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Behavioral Couple Therapy

Partner-Involved Treatment for Substance-Abusing Women

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Among the various psychosocial interventions presently available to treat alcohol and drug abuse, it could be argued that partner-involved treatments are the most broadly efficacious. There is not only substantial empirical support for the use of couple-based treatments in terms of improvements in primary targeted outcomes, such as substance use and relationship adjustment, but also in other areas that are of clear public health significance, including intimate partner violence (IPV), children's adjustment, and cost-benefit ratio and cost-effectiveness. During the last few decades, programmatic research on the application of partner-involved therapies for substance abuse has been among the most active and fruitful.

Although marital and family therapies for substance abuse have been used with a wide variety of patient populations, the purpose of this chapter is to focus on the application of partner-involved interventions with women who abuse substances and are in intimate relationships. More specifically, we (1) provide a conceptual rationale as to why couple therapy for female patients with substance abuse problems may be particularly appealing, compared to more traditional individual-based approaches; (2) describe theoretical and practical considerations involved when implementing couple therapy with these patients; (3) examine available evidence for the efficacy of couple therapy with female patients who abuse alcohol and drug; and (4) discuss future directions with respect to partner-involved therapies with these patients.

TREATING SUBSTANCE ABUSE AMONG FEMALE PATIENTS WITH SUBSTANCE USE DISORDERS: THE CASE FOR PARTNER-INVOLVED INTERVENTIONS

As highlighted throughout this volume, alcohol and drug use disorders have historically been conceptualized as problems of men. In turn, it has been the study of addictive behavior in

men that has shaped our understanding of the etiology, course, and treatment of these disorders (e.g., Jellinek, 1952; Vaillant, 1995). Both researchers and clinicians have posited that, due to significant behavioral, social, and emotional differences between treatment-seeking men and women who abuse substances, the findings from intervention studies that have focused largely or exclusively on men may not generalize to women who suffer with these disorders (e.g., Gerolamo, 2004; Straussner & Zelvin, 1997).

Treatment Response and Outcomes: Women versus Men

Comparisons of men and women entering substance abuse treatment have indicated that women (1) have a briefer transition from substance use to addiction, but tend to enter treatment after a shorter period of regular use (e.g., Grella, Scott, Foss, Joshi, & Hser, 2003; Randall et al., 1999); (2) are younger, poorer, and more likely to have direct responsibility for children (e.g., Brady & Randall, 1999; Oggins, Guydish, & Delucchi, 2001; Stewart, Gossop, & Trakada, 2007); (3) receive less emotional support from their intimate partners and others (Blum, Nielsen, & Riggs, 1998; Kail & Elberth, 2002); (4) are more likely to have partners, friends, and family members who use drugs (e.g., Bendtsen, Dahlström, & Lejman, 2002; Hser, Evans, & Huang, 2005); and (5) have a higher prevalence of psychiatric disorders, such as depression and anxiety (Hernandez-Avila, Rounsaville, & Kranzler, 2004; Kidorf et al., 2004; Sonne, Back, Zuniga, Randall, & Brady, 2003; Webster, Rosen, & McDonald, 2007).

Not surprisingly, several studies have also found differences in substance abuse treatment response and outcomes for male and female patients. For example, one of the few significant predictors of posttreatment outcomes to emerge from Project MATCH (Matching Alcoholism Treatments to Client Heterogeneity), the most comprehensive alcoholism treatment outcome study conducted to date, was sex; women had a significantly higher percentage of days abstinent from alcohol after treatment than men (Project MATCH Research Group, 1998a, 1998b). Similarly, Sanchez-Craig, Leigh, Spivak, and Lei (1989) reported that women with alcohol dependence had greater reductions in heavy and problem drinking after brief outpatient treatment than men. In a study of men and women predominantly in treatment for drug use, women's responses to treatment and self-help participation appeared more consistent in reducing drug use during the follow-up period (Greenfield et al., 2007; Hser, Huang, Teruya, & Anglin, 2004).

Thus, despite what is generally a positive response to intervention, women have been substantially underrepresented in substance abuse treatment programs included in most studies exploring outcomes of different treatments for alcoholism and drug abuse. As a result, the effects of different intervention approaches on women's outcomes are far less understood than they are for men.

