td>
</tr>
<tr>
<td>MON 4/6</td>
<td>Waited to have dinner with me when I had to stay late at work</td>
</tr>
<tr>
<td>TUES 4/7</td>
<td>Told me she loved me</td>
</tr>
<tr>
<td>WED 4/8</td>
<td>Cooked a delicious dinner</td>
</tr>
<tr>
<td>THUR 4/9</td>
<td>Was patient with me when I came home tired and moody from work</td>
</tr>
<tr>
<td>FRI 4/10</td>
<td>Enjoyed a walk together</td>
</tr>
<tr>
<td>SAT 4/11</td>
<td>Woke me gently and rubbed my back</td>
</tr>
<tr>
<td>SUN 4/12</td>
<td>Helped plan a picnic with friends</td>
</tr>
</tbody>
</table>
gins initiating more caring behaviors. Often the weekly reports of daily caring behaviors show that one or both spouses are fulfilling requests for desired change voiced before the therapy. In addition, many couples report that the 2-5 minute communication sessions result in more extensive conversations.

Caring Day. A final assignment is that each partner give the other a “Caring Day” during the coming week by performing special acts to show caring for the spouse. Encourage each partner to take risks and to act lovingly toward the spouse rather than wait for the other to make the first move. Finally, remind spouses that at the start of therapy they agreed to act differently (e.g., more lovingly) and then assess changes in feelings, rather than wait to feel more positively toward their partner before instituting changes in their own behavior.

Planning Shared Rewarding Activities. Many substance abusers’ families stop shared recreational and leisure activities due to strained relationships and embarrassing substance-related incidents. Reversing this trend is important because participation by the couple and family in social and recreational activities improves substance abuse treatment outcomes. Planning and engaging in shared rewarding activities can be started by simply having each spouse make a separate list of possible activities. Each activity must involve both spouses, either by themselves or with their children or other adults and can be at or away from home. Before giving the couple homework of planning a shared activity, model planning an activity to illustrate solutions to common pitfalls (e.g., waiting until the last minute so that necessary preparations cannot be made, getting sidetracked on trivial practical arrangements). Finally, instruct the couple to refrain from discussing problems or conflicts during their planned activity.

**Teaching Communication Skills**

We generally begin our work on training in communication skills by defining effective communication as “message intended (by speaker) equals message received (by listener)” and emphasizing the need to learn both “listening” and “speaking” skills. The chart presented below helps expand this definition further including factors (e.g., “filters”) in each person that can impede communication. Teaching couples communication skills of listening and speaking and how to use planned communication sessions are essential prerequisites for negotiating desired behavior changes. Start this training with non-problem areas that are positive or neutral and move to problem areas and emotionally charged issues only after each skill has been practiced on easier topics.

**Listening Skills.** Good listening helps each spouse to feel understood and supported and to slow down couple interactions to prevent quick escalation of aversive exchanges. Instruct spouses to repeat both the words and the feelings of the speaker’s message and to check to see if the message they received was the message intended by their partner (“What I heard you say was_________. Is that right?”) When the listener has understood the speaker’s message, roles change and the first listener then speaks. Teaching a partner to communicate support and understanding by summarizing the spouse’s message and checking the accuracy of the received message before stating his or her own position is often a major accomplishment that has to be achieved gradually. A partner’s failure to separate understanding the spouse’s position from agreement with it often is an obstacle that must be overcome.

**Expressing Feelings Directly.** Expressing both positive and negative feelings directly is an alternative to the blaming, hostile, and indirect responsibility-avoiding communication behaviors that characterize many substance abusers’ relationships. Emphasize that when the speaker expresses feelings directly, there is a greater chance that he or she will be heard because the speaker says these are his or her feelings, his or her point of view, and not some objective fact about the other person. The speaker takes responsibility for his or her own feelings and does not blame the other person for how he or she feels. This reduces listener defensiveness and makes it easier for the listener to receive the intended message. Present examples of differences between direct expressions of feelings and indirect and ineffective or hurtful expressions. The use of statements beginning with “I” rather than “you” is emphasized. After presenting the rationale and instructions, model correct and incorrect ways of expressing feelings and elicit the couple’s reactions to these modeled scenes. Then have the couple role-play a communication session in which spouses take turns being speaker and listener, with the speaker expressing feelings directly and the listener using the listening response. During this role-playing, coach the couple as they practice reflecting the direct expressions of feelings. Assign for homework similar communication sessions, 10-15 minutes each, three to four times weekly. Subsequent therapy sessions involve more practice with role-playing, both during the sessions and for homework. Increase in difficulty each week the topics on which the couple practices.

**Communication Sessions.** These are planned, structured discussions in which spouses talk privately, face-to-face, without distractions, and with each spouse taking turns expressing his or her point of view without interruptions. Communication sessions can be introduced for 2-5 minutes daily when couples first practice acknowledging caring behaviors, and in 10-15 minute sessions three to four times a week in later sessions when the couple discusses current relationship problems or concerns. Discuss with the couple the time and place that they plan to have their assigned communication practice sessions. Assess the success of this plan at the next session, and suggest any needed changes. Just establishing a com-
munication session as a method for discussing feelings, events, and problems can be very helpful for many couples. Encourage couples to ask each other for a communication session when they want to discuss an issue or problem, keeping in mind the ground rules of behavior that characterize such a session.

