Engaging Partners in the Treatment of Addictions

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For the purposes of this article I am primarily focusing on alcohol as the source of addiction as this is the most common presentation I am seeing in my private practice however the approaches are relevant in the treatment of other substances use issues.

In working with couples or families where one partner has an addiction it is a common scenario to see family members move between avoiding, detachment, confrontation and coercion. Adding to the difficulty, treatment had historically had an individual focus with families and children becoming marginalised in the process.

For this reason it is imperative to have an approach to working with these cases that involves partners and family members in order to have the best chance of success.

Diagnosis and Impact

Problem drinking that becomes severe is given the diagnosis "Alcohol Use Disorder" in the DSM V. This is a chronic relapsing brain disease characterised by compulsive alcohol use, loss of control over alcohol intake and a negative emotional state when not drinking. To be diagnosed the person must meet the criteria set out in the DSM V and can be classified as mild, moderate or severe (National Institute of Alcohol Use and Alcoholism). The impacts of AUD are significant with partners and children experiencing psychological distress, health and behavioural problems. According to the Australian Institute of Health and Welfare 1 in 6 people in Australia (17%) consume alcohol at levels placing them at a life time risk of an alcohol related disease or injury. In the UK approximately 920, 000 children are living in a home where one or both parents misuse alcohol (NIAAA). In the United States approximately 16 million adults (6.2%) have AUD and an estimated 623,000 adolescents ages 12–17 were diagnosed with AUD (NIAAA).

Treatment Options

12 step programs and The Johnson Intervention

The most common and perhaps well known treatment for addictions is the 12 step program. The 12 step method involves a set of guiding principles that outlines a process of recovery from addiction. The 12 step method was proposed by Alcoholics Anonymous which is a mutual self help group founded in Ohio in the mid 1930's. Its founders were Bill Wilson and Dr Bob Smith who were both alcoholics who struggled with the disease before finding a solution in abstinence, fellowship with others and surrender to a higher spiritual power. The process originally involved the following 6 steps (and was later expanded to 12).

- Admitting that one cannot control one's alcoholism, addiction or compulsion
- Honesty and self awareness about the disease of alcoholism
- Recognizing a higher power that can give strength
- Sharing self awareness anonymously with one other person
- Examining past errors with the help of a sponsor (experienced member) and making amends for these errors
- Learning to live a new life with a new code of behaviour and working with others and helping other alcoholics with no expectation of recognition.

Additionally there are family support groups (Al-Anon and Al-Ateen) where there is support and education given around areas such as self care, self blame and education.

The Johnson Intervention was developed by Episcopal priest Vernon Johnson (1920-1999) who was a recovered alcoholic and devoted his life to alcohol intervention. The intervention is aimed at being a catalyst for the substance-abusing person's entry into a treatment program. Although there is no immediate focus on the caregiver's well-being, it is thought that caregiving burden may be reduced if professional help can be accessed.

The approach is to plan and implement a confrontation of the substance abuser by one or more caregivers. Planning initially engages the caregiver in help, assessing the person's social network and evaluating the likelihood of engaging other network members into a counselling session. Following this there are 2 sessions with the network to educate them about the dangers of enabling, the goals of the confrontational intervention, and problem-solving strategies to determine the needs of caregivers themselves, and how they would accomplish the planned confrontation. The final session involves the planned confrontation of the alcoholic by the social network in the presence of the therapist.

The above mentioned programs have provided important avenues for treatment over the decades however more recently there has been greater focus and recognition on the impact of family relationships in the etiology and maintenance of an addiction.

I will now outline three approaches to working with couples as further treatment options.

Behavioural Couples Therapy for Alcohol Use Disorders (ABCT) is an outpatient based program with a rigorous research base. Research suggests that ABCT results in a significant reduction in alcohol consumption and improvement in couple functioning (Epstein and McCrady, 1998). Adaptations by Fals-Stewart and O'Farrell et.al. (2005), O'Farrell and Schein (2000) have also shown promising results. The model also suggests that abstinence is not a necessary prerequisite as in some traditional approaches and considers reduction and controlled drinking interventions as acceptable goals, resulting in greater willingness to enter therapy. ABCT can be used alongside 12-step programs.