The Influence of Partner and Family Relationships of Women with Substance Abuse on Treatment Response and Outcomes

Among the most important characteristics that distinguishes men and women who have substance use disorders (SUDs) is the role of dyadic conflict and relationship stress in problematic substance abuse and relapse. For example, Allan and Cooke (1985) found that, compared to men, women were more likely to drink in response to current life stressors and life events such as marital discord, divorce, and children leaving the home. Consistent with these findings, Annis and Graham (1995) found that women were more likely than men to report

heavy drinking in response to negative emotional states and interpersonal conflict with others.

Similarly, relationship issues have been found to affect relapse to substance abuse. Lemke, Brennan, and Schutte (2007) found that family problems and emotional distress were linked to relapse for women with alcohol dependence. Connors, Maisto, and Zywiak (1998) found that women alcohol dependence were significantly more likely than men with alcohol dependence to attribute conflict with their spouse or romantic partner as a primary precipitant for relapse. Although women frequently report using or discontinuing use for the sake of their partner (Sun, 2007), having a partner that abuses alcohol or other psychoactive substances is more strongly related to higher rates of relapse for women than for men (Grella et al., 2003). Clearly, these findings indicate that a woman's recovery attempts appear vulnerable to problems in her relationships and her partner's substance use.

Because family and relationship factors play a critical role in the maintenance and exacerbation of drinking and drug problems, as well as relapses after treatment, interventions specifically designed to address both relationship and substance abuse issues concurrently would seem likely to have particular benefit for women with SUDs. Yet, this viewpoint has not been universally held by alcohol and drug abuse treatment researchers or clinicians. In their influential review of therapies for alcohol dependence, Edwards and Steinglass (1995) reported that studies finding family treatment superior to control treatments in reducing alcohol consumption generally examined more male patients (i.e., an average of 6% of participants in family treatment were women) than those investigations finding no differences in drinking outcomes between family versus control treatments (average of 30% female participants). They argued that, in studies "with a preponderance of male alcoholics, marital or family therapy may be more likely to yield positive results; family therapy for female alcoholics may lose its edge over individual treatment" (p. 502). The authors, however, did not examine whether gender was a moderating variable in the effect size for couple/family therapies versus individual treatments. The contrasting positions set the stage for an empirical evaluation of family-involved therapies for women with SUDs.

Of course, a fundamental issue in any such study is the type of family-involved therapy that should be tested. A family-based treatment approach for alcohol and drug use disorders that may have particular benefit for women is behavioral couple therapy (BCT). During the last 3 decades, various forms of BCT have been associated with positive outcomes for men with alcohol dependence and their families, in terms of reduced drinking and improved relationship adjustment (e.g., McCrady, Hayaki, Epstein, & Hirsch, 2002; O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992), decreased IPV (e.g., O'Farrell, Murphy, & Stephan, 2004), and reduced emotional and behavioral problems of the couples' children (Kelley & Fals-Stewart, 2002; Kelley & Fals-Stewart, 2007). BCT has also been shown to be effective for reducing drug use and improving dyadic relationships (e.g., Epstein, McCrady, & Morgan, 2007; Fals-Stewart, Kashdan, O'Farrell, & Birchler, 2002; Fals-Stewart, O'Farrell, & Birchler, 2001).

As such, BCT was a natural selection as a family-based treatment to test with women with SUDs. Findings in the BCT trials that have been conducted thus far, which are reviewed later in this chapter, have shown positive effects for BCT with women with SUDs, compared to individual-based treatments and attention controls (Fals-Stewart, Birchler, & Kelley, 2006; Winters, Fals-Stewart, O'Farrell, Birchler, & Kelley, 2002). These findings are extremely encouraging and suggest that BCT may be an important intervention approach with women who seek treatment for alcohol or drug abuse.

BCT FOR SUBSTANCE ABUSE: CONCEPTUAL CONSIDERATIONS AND PRACTICAL APPLICATION

The causal connections between substance use and relationship discord are complex and appear to interact reciprocally. For example, chronic substance use outside the home is correlated with reduced marital satisfaction for spouses (e.g., Dunn, Jacob, Hummon, & Seilhamer, 1987). At the same time, however, stressful marital interactions are related to increased problematic substance use and are related to posttreatment relapse among those who abuse alcohol and drugs (e.g., Fals-Stewart & Birchler, 1994; Maisto, O'Farrell, McKay, Connors, & Pelcovitz, 1988). Thus, 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.