Negotiating for Requests. Many changes that spouses desire from their partners can be achieved through the aforementioned caring behaviors, rewarding activities, communication and problem-solving skills. However, deeper, emotion-laden conflicts that have caused considerable hostility and coercive interaction for years are more resistant to change. Learning to make positive specific requests and to negotiate and compromise can lead to agreements to resolve such issues.

Positive specific requests are an alternative to the all-too-frequent practice of couples complaining in vague and unclear terms and trying to coerce, browbeat, and force the other partner to change. For homework each partner lists at least five requests. Negotiation and compromise comes next. Spouses share their lists of requests, starting with the most specific and positive items. Give feedback on the requests presented and help rewrite items as needed. Then explain that negotiating and compromising can help couples reach an agreement in which each partner will do one thing requested by the other. After giving instructions and examples, coach a couple while they have a communication session in which requests are made in a positive specific form, heard by each partner, and translated into a mutually satisfactory, realistic agreement for the upcoming week. Finally, record the agreement on a homework sheet that the couple knows you will review with them during the next session. Such agreements can be a major focus of a number of BCT sessions.

Maintenance and Relapse Prevention

Methods to ensure long-term maintenance of the changes in substance problems made through BCT are beginning to receive attention. We use three general methods during the maintenance phase of treatment, defined somewhat arbitrarily as the phase that begins after at least 3-6 consecutive months of abstinence have been achieved. First, plan maintenance prior to the termination of the active treatment phase.

This involves helping the couple complete a Continuing Recovery Plan that specifies which of the behaviors from the previous BCT sessions they wish to continue (e.g., daily Sobriety Contract, AA meetings, shared rewarding activities, communication sessions). Second, anticipate what high-risk situations for relapse may occur after treatment. Discuss and rehearse possible coping strategies that the substance abuser and spouse can use to prevent relapse when confronted with such situations. Third, discuss and rehearse how to cope with a relapse if it occurs. A specific relapse plan, written and rehearsed prior to ending active treatment, can be particularly useful. Early intervention at the beginning of a relapse episode is essential: impress the couple with this point. Often, individuals wait until the substance use has reached dangerous lev-

We suggest continued contact with the couple/family via planned in-person and telephone follow-up sessions, at regular and then gradually increasing intervals, preferably for 3 to 5 years after a stable pattern of recovery has been achieved. Use this ongoing contact to monitor progress, to assess compliance with the Continuing Recovery Plan, and to evaluate the need for additional therapy sessions. You must take responsibility for scheduling and reminding the family of follow-up sessions and for placing agreed-upon phone calls so that continued contact can be maintained successfully. Tell couples the reason for continued contact is that substance abuse is a chronic health problem that requires active, aggressive, ongoing monitoring to prevent or to quickly treat relapses for at least 5 years after an initial stable pattern of recovery has been established. The follow-up contact also provides the opportunity to deal with couple and family issues that appear after a period of recovery.

Contraindications for BCT

A few contraindications for BCT should be considered. The first is current psychosis for either the alcoholic patient or the family member. The second is an acute risk of severe family violence with a potential for serious injury or death. Cases with less severe forms of family violence can be treated successfully in BCT. In such cases, conflict containment is an explicit goal of the therapy from the outset, and you will need to take specific steps to avoid violence (for more details see O’Farrell & Murphy, 2002). Most of the partner violence seen in patients seeking substance abuse treatment is not the severe terrorist violence seen in court mandated batterers for whom BCT is not appropriate. Third, couples in which there is a court-issued restraining order for the spouses not to have contact with each other should not be seen together in therapy until the restraining order is lifted or modified to allow contact in counseling. Finally, if the spouse also has a current alcohol or drug problem, BCT may not be effective. In the past, we have often taken the stance that if both members of a couple have a substance use problem, then we will not treat them together unless one member of the couple has at least 90 days abstinence. However, in a recent project we successfully treated over 20 couples in which both the male and female partner had a current alcoholism problem. If both members of the couple want to stop drinking or if this mutual decision to change can be reached in the first few sessions, then BCT may be workable.

Relapse Prevention Plan

- Identify high risk situations and early warning signs
- Formulate and rehearse plan to
  - Prevent relapse;
  - Minimize duration and negative consequences of substance use if it occurs
The Codependency Idea: When Caring Becomes a Disease


The now tenacious attachment of the disease model and 12-step philosophy to caring behavior, commonly known as codependency, represents to me the most confusing, and iatrogenic ideas in the realm of clinical psychology. This popular construct is shunned by research psychologists and behaviorally-oriented clinical psychologists particularly for its lack of empirical support. The allure of codependency is demonstrated by the sales of books on the topic (the only resources on codependency come from self-help sections and fluffy journals). Millions of codependency books have been sold over the past ten years. One of the more popular ones, Codependency No More, by Mellody Beattie, has sold over three million copies (according to the publisher). This one is also available on audio cassette, for those codependents on the move.

Where Did Codependency Come From?

Co-dependent, or co-alcoholic, was originally defined in the late 1970s and early 1980s to help families and spouses of individuals with alcohol and drug problems. Mostly in line with family systems ideas, the model addressed the family members, especially wives, who “interfered” with the recovery. It was suggested that their behavior made it less difficult for the addict to continue drinking or using drugs. The idea was that the caring behavior manifested by family members and spouses actually “enabled” the addict to continue using. At first glance, the emphasis on the family was certainly a welcome step. Regardless of theoretical orientation working with a substance abuser in isolation, who is in an intimate relationship, is missing a rich opportunity to recruit more players into the change agenda. Unfortunately, from the mid-eighties to the present, the codependency idea has become bastardized, and with each new self-help book the symptoms of codependency mount. It is literally impossible for anyone walking the planet, with a fourth grade English reading capacity, to finish one of these books and not consider the possibility that he or she is a codependent. What began as a term to help spouses of addicts encourage sobriety and not inadvertently make it easy to continue, the codependency movement of the 80s and 90s has thrown the baby out with the bath water: Not only is all caring manifested by the spouse of an alcoholic deemed pathological, but the very act of compromising one’s needs to aid a loved one is now deemed symptomatic of a progressive disease processes, a relationship addiction.