"The relationship between substance use and marital problems is not unidirectional with one consistently causing the other, but rather each can serve as a precursor to the other, creating a vicious cycle from which couples that include a partner who abuses drugs or alcohol often have difficulty escaping" . Stewart W et.al. (2005)

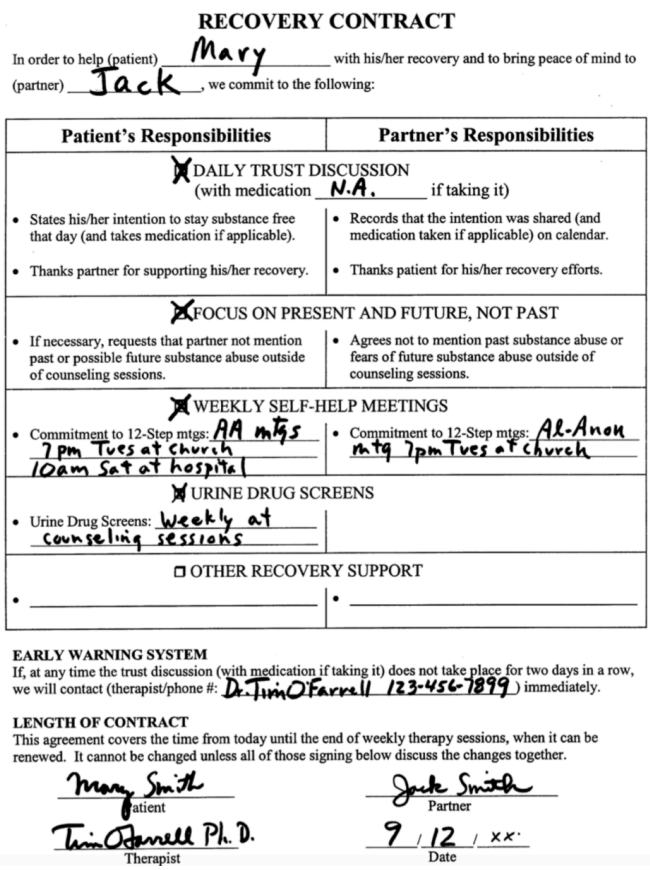
The treatment involves an initial assessment phase with the couple followed by 12-20 weekly sessions. Initially the focus is on "substance focused interventions" such as abstinence, medication and possible urine testing and once this is stabilised the focus moves to "relationship focused interventions" such as positive actions and communication. The model is based on the following assumptions:

1. That couple interactions can be a trigger for drinking
2. Partners can reward abstinence
3. A positive relationship is a strong source of motivation for change
4. Reducing relationship distress lessens risk of relapse

The ABCT model suggests the use of a daily Recovery Contract (See figure 1) where the client agrees to not consume alcohol for that day (in the tradition of one day at a time) and the partner expresses support for their efforts, this may include attendance at weekly self help meetings, witnessing the use of medication such as Disulfiram to assist with abstinence and an agreement to focus on the present not the past on order to reduce the possibility of conflict which can trigger relapse. The couple will also make use of structured exercises and assignments such as "catching your partner doing something nice", increasing positive couple interactions through pleasant activities, improving communication, problem solving and coping skills, decreasing behaviours that reinforce drinking, strengthening partners support of the clients efforts and identifying upcoming high risk situations. My experience with this style of working has been that the couple benefit from the structure and containment however it is also important to tune into any feelings of shame or stigma and pathologising given the focus on the individual recovery in the initial stages.

"Once the recovery contract is going smoothly there can be an increased focus on relationships, partners often feel resentment about the past along with fear and distrust. The goals are around increasing goodwill and commitment and teaching better conflict resolution skills through modelling this in session and couple practicing under supervision (O'Farrell, 2000:4)

Figure 1 RECOVERY CONTRACT AND CALENDAR (O'Farrell and Schein, 2000:15)



RECOVERY CONTRACT

In order to help (patient) Mary with his/her recovery and to bring peace of mind to (partner) Jack, we commit to the following:

Patient's Responsibilities	Partner's Responsibilities
☒ DAILY TRUST DISCUSSION (with medication N.A. if taking it)	
• States his/her intention to stay substance free that day (and takes medication if applicable).	• Records that the intention was shared (and medication taken if applicable) on calendar.
• Thanks partner for supporting his/her recovery.	• Thanks patient for his/her recovery efforts.
☒ FOCUS ON PRESENT AND FUTURE, NOT PAST	
• If necessary, requests that partner not mention past or possible future substance abuse outside of counseling sessions.	• Agrees not to mention past substance abuse or fears of future substance abuse outside of counseling sessions.
☒ WEEKLY SELF-HELP MEETINGS	
• Commitment to 12-Step mtgs: AA mtgs 7pm Tues at church 10am Sat at hospital	• Commitment to 12-Step mtgs: Al-Anon mtg 7pm Tues at church
☒ URINE DRUG SCREENS	
• Urine Drug Screens: Weekly at counseling sessions	
☐ OTHER RECOVERY SUPPORT	
•	•