Viewed from a family systems perspective, several familial antecedent conditions and reinforcing consequences of substance use can be identified. Poor communication and problem-solving abilities, arguing, financial stressors, and nagging are common antecedents to substance use. Consequences of substance use can be positively or negatively reinforcing, thus increasing or decreasing the likelihood of future substance use. For instance, certain behaviors by a non-substance-abusing spouse—such as avoiding conflict with the partner with SUDs when he or she is intoxicated, or engaging in caretaking behaviors during or after episodes of drinking or drug taking—can inadvertently reinforce continued substance-using behavior. Partners making disapproving verbal comments about the other's drinking or drug use is perhaps the most commonly observed negative interaction sequela of substance abuse (e.g., Becker & Miller, 1976), and can inadvertently serve to increase the likelihood of future drinking or drug use. Other negative effects of substance use on the family—such as psychological distress of the spouse; increased social, behavioral, academic, and emotional problems among children; and elevated levels of stress in the family system—can lead to, or exacerbate, substance use (Moos, Finney, & Cronkite, 1990).

The strong interrelationship between substance use and family interaction suggests that interventions that address only one aspect of this relationship would be less than optimal. However, traditional interventions for substance abuse, which focus largely on the individual patient with an SUD, often do just that. In contrast, BCT (and, for that matter, family-based treatments for substance abuse in general) have two primary objectives that evolve from a recognition of the interrelationship between substance use and family interaction: (1) eliminate abusive drinking and drug use and harness the support of the family to support the patient's efforts to change and (2) alter dyadic and family interaction patterns to promote a family environment that is more conducive to sobriety. Viewed from a marital or intimate relationship context, a high priority is to change substance-related interaction patterns between partners, such as nagging about past drinking and drug use, and ignoring or otherwise minimizing positive aspects of current sober behavior. Continued discussions about and focus on past or "possible" future drinking or drug use increases the likelihood of relapse (Maisto et al., 1988). Thus, abstinent patients and their partners are encouraged to engage in, and are provided training in, behaviors that are more pleasing to each other.

Taking into account our conceptual understanding of the cyclic interplay between substance use and family distress, the BCT intervention for substance abuse is founded upon two fundamental assumptions. First, family members, specifically spouses or other intimate partners, can reward abstinence. Second, reduction of relationship distress and conflict reduces a very significant set of powerful antecedents to substance use and relapse, thereby leading to improved substance use outcomes.

BCT Treatment Methods

When delivering BCT to a married or cohabiting patient with an SUD, a therapist treats this patient with his or her intimate partner and works to build support for abstinence within the dyadic system. The therapist, with extensive input from the partners, develops, and has the partners enter into, a daily Recovery Contract (which is also referred to as a Sobriety Contract). As part of the contract, partners agree to engage in a daily Sobriety Trust Discussion, in which the partner with an SUD states (if true, of course) his or her success in staying sober and the intention not to drink or use drugs that day (e.g., “I have been sober for the last 24 hours, and it is my intention to stay sober for the next 24 hours”). In turn, the non-substance-abusing partner verbally expresses positive support for the patient’s efforts to remain sober (e.g., “Thank you for staying sober and please let me know if there is anything I can do to help you stay sober for the next 24 hours”). For patients with SUDs who are medically cleared and willing, daily ingestion of medications designed to support abstinence (e.g., naltrexone, disulfiram), witnessed and verbally reinforced by the non-substance-abusing partner, is often a component that occurs during the daily Sobriety Trust Discussion. The non-substance-abusing partner records the performance of the Sobriety Trust Discussion (and consumption of medication, if applicable) on a calendar provided by the therapist. As a condition of the Recovery Contract, both partners agree not to discuss past drinking or drug use or fears of future substance use when at home (i.e., between scheduled BCT sessions) during the course of couple treatment. This agreement is put in place to reduce the likelihood of substance-related conflicts occurring outside the safety of the therapy sessions, possibly triggering relapse. Partners are asked to reserve such discussions for the BCT therapy sessions, which can then be monitored and, if needed, mediated by the therapist. Many contracts also include specific provisions for partners’ regular attendance at self-help meetings (e.g., Alcoholics Anonymous, Al-Anon), which are also marked on the provided calendar during the course of treatment.