I’ve read a fair amount of what the popular press has bequeathed upon us regarding the codependency idea. The three books I scrutinized the most were the most popular. They were Facing Codependency, by Pia Mellody, Codependency No More, by Melody Beattie and Codependency, Misunderstood, Mistrated. by Anne Wilson Schaef. It is my understanding that the majority of people who consider themselves “versed” in the codependency idea, gained at least some of their knowledge from one or more of these three books. Below is my understanding of these authors’ conceptualizations:

Codependency is a progressive disease brought about by child abuse, which takes the form of anything “less than nurturing.” Codependency is epidemic (maybe all of us are codependent) and defines a vast array of psychological and physical symptoms. The caring manifested by codependents is an unconscious effort to keep repressed pain at bay, and the codependent actually contributes to the addictive behavior of their loved ones by enabling. Enabling keeps the loved one addicted so the codependent can go on caring to gain a sense of self worth. Recovery from codependency requires drastic attitude and lifestyle change (Detachment) and a lifelong commitment to the 12-step regime.

Why would a psychologist wish to criticize the codependency idea? Many people claim to have been helped by codependency books and codependency self-help groups. I don’t wish to take away anyone’s belief that they are better for having integrated the codependency idea into their lifestyles. But it definitely isn’t for everyone. Codependency is a nebulous idea, born not of science but of the gut feelings of counselors and frustrated lay people. It’s black and white requirements for recovery, though seeming reasonable on the surface, are not in line with empirical research and have dangerous implications with regard to the most human of attributes, caring. My two primary concerns with the codependency idea are:

- The Codependency Idea Pathologizes the Natural Tendency to Care for Others.
- The cure for Codependency Mandates Action which is Not Necessarily in Line With Prosocial Values.

IV. SUMMARY

The purpose of Behavioral Couples Therapy is to build support for abstinence and to improve relationship functioning among married or cohabiting individuals seeking help for alcoholism or drug abuse. Research shows that BCT produces greater abstinence and better relationship functioning than typical individual-based treatment and reduces social costs, domestic violence, and emotional problems of the couple’s children. BCT fits well with 12-step or other self-help groups, individual or group substance abuse counseling, and recovery medications. We hope this clinical guideline will lead to increased use of BCT to the benefit of substance abusing patients and their families.

Family Involvement in the Treatment of Addictions

These articles discuss the importance of using empirically-based methods for the treatment of addictions. The first article presents a well-researched model for behavioral couples therapy for alcohol and drug abuse. The second article critiques the concept of codependency for its lack of empirical support.

WHY THE ALLURE?
Lots of different people buy codependency books. For the most part I’ve found that people who buy them are having problems being assertive in their relationships. I imagine that a fair number of people are able to extract a few tips from these books which help them feel more confident, more able to voice their needs appropriately and more efficient at carrying them out. However, these three books are about more than just being unassertive and needing a few tips toward being more independent. What is conjected is an underlying disease process, a progressive malady which will end in death if gone untreated. They also list symptom after symptom after symptom which weaves a net large enough to include just about any reader.

Do people want to be included in this net? I think many do. What is so attractive about being a victim of a disease? Simply, it renders one in control. Crazy as it sounds, when relationships aren’t panning out and life is riddled with pain, anxiety, loneliness and poor decisions regarding our intimate partners, nothing quenches thirst better than an all-inclusive diagnosis. Enduring negative emotional states or repeated life upsets are no longer deemed maladaptive habits, skill deficits or the function distorted principles and styles of thinking, but diseases.

Accountability for our happiness is a scary thing. Codependency allows one to relinquish responsibility for our frustrating lifestyles. Plus we can dump all the blame on our parents, something the psychodynamic people have been advocating for almost a century.

**ALTERNATIVES**

**Caring for an Addicted Person is Not Synonymous with Pathology**

After reading these 3 books I felt quite gloomy. I kept conjuring images of women in very difficult situations trying desperately to make order in their lives receiving the message that their compassion and caring are character flaws, needing to be abandoned for overall psychological health. I’ve heard anecdotes from clients who report that they were told by addiction counselors that they had to evict their child, or spouse in order to help them, that there is absolutely no way that they could aid in helping their family member change other than complete detachment. Or I imagine people who are selfish already and unhappy with their lifestyles coming to the conclusion after reading one or two of these books that they meet the criteria for codependency (a sociopath would find enough criteria in Beattie’s book). I’ve been to parties and had acquaintances report that they were working on “codependency issues” and almost inhaled my pate. Some of these folks need a dose of codependency! Selfish people aligning themselves with the codependency idea certainly makes sense, because it affords license to be more selfish. But this isn’t as much of a concern to me as the people who have the capacity for genuine empathy and have instilled strong values for kind treatment toward others getting the message that to act on it (unless it’s reciprocated in equivalent allotments) is wrong. Empathy is good and caring is good. Friendships which last are usually based on mutual caring and even occasional self-sacrifice. Melody Beattie’s idea that relationships should always be equitable reflects the temperament of a five-year old. And with regard to the notion that being in a relationship with someone who is addicted is synonymous with pathology, Absurd. There is no empirical data to support the belief that being a member of a family in which there is addiction warrants diagnosis of a personality disorder (e.g. Gomberg,1989).