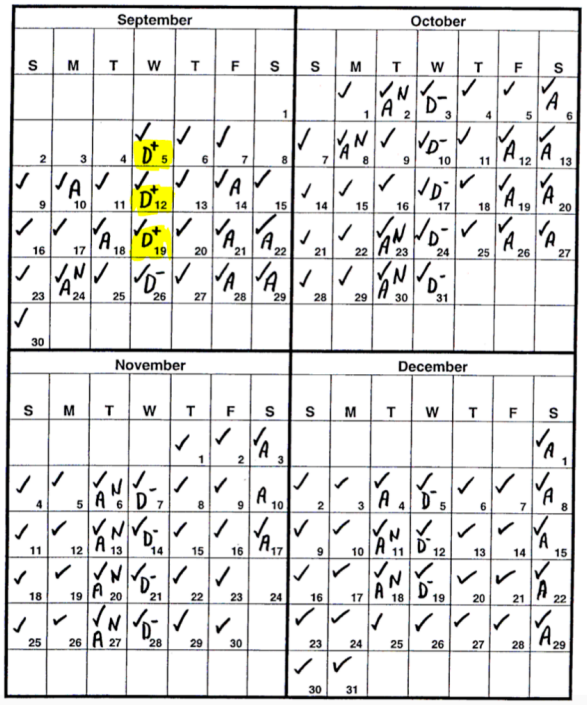
EARLY WARNING SYSTEM
If, at any time the trust discussion (with medication if taking it) does not take place for two days in a row, we will contact (therapist/phone #: Dr. Tim O'Farrell 123-456-7899) immediately.

LENGTH OF CONTRACT
This agreement covers the time from today until the end of weekly therapy sessions, when it can be renewed. It cannot be changed unless all of those signing below discuss the changes together.

Mary Smith — Patient
Jack Smith — Partner
Tim O'Farrell Ph. D. — Therapist
9 / 12 / xx — Date

Recovery Contract Calendar

☒ ✓ = Trust Discussion Done
☐ (✓) = Trust Discussion with Medication (_____)
☒ A = AA or NA meeting
☒ N = Alanon or Naranon
☒ D = Drug Urine + or –
☐ O = Other (_____)



September

S	M	T	W	T	F	S
						✓ 1
✓ 2	✓ 3	✓ 4	✓ D+ 5	✓ 6	✓ 7	✓ 8
✓ 9	✓ A 10	✓ 11	✓ D+ 12	✓ 13	✓ A 14	✓ 15
✓ 16	✓ 17	✓ A 18	✓ D+ 19	✓ 20	✓ A 21	✓ A 22
✓ 23	✓ A 24	✓ 25	✓ D- 26	✓ 27	✓ A 28	✓ A 29
✓ 30						

October

S	M	T	W	T	F	S
	✓ 1	✓ A N 2	✓ D- 3	✓ 4	✓ 5	✓ A 6
✓ 7	✓ A N 8	✓ 9	✓ D- 10	✓ 11	✓ A 12	✓ A 13
✓ 14	✓ 15	✓ 16	✓ D- 17	✓ 18	✓ A 19	✓ A 20
✓ 21	✓ 22	✓ A N 23	✓ D- 24	✓ 25	✓ A 26	✓ A 27
✓ 28	✓ 29	✓ A N 30	✓ D- 31			

November

S	M	T	W	T	F	S
				✓ 1	✓ 2	✓ A 3
✓ 4	✓ 5	✓ A N 6	✓ D- 7	✓ 8	✓ 9	A 10
✓ 11	✓ 12	✓ A N 13	✓ D- 14	✓ 15	✓ 16	✓ A 17
✓ 18	✓ 19	✓ A N 20	✓ D- 21	✓ 22	✓ 23	24
✓ 25	✓ 26	✓ A N 27	✓ D- 28	✓ 29	✓ 30	

December

S	M	T	W	T	F	S
						✓ A 1
✓ 2	✓ 3	✓ A 4	✓ D- 5	✓ 6	✓ 7	✓ A 8
✓ 9	✓ 10	✓ A N 11	✓ D- 12	✓ 13	✓ 14	✓ A 15
✓ 16	✓ 17	✓ A N 18	✓ D- 19	✓ 20	✓ 21	✓ A 22
✓ 23	✓ 24	✓ 25	✓ 26	✓ 27	✓ 28	✓ A 29
✓ 30	✓ 31					

A second approach **The Couple Recovery Development Approach (CDDA)** developed by Dr Robert Navarra at the Mental Research Institute in California takes a different approach to working with couples. Based on foundations of Gottman Method Couples Therapy the approach views both people in the couple as being in "recovery". The word recovery can be interchanged with the word "wellness" if this is more relatable. Taking a relational approach to recovery the model uses a card deck titled the "Recovery Map Card Deck" in order to create safe ways to talk about what's happening for the couple. Dr Navarra points out that addictions are often described as "the elephant in the living room" by very nature of the fact that the addiction is seen but not talked about. This has been compounded by the idea that in the past couples have been discouraged from talking to each other about recovery and how it impacts the relationship. This model aims to give couples a way of talking about the recovery by encouraging partners to be responsible for their own recovery and to take joint responsibility for the relationship.