At the start of a typical BCT session, the therapist reviews the calendar to ascertain overall compliance with different components of the contract. The calendar provides an ongoing record of progress that is rewarded verbally by the therapist at each session; it also provides a visual (and temporal) record of problems with adherence that can be addressed each week. When possible, the partners perform behaviors that are aspects of their Recovery Contract (e.g., Sobriety Trust Discussion, consumption of abstinence-supporting medication) in each scheduled BCT session to highlight its importance and to allow the therapist to observe their behaviors and provide corrective feedback as needed.

Through the use of standard couple-based behavioral assignments, BCT also seeks to increase positive feelings, shared activities, and constructive communication—relationship factors that are viewed as conducive to sobriety. In the assignment “Catch Your Partner Doing Something Nice” each partner notices and acknowledges one pleasing behavior performed by the other each day. In the “Caring Day” assignment, each partner plans ahead to surprise the significant other with a day when he or she does some special things to show his or her caring. Planning and engaging in mutually agreed-upon “Shared Rewarding Activities” is important because many families with drug problems have ceased engaging in shared pleasing activities, and such activities have been associated with positive recovery outcomes (Moos et al., 1990). Each activity must involve both partners, either as a couple only or with their children or other adults, and can be performed at or away from home. Teaching “Communication Skills” (e.g., paraphrasing, empathizing, validating) can help the patient with an SUD and his or her partner better address stressors in their relationship and in their lives as they arise, which is also viewed as reducing the risk of relapse.

Relapse prevention planning occurs in the final stages of BCT. At the end of weekly BCT

sessions, each couple completes a "Continuing Recovery Plan." This written plan provides an overview of the couple's ongoing post-BCT activities to promote stable sobriety (e.g., continuation of a daily Sobriety Trust Discussion, attending self-help support meetings) and contingency plans if relapses occur (e.g., recontacting the therapist, reengaging in self-help support meetings, contacting a sponsor).

BCT sessions tend to be moderately to highly structured, with the therapist setting a specific agenda for the sessions from the outset of each meeting. A typical BCT session begins with an inquiry about any drinking or use of drugs that has occurred since the last session. Compliance with different aspects of the Recovery Contract that have been negotiated is also reviewed and any difficulties with compliance are discussed and addressed. The session then moves to a detailed review of homework assigned during the previous session and the partners' success in completing the assignments. The therapist then identifies any relationship or other types of problems that may have arisen during the last week that can be addressed in session, with the goal of resolving the problems or designing a plan for resolution. Therapists then introduce new material, such as instruction in, and rehearsal of, skills to be practiced at home during the week. Toward the end of the session, partners are given specific homework assignments to complete during the subsequent week.

During initial sessions, BCT therapists focus on decreasing negative feelings and interactions about past and possible future drinking or drug use, and increasing positive behavioral exchanges between partners. Later sessions engage partners in communication skills training, problem-solving strategies, and negotiating behavior change agreements.

Traditionally, the patient with the SUD and his or her partner are seen together in BCT, typically for 15–20 outpatient couple sessions over 5–6 months, although BCT has been reduced to as few as six sessions (Fals-Stewart, Birchler, & O'Farrell, 2001). BCT can also be delivered as a stand-alone intervention or as an adjunct to standard individual substance abuse counseling. Appropriate candidates for BCT are (1) couples in which partners are married or have cohabited for at least a year; (2) couples in which neither partner has a co-occurring psychiatric condition that may significantly interfere with engaging in BCT (e.g., schizophrenia, psychosis); and (3) dyads in which only one member of the couple has a current problem with alcohol or drug abuse.

BCT for Women and Men: Comparable Outcomes, Different Processes

BCT with men and women who abuse substances have shown comparable effects in terms of substance use reductions, dyadic adjustment, and other outcomes. The BCT intervention is manualized but allows for some modification and changes in emphases, depending on the needs of the patients and the couples. With that stated, it has been our experience that the clinical content of BCT sessions with couples in which a female partner has an SUD focuses substantially more on relationship issues, whereas therapy sessions with couples in which the male partner has the SUD tend to focus more on substance use reduction and elimination. This is not by design, but tends to evolve based on the wants and needs of different couple types entering BCT.