No more flagrant was this mind set that caring for an addicted person is an illness articulated than in Ann Wilson Sheff’s book. She recklessly articulates that mental health practitioners, are, by definition codependent, her words: “The mental health field has simply not identified the addictive process and the syndrome of codependency because people in the field are non-recovering codependents who have not recognized that their professional practice is closely linked with the practice of their untreated disease.” (95). I hope my colleagues share my belief that helping people as a profession brings tremendous feelings of agency and is in no way a flaw. What would these authors recommend that mental health professionals do to address this untreated ailment, I hope it is not the same advise non-professionals are offered, detachment.

**The Idea that the Caring Partner is Somehow Responsible for the Endurance of the Addictive Behavior**

Judith Gordon and Kimberly Barret, in an excellent critique of the codependency movement, write that this mind set presents a “divide and conquer attitude toward addictive families.(323). Schaeff, without a page of empirical data to back it up, recklessly suggests that alcoholism is a “family disease.” She conjeets, “The entire family is affected and each member plays a role in helping the disease perpetuate itself.” (9). Moos, Finney and Cronkite (1990) found that, contrary to the idea that caring for an addict perpetuates the addiction, families with a broad range of supportive behaviors actually correlate with success in maintaining sobriety.

A case from several years ago comes to mind involving a caring mother who’s 27-year old daughter had been abusing prescription opioids and benzodiazepines for ten years. The daughter finally made the decision to attempt a methadone detox, following two months of methadone maintenance. The MD at the methadone clinic recommended that she taper the benzodiazapine, which was Valium (methadone doesn’t cover non-opiate drugs). The mother was very invested in her daughter’s change efforts and subsequently flew in from out of state to live with her while she detoxed. She agreed to dole out the Valium because the daughter felt that she could not do it on her own without relapsing. The mother hid them in her car and stood watch over her daughter during the first three weeks of her transition. The patient voiced that her mother’s presence was imperative for relapse prevention at this time. The mother voiced that it made her feel as though she was needed tenacity to their standards. Many are given such guidance
and are left in a complete quandary. The mother’s contention was
that her daughter was completely responsible for her choice to use
or not use. She recognized that her daughter had crippling prob-
lems with anxiety and panic and had used the drugs to medicate
these states. Though her daughter made the choices, she felt that
there was a way she could help her daughter follow through with
her motivation to better her life. She knew that if she went back
home, her daughter would relapse and that relapse at this point
would be devastating to her daughter, who had tried just about ev-
every method of quitting imaginable. She fathomed that her daugh-
ter might discount the whole methadone choice and revert to pre-
scription drug abuse again.

Alternatives to the Enabling idea are:

1. No one can cause another person’s addictive behavior.
Addictive behaviors are learned habits fueled by expectancies
that following through with the behavior will bring about ease, comfort, or the reduction of something
negative.

2. Caregiving is not enabling. Caregiving is fueled by the
capacity to experience empathy and the desire to make
the lives of our intimates more happy. One of the most
robust indicators for a positive outcome from most psy-
chiatric maladies is social support.

3. What works in one relationship will not necessarily work
in others, and what used to work in one relationship
may be ineffective given new circumstances. This does
not mean that the previous behaviors need to be aban-
don, or viewed as pathogenic. It means that those in
a relationship with an addicted person need to evaluate
whether modification of one or several behaviors would
aid in the motivation to change on behalf of the addicted
person.

The Idea That “Less than Nurturing”
Experiences are Necessarily Traumatic

We expect relief--quick relief. We are fortunate to live in a time
when quick relief for many of the discomforts of life is available,
often at a very low price. We not only have remedies for such
nuisances as a headache, we can choose between ibuprofen, ac-
etaminophen or aspirin, depending on your preferred means of
pain relief. We live in an age in which people believe that life
should be fair and comfortable. You don’t have to go back very
many decades to be assured that things are pretty fair and comfort-
able these days relative to the lifestyles of our ancestors. I imag-
ine if one of these codependency books was published a century
ago there would be very few who would have taken it seri-
ously. Imagine a family migrating west in the 1800s, just barely sur-
viving. Imagine an exhausted wife and mother bouncing along
in a horse led wagon, face chapped from the sweltering midday
heat. She opens up Pia Mellody’s book as she breast feeds her in-
fant while leaning on a loaded shot gun and nursing her husband’s
wounded arm. Her eyes open wide. She says to herself? “What?
a disease of caring?” “I need to relive the “shame” of my child-
hood and hold all the “bad” people accountable, detach and learn
to live for myself because I don’t have to take care of anyone but
myself?” You can bet Beattie’s book would be fire bait that cold
dessert night.

The codependency idea offers an easy route to relief in this age of
quick cure. In fact, Melody Beattie says “It is not only fun, it is
simple (54). At last people who are angry, frustrated, bored, unhappy,
clingy, irrational, or guilt ridden can have a diagnosis. What’s
even more fun is we get to reexamine our childhoods, our fami-
lies, Everyone’s favorite soap opera, as Wendy Kamminer writes
in I’m Dysfunctional You’re Dysfunctional. Codependency man-
dates a poignant story. We get to ask, “How did I become code-
pendent? Mellody will respond, “Carried Feelings.” She will of-
fer an electrical circuit analogy. You, the child, because of your ill
developed boundaries were literally a conduit for the intense feel-
ings of shame which were discharged by your parents. As a child
you incorporated these into a “shame core” which is manifested in
your “shame attacks” today. You will pass on shame cores to your
children unless you unleash the bottled up pain today.