The card deck consists of 60 cards that can be selected by each partner during a couple session to reflect where they are at in the recovery for example may read "something I want you to know about my recovery", "something that I am nervous about", "something I would like help with is". The therapy ideally uses these prompts as a way to address some of the following areas:

- Dealing with denial
- Improving conflict resolution skills
- Know the difference between codependency and interdependency
- Moving towards wellness as an individual and couple

My experience with this model is that facilitating conversation that is more equal between both partners feels less pathologising and thus increases the chance of the couple staying in therapy and being able to reinforce positive changes.

The Community Reinforcement And Family Training (CRAFT) approach has been developed to incorporate families in treatment and offers inpatient and outpatient treatment by the founders Robert J Meyers and Jane Ellen Smith in New Mexico.

Some studies have shown greater success with this model such as Miller et al. (1999) who conducted a controlled comparison of CRAFT, the Johnson Intervention, and Al-Anon 12 Step Facilitation (TSF) of 130 caregivers of problem drinkers to receive 12 hours of contact in one of the three conditions. CRAFT and TSF had better retention than the Johnson Intervention. Consistent with previous studies, participants tended to drop out of the Johnson Intervention in order to avoid the family confrontation with the drinker. The CRAFT intervention also engaged substantially more drinkers into treatment (64% vs 23% Johnson and 13% Al-Anon /12 step facilitation).

The model has expanded over time and other resources for families have been developed such as Beyond Addiction by Jeffrey Foote, J and Carrie Wilkens (2014) which follow similar principles of collaborative involvement. In his book "Get your loved one sober: Alternatives to Nagging, Pleading and Threatening" Meyers suggests that taking a collaborative therapeutic style is associated with less resistance (he proposes that previous models such as the Johnson Institute Method as mentioned above were overly confrontational).

CRAFT is a family counselling approach that aims to increase the rate of engagement for the family and for the individual with the addiction. The therapy with the family involves areas such as communication skills training, contingency management and functional analysis.

The CRAFT model uses Motivational Interviewing, DBT and CBT techniques with both the individual and partner and covers concepts such as:

- Increasing each persons level of understanding the problem
- Reinforcing positive change
- Positive communication strategies such as open questions, reflecting, affirming, validating and assertiveness
- Self care and self compassion
- Managing emotions
- Dealing with shame (eg by isolating, seeking perfection or blaming others)
- Introducing new interests and reducing isolation by engaging with the community
- Avoiding black and white thinking (one size fits all)
- Dealing with ambivalence

Figure 2: The 20 Minute Guide - A guide for partners about how to help their loved one change their substance use.
Centre for Motivation and Change.
www.motivationandchange.com

In this model there is a focus on de-stigmatising families and sufferers in an effort to enhance support, involvement and motivation and eliciting support from friends in order to reduce the feelings of shame and guilt which increases isolation. One resource used is the "20 Minute Guide" for families (see figure 2) which teaches partners such things as how to react when the partner has been using substances, how to talk to their partner so that they are more likely to be heard and self care strategies. This can be downloaded at https://the20minuteguide.com/partners/introduction-partners-guide/introduction-partners-guide-pdf/ for a small fee and is a useful resource for families. I have found this to be an excellent resource for partners due to its comprehensive nature and the fact that it covers a wide range of areas of difficulty.

Other Resources and Programs

Lastly, encouraging couples to make use of resources on offer by organisations such as the Betty Hazelden Ford Foundation can be helpful. Hazelden Betty Ford Foundation was named after Elizabeth Anne Ford who was the First Lady of the US in 1974-1977 as wife to Republican President Gerald Ford. The history is that in 1978, the Ford family staged an intervention and forced her to confront her alcoholism and an addiction to opioids which had been prescribed in the early 1960s for pain. In 1982 she established the Betty Ford Centre in California. The name "Hazelden" came from the original male only alcohol treatment program based in the US which began in the 1940's and merged with the Betty Ford Foundation in 2014. Since then it has developed treatment programs and online resources for sufferers and families.

Summary

Overall the involvement of partners in treatment where one partner has an addiction is a complex issue. Partners suffer from a range of emotions such as anger, hopelessness and helplessness and the consequences of increased levels of uncertainty and chaos impacting daily family life, career, the well-being of children and general daily tasks. Having an approach that engages both partners in this area is crucial for sustaining recovery. A combination of a behavioural approach such as ACBT, Motivational Interviewing and DBT can be effective. The use of a daily recovery contract and regular positive communication, caring behaviour and regular trust discussions can all be effective along with focussing on present behaviour, and supporting attendance at individually based treatment such as self-help groups. Encouraging open dialogue between partners is crucial along with reducing isolation, dealing with the substance abusing partners ambivalence and having a place to address and work on both partners coping responses to support wellness.

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