It is recommended that codependents do an inventory of all “less
than nurturing” experiences of childhood. Pia Mellody asks that
you look at your life from birth to age 17 and identify all the peo-
ple responsible for “abusing you.” No attempt should be made to
make excuses for the offenders in our lives or to tell ourselves that
they didn’t mean it, even if they didn’t mean it. These perpetra-
tors include, first and foremost, our mothers and fathers, but also
siblings, extended family and members of the community, such as
neighbors and teachers and angry garbage men.

Mellody Beattie recommends that we grieve. The purpose of “grief
work” is to “separate the abuse from the precious child (118).”
This is an actual mandate for recovery, “We must purge from our
bodies the childhood feeling reality we have about being abused.
The only way we can connect the feeling reality to what happened
is to know what happened (122).”

I think few, if any, events rival physical and sexual abuse in terms
of the horrible effects that can plague the victim in later life. Talking about these events, identifying the offender and disputing
the victim’s ideas that she is responsible are integral to adult psy-
chological health. However, these authors are talking about more
than physical and sexual abuse. In fact, they pay lip service to the
horrors of child abuse by deeming any event in which our parents
were harsh, impatient or unfair as abuse. All of the events men-
tioned in the books having to do with humiliating a child, name
calling, yelling at a child and threatening a child are all instances
of poor parenting, they may even be associated with ongoing suf-
ferring and marred interpersonal relationships. But they don’t nec-
essarily make a person a victim of child abuse.

These authors suggest that negative events necessarily lead to
pathology, as though the caregivers of our past now hold pup-
pet strings on our continued existence. If you are unhappy, you
must examine what happened to you and identify the perpetra-
tors and assign all the unhappiness you experience now to these
ghosts. As Wendy Kaminer proclaims in her witty and erudite
“I’m Dysfunctional, You’re Dysfunctional, “The trouble is that
for codependency consumers, someone else is always writing the
script. They are encouraged to see themselves as victims of family
life rather than self-determining participants. They are encouraged
to believe in the impossibility of individual autonomy (13).”
The mandate that we assume the role of damaged victim in order to get better is contrary to not only a century of Existential philosophy and fiction—in which tragedy is discussed as opportunity for transcendence, clarity and strength—but also to a fair number of empirical studies which have suggested that the way people construe past events, not the events themselves, will determine later functioning. These findings are completely opposite the non-scientific recommendations of codependency authors.

For example, in a recent study by McMillen, Zurvin and Rideout (1995) a large sample of adults sexually abused as children were interviewed and asked if they felt that they had benefited in any way from the experience. 47% said that they had. Responses ranged from “growing stronger as a person,” “feeling more adept at protecting their children from abuse,” “increased knowledge of sexual abuse” and the belief in one’s ability to self-protect. In turn, regardless of quality or duration of the abuse, those who saw some benefit scored higher on a number of adjustment.

Not just sexual abuse has been evaluated in this regard, those who experiences natural disasters, serious health problems and personal tragedies have been found to have common perceptions of benefit such as positive personality changes, changes in priorities and enhanced family relationships (e.g. Affleck, Tennen, and Rowe (1991).

The whole basis of cognitive therapy is to help individuals learn to recognize and dispute exaggerated, biased and overly negative automatic thoughts, beliefs, values and standards. The attitude of the codependent authors is Jr. Psychoanalyst. Somehow “events” in their pure form are stored in the labyrinth of ones unconscious and need to be purged and experienced in all their horror in order for the person to get beyond them. As said, people’s ongoing unhappiness is not a direct result of the negative events that befell us, but rather they way the negative events are appraised, or the meaning assigned the events by the recipient. People vary tremendously in terms of their appreciation of the same event. The mandate that we catastrophize then detach appears to me more a prescription for a phobia than recovery. As opposed to taking a victimization inventory, the most healthy thing to do would be to conduct a coping inventory, in which negative events of the past are re-evaluat- ed in a manner that makes you stronger, more resilient. There are opportunities to learn and grow from the tragedies and mishaps in our pasts...or there is a quagmire of despair, deception, bad, bad mommies and daddies and precious little lambs with throats ex- tended. You pick.

**The Idea that 12-Step Groups are Necessary for Those Involved with an Addicted Person**

Whether they commit themselves to the idea that codependency is a disease or not, the three authors are adamant about codependency being a lifelong illness which doesn’t go away; rather goes into remission (if you’re lucky), like diabetes or schizophrenia. Like neuroleptics and psychosis, codependency and AA-like support groups are intimately linked by these authors. Psychotherapy is deemed insufficient by these authors. Mellody Beattie, by way of an “invisible boat (194-195)” story, implies that therapy is fine for starters, but that the journey will end, and given the fact that codependency is progressive, one will need the 12-steps to con- tinue on course. It is stated in all three books that one has to be a codependent to understand what is gong on with the codependent. That kind of reasoning is as absurd as me firing my rheumatologist, who is chief of staff at a respected hospital in San Diego, because he doesn’t have any swollen joints. Some painful knees would be a better qualification than board certification. I should ask a patient in the waiting room if they wouldn’t mind taking over my case because of his or her capacity to feel the same throb- bing joint pain as me.

The 12-step philosophy endorses the relinquishing of control to a higher power. Though claiming that it’s spiritual emphasis is not religious, and that virtually anything can be ones higher pow- er, this is really a clever bait and switch. 12-step groups are more like going to a prayer group than anything else. For many, this for- um is commensurate to existing needs and values. For others, it is the antithesis of stable worldviews. As is the case with alcohol- ics and drug dependent individuals, you are hard pressed to find alternatives to the 12-step approach. Those desiring help who find the mentality of AA irrelevant or offensive are deemed “in denial” or “into their disease.”

Most disturbing is the fact that codependency authors are unaware of the volumes of empirical data backing up non-12-step methods of change for the symptoms delineated in codependency books (anger control problems, depression, anxiety, commu- nication problems, to name but a few of those symptoms listed in Beattie’s book). Also behaviorally oriented family therapists have developed methods for helping families in which addiction occurs without the use of 12-step mentality (e.g. O’Farrell, et. al.).

**One Step at a Time**

It’s probably “codependent” of me to believe that I alone can strike the term codependency from the English language. It’s entrenched in the addiction vernacular, and though defined in many, many ways depending on which symptoms a person selects from the vast lists, has been implemented into the self concepts of many. I’m sure the codependency books critiqued in this essay, like all self-help books, were written with good intentions, the hope that people’s lives would be improved. If your life feels better for hav- ing read and followed through with the recommendations of these authors, who am I to try to take that away. My article was written primarily as a caveat, a warning that what appears right and good on the surface, may have unhealthy ramifications in the long run if taken on to aggressively, a warning that just because a self-help author mandates one path to happiness, doesn’t make it accurate.

As opposed to swallowing the codependency idea whole, I encour- age those struggling with problematic relationships or a family member’s addictive behavior to use the basic advice of AA, “one step at a time.” The codependency idea is so broad that it is possible to extract useful principles and guidance from it. Given the lack of scientific drive behind this concept it behooves you to examine all aspects of your life which are being addressed by this concept. Just because one component of the codependency mind set hits home, doesn’t mean you have to engulf the entire world view.
1. Leave the term in the realm of addiction. The codependency idea was designed to help spouses and families of alcoholics and drug users. In this realm it appears to have some implications. Some of the advice in these books may be useful in helping to make sobriety easier for the addicted person. However, with regard to the use of the term for people who have relationship problems or who have difficulty putting themselves first, or who are dysphoric, there are many more specific terms which afford the sufferer some practical tools, without having to incorporate the disease idea, or “purging the unconscious.” Earlier I mentioned specific treatments, mostly in the cognitive-behavioral realm for addressing such problems as anxiety, depression, anger control, relationships problems. Before tossing your whole system of values and making the plunge into the recovery lifestyle, consider less invasive measures. If they prove insufficient, up the ante. The treatment tiering approach is very appropriate here. In the realm of medicine, least invasive treatments are usually tried first, and when proven insufficient or inadequate treatment intensity is increased. Arthritis is an analogy I usually use. A competent MD would not prescribe joint replacement as an initial treatment for painful joints. She would first attempt less potentially dangerous treatments, such as non-steroid anti-inflammatories. If these prove insufficient, she might try steroids, then up to more intense drugs with potential side effects and so on. I believe the treatment tiering model is relevant to all psychological problems. Consider the least invasive and most potentially effective intervention first, not the most drastic.

There are so many potential problems with over diagnosing and over treating. When people begin to believe that their problems are bigger than life they begin to question the effectiveness of their coping in realms previously not questioned. This doubt and insecurity, which can be perpetuated by “long term therapy” and nebulous diagnoses like codependency, dissolve the mind set that one is robust or resilient, and replace it with one in which one is weak and vulnerable in a cruel world. Our ever broadening “self awareness” results in our becoming chronically ill equipped.

2. Avoid victim making. Victim making is crazy making. The hydraulic model of psychodynamic theory has not been supported by research. The nasty “events” in our past do not stockpile in a cauldron called the unconscious festering like an infection until the host re-experiences them in their full horror, unleashing the past so that serenity can at last be found. This exorcism mentality, though popular in the field of clinical psychology, and good fodder for Hitchcock films, does not fit with current information processing literature, which has demonstrated that the chronic activation of negative information perpetuates negative mood states. Furthermore, the exaggeration of negative information and the belief of “helplessness” is strongly associated with depression. The bottom line is that it is quite unlikely that you must do “grief work” in order to become more assertive or less depressed. Adult functioning is not linked to events in our past, but how those events have been assigned meaning. Instead of separating the “precious child” from the harsh cruel world, assign new meaning to events from the perspective of a coping adult who has survived. Do an inventory of the events, which you overcame. Consider adult qualities, which were related to surpassing and having insight into difficult times in the past. Victimhood, though stylish these days, creates a historical distraction for incoming information that is not healthy.

3. Acceptance is often the greatest change one can make. In working with couples, partners often come in pointing fingers at each other. She Points, “He needs to stop being so controlling.” He points back, “She is so damn emotional and irrational!” I find that lasting change occurs, not when couples make marked changes in their behavior (like he becomes less controlling or she less emotional), but when partners--both partners--gain clarity with regard to the other’s uniqueness and of their relationship as completely singular in terms of what will help it survive or not, in short, come to understand and accept each other. The codependency authors who believe that relationships should be fair, and that there is some standard to which all relationships should be compared, are living on Fantasy Island. A good thorough read of one of Camilia Paglia’s books might illuminate the reality that there is nothing tidy about intimacy, that love is driven by irrational, uncontrollable, often self defeating urges and very different agendas depending on ones gender. Codependency authors, like some feminists, want sexual equality, blame males for all the unhappiness which befalls women and believe that “equality” once achieved will pan out in complete ease in relationships. Impossible, says Paglia. Men and women are vastly different and their differences, though creating an often chaotic world for one and other, are what passion is all about. Modern feminist attitudes “have a childlike faith in the perfectibility of the universe, which they see as blighted solely by nasty men.(25, Paglia, Vamps and Tramps)” Relationships are never completely balanced. There is always some degree of hierarchy. In fact, relationships function often on many hierarchies simultaneously, and balances shift during the course of relationships, often many times. The “raw material” which makes up one relationship is completely different from any other, and gauging balance against other relationships, or the ideal of complete equity in all regards is futile, impossible. Paglia says, “(Feminism) sees every hierarchy as repressive, a social fiction... Feminism has exceeded its proper mission of seeking political equality for women and has ended by rejecting contingency, that is, human limitation by nature or fate (3, Sexual Personae).”

Caring is good. Some people care more than others, and caring often endures despite inequality. Thankfully, we live in a world in which caring can shower itself on the good, bad and ugly. Sometimes this results in imbalance. Imbalance is not necessarily bad, and to deem it so would require us to reckon the most altruistic individuals in history as flawed.

So what is an alternative to the idea that caring contributes to the problem or directly perpetuates it? How bout the exact opposite? “I’m in no way responsible for the endurance of your addictive habit. You are making a decision to drink, use drugs, squander, overeat or whatever. Period. Now that we have that settled, let’s examine my behavior. Well, I do a lot to make his life comfortable. I’ve been that way for as long as I’ve known him. And now our lifestyle has changed and we have this awful substance abuse problem and I’m feeling spent and frustrated most of the day because he won’t change. I wonder if there are certain behaviors that, in and of themselves are okay, but which make his quitting this habit more difficult now, at this juncture of our lives.” This mind set results in an examination of many caring behaviors...
and the possibility that some many need modification while others may not.

I once worked with a young man who was in his 40s and living at home with his mother. He had moved in with her secondary to a nasty divorce and a bout of depression, which was proving particularly tenacious. This fellow was drinking heavily every night and the mother finally had it and mandated that he get some help. She went to an outpatient clinic and was told that she was the majority of the problem with regard to her son’s addiction, which she was enabling. She took the bait and evicted her son, and told him that she could not be responsible for his problems any more. She wouldn’t take his calls and had her locks changed.

This would have been fine and dandy, but the woman felt miserable. She went to Al-anon meetings and left feeling depressed. She constantly worried about her son, about his well-being, his health, his depression. Ultimately she made the decision to let him come back home. She was quickly back where she started. He was depressed and drinking heavily in the evening. To boot, she felt even more helpless than before, because she now felt that she was causing his problems, though she simply could not abandon her son as the counselor had suggested. When the family came to me they had been told that I had a different clinical conceptualization of addictive behavior and family involvement. Initially I met with the son and thoroughly assessed his alcohol abuse problem, which was clearly triggered by his tenacious depression. After a medically supervised detoxification and thorough evaluation by a psychiatrist it was agreed to afford him a pharmacological regime as well as cognitive therapy, emphasizing the acquisition of skills to counter urges and craving, prevent and cope with relapse, modify lifestyle and manage negative mood states. Upon meeting with the mother and the son together, the idea of enabling, which had been so indoctrinated by the previous counselor, was discussed. She was told that her son’s depression was not 75% her fault, as she had been told. I also encouraged her to entertain the possibility that the parent’s behavior was being driven by the need to feel better, not by her actions. I told her that her housing of her son, providing meals and so forth were manifestations of a caring mother, and in and of themselves were not pathological. She agreed that these qualities had been utilized in the rearing of her other three children and in her friendships, none of whom had addiction problems. I encouraged her to consider the present situation with her son as a special situation in might evaluate all behaviors involving her son, and make a determination whether they are making it less easy or more easy to change. She came to the conclusion that providing shelter for her son in intoxicated states and while recuperating was probably making it less easy for him to change. She felt that “kicking him out” while he was attempting to recover from such a long standing depression was counter to her convictions regarding family and probably wouldn’t help him either. She was able to give herself permission not to do this. The son was able to articulate that he would very much like to be independent and have his own place again, and didn’t feel he was in a position to take on independent living at that time. He also saw how a comfortable bed to drink in and nurse his withdrawal was not going to help him change. The mother was receptive to my “recruiting” her in the effort of helping her son stay on course with regard to his rehabilitation and agreed to make her house available to her son as long as he avoided alcohol. If she suspected he was drinking, he was to find another place to stay for the next 72 hours or until he was not intoxicated or withdrawing.

The mother did not have to follow through with this condition, as the threat alone served to help the patient stay on course. She felt that it was okay to provide the caring she had always provided and did not feel as though this condition conflicted with her values.

So you’ve tried to “stop caring” and found that it makes life dreadful? Maybe you don’t have to relinquish core standards to be happier. Perhaps you’re trying to eliminate the foundation and expect the building to continue standing. Maybe it’s okay to “care too much.” Can you “care too much” and be happier than you are now? That would take a lot of re-evaluation...of yourself, of your spouse, of your family, maybe even your past. Now that’s a challenge!

References for “The Codependency Idea: When Caring Becomes a Disease”


References for “Behavioral Couples Therapy for Alcoholism and Drug Abuse


To get citations for all the research studies described in this article, at www.bhrm.org click on clinical guidelines, then addiction guidelines.

RESOURCE LIST

Harvard Medical School
Division on Addictions
The Landmark Center
401 Park Drive, 2nd Floor East
Boston, MA 02215
617-384-9030
www.hms.harvard.edu/doa/
The Division on Addictions at Harvard Medical School is dedicated to strengthening worldwide understanding of addiction through innovative research, education, and the global exchange of information.

Project CALM
VA Boston Healthcare System
940 Belmont Street, Brockton MA 02301
508-583-4500 ext 3493
CALM provides Behavioral Couples Therapy for alcoholism and drug abuse to veterans and their families. The authors of this article direct the CALM program.

Alcohol & Drug Referral Hotline
800-327-5050: 24 hour service

Alcohol Information Center
781-321-2600

Alcoholism Hotline
800-252-6465

Coalition on Addiction, Pregnancy & Parenting
617-661-3991, 9am-5pm M-F

MA Substance Abuse Hotline
800-327-5050 / 617-338-6020: 24 hour support, information and referral line. Helps to determine need and provides phone numbers for appropriate resources.

National Drug and Treatment Referral Routing Service
1-800-662-HELP (4357) provides a toll-free telephone number for alcohol and drug information/treatment referral assistance.

Statewide Substance Abuse Information Line
800-ALCOHOL / 800-COCAINE

Alcoholics Anonymous Meetings Boston Central Service
617 426-9444 http://www.theagapecenter.com/AAinUSA/Massachusetts.htm

Massachusetts Organization for Addiction Recovery (MOAR)
30 Winter Street, 3rd Floor, Boston MA 02108
(617) 423-6627
Toll free: 1-877-423-6627
www.neaar.org/moar
Behavioral Couples Therapy for Alcoholism and Drug Abuse

Post Test
Circle ALL correct answers for each question:
All questions are based on information provided in the articles presented on these previous pages of course.

1. Behavioral Couples Therapy is incompatible with Alcoholics Anonymous.
   a) True
   b) False

2. Which of the following are BCT interventions for promoting sobriety?
   a) Antabuse Contract
   b) Daily Trust Discussion
   c) Crisis intervention for substance use episodes

3. Which of the following are BCT interventions for increasing positive couple/family activities?
   a) Catch Your Partner Doing Something Nice
   b) Shared Rewarding Activities
   c) Systematic Desensitization
   d) Caring Days

4. Which of the following are BCT interventions for teaching communication skills?
   a) Listening Skills
   b) Expressing Feelings Directly
   c) Electric Shock Avoidance Conditioning
   d) Communication Sessions

5. A daily ritual unique to BCT that is used by partners to reinforce abstinence is:
   a) Meditating together
   b) Pros and cons list
   c) Trust discussion
   d) Attending self-help meetings together
   e) Journaling

6. Medication known to aid recovery include:
   a) Amphetamines
   b) Antabuse
   c) Naltrexone
   d) Cannabinoids

7. Many couples and families break up during the first 1 or 2 years of the substance abusing individual’s recovery.
   a) True
   b) False

8. The BCT exercise that is designed to encourage partners to plan and enjoy non-substance using activities together is:
   a) Positive Specific Requests
   b) Daily Trust Discussion
   c) Shared Rewarding Activity
   d) One-tank Getaway

9. Westmeyer criticizes the concept of codependency as:
   a) Pathologizing the natural impulse to care for others
   b) Failing to use psychoanalytic principles
   c) Promoting victim-hood
   d) Lacking empirical support

10. Which of the following asks partners to begin noticing pleasing or caring behaviors (compliments, gestures, hugs, etc.) on a daily basis?
    a) Shared Rewarding Activity
    b) Catch Your Partner Doing Something Nice
    c) Keep Up the Good Work
    d) Caring Day

11. BCT is the family therapy method for substance abuse with the strongest research support.
    a) True
    b) False

12. The purpose of BCT is to:
    a) Help clients develop insight into their alcoholism or drug abuse
    b) Improve the relationship of married or cohabiting couples
    c) Address ACOA issues
    d) Build support for abstinence

13. Studies have shown that as a result of BCT the average social cost (e.g., health care, criminal justice system, public assistance, etc.) per case decreased ___________ compared to the year before BCT.
    a) $50.00 - $65.00
    b) $500.00 - $650.00
    c) $5,000.00 - $6500.00
    d) $50,000 - $65,000

14. In the event a patient “slips” and uses drugs or alcohol during BCT, the therapist should make an immediate referral to inpatient treatment.
    a) True
    b) False

15. The following conditions would make a substance abuse patient or partner unsuitable for BCT:
    a) Couples in which there is a court-issued restraining order against contact with each other
    b) One or both partners meet DSM-IV criteria for current psychosis
    c) There is an acute risk of severe family violence with a potential for serious injury or death
    d) One or both partners are on methadone maintenance
# Family Involvement in the Treatment of Addictions

## Course Evaluation (please circle your answer)

1. Was this information relevant to your practice?  
   - No  
   - 1 2 3 4 5 Very

2. Was the content presented clearly?  
   - No  
   - 1 2 3 4 5 Very

3. Would you like us to continue offering CEs in FOCUS?  
   - No  
   - 1 2 3 4 5 Absolutely

4. Comments/Suggestions:  
   ___________________________________________________________
   ___________________________________________________________
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**Complete and return Post-Test and Course Evaluation after reading the CE course in this issue of FOCUS.**

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