BCT FOR FEMALES WITH SUDs: RESULTS FROM RANDOMIZED CLINICAL TRIALS

Since the 1970s, multiple studies have consistently found that participation in BCT by married or cohabiting patients with SUDs results in significant reductions in substance use,

decreased problems related to substance use (e.g., job loss, hospitalization), and improved relationship satisfaction. Recently, investigations exploring other outcomes have found that, compared to traditional individual-based treatments, participation in BCT results in significantly (1) higher reductions in partner violence, (2) greater improvements in the psychosocial functioning of children who live with parents who receive the intervention, and (3) better cost-benefit and cost-effectiveness (for a comprehensive review, see Fals-Stewart, O'Farrell, Birchler, Cordova, & Kelley, 2005).

As noted earlier, these findings are based largely on studies that enrolled men with SUDs and their non-substance-abusing female partners. Recent randomized clinical trials of BCT with female patients with SUDs have demonstrated promising evidence of effectiveness with women (Fals-Stewart et al., 2006; Winters et al., 2002). The following sections describe these studies in detail.

BCT with Female Patients with Alcohol Use Disorder

In a randomized trial that we conducted (Fals-Stewart et al., 2006), participants were heterosexual couples ($n = 138$) in which married or cohabiting women were entering outpatient treatment for an alcohol use disorder. Participating couples were then randomly assigned to one of three equally intensive interventions: (1) a BCT therapy condition, which consisted of individual alcohol counseling plus BCT sessions; (2) an individual-based treatment (IBT) condition, consisting of individual alcohol counseling only; or (3) psychoeducational attention control treatment (PACT) condition, consisting of individual alcohol counseling plus couple-based lectures.

During the first 4 weeks after admission, female patients in each condition participated in an *orientation phase*, during which background and medical information were collected. They also began weekly 12-step facilitation individual counseling sessions with their assigned counselor. During the following 12-week *primary treatment phase*, the female patients randomly assigned to the BCT condition began attending conjoint behavioral couple therapy sessions with their partners one time weekly, in addition to one individual counseling session each week. Female partners assigned to PACT began attending the conjoint psychoeducational lectures with their partners one time weekly, in addition to one individual counseling session weekly. Female partners assigned to the IBT condition attended two individual counseling sessions each week. Thus, during the primary treatment phase, female participants in all conditions were scheduled to receive 24 sessions. For the final 4 weeks, or the *discharge phase*, all female participants were scheduled to meet with their counselor for 12-step individual counseling sessions for one 60-minute session each week. Women in each condition were allowed to attend emergency individual counseling sessions at any time during any treatment phase.

Upon entering the study, at the completion of the discharge phase of treatment, and every 3 months thereafter for 1 year, female patients and their male partners were contacted and interviewed by a research assistant. During each of these assessments, participants were interviewed about the female partner's drinking and the couple's relationship satisfaction and adjustment.

In this randomized study, BCT was significantly more effective in terms of improving outcomes along different dimensions of drinking behavior and relationship adjustment than the other treatment conditions. More specifically, compared to female patients who received IBT or PACT, those who participated in BCT with their non-substance-abusing partners reported significantly fewer days of drinking and higher levels of dyadic adjustment during a 12-month posttreatment follow-up period. Additionally, the positive effects of BCT on

drinking and dyadic adjustment were more enduring during the posttreatment period than the positive effects of IBT or PACT, as evidenced by the slower rate of return to drinking and slower reductions in relationship satisfaction during follow-up.

Although drinking behavior and relationship satisfaction were the primary targets of the BCT intervention, the comparatively positive results for BCT were observed in other significant areas of psychosocial adjustment. In particular, women who participated in BCT reported fewer total negative consequences as a result of drinking during the year after treatment, particularly in terms of interpersonal, intrapersonal, and social responsibility consequences, than women who participated in IBT or PACT. Couples participating in BCT versus those participating in IBT or PACT reported fewer days of partner violence incidents, both in terms of male-to-female and female-to-male physical aggression. Because IPV is a significant and prevalent problem among alcoholic dyads, in general, identification and use of interventions that serve to reduce it in this population, as well as substance use, may be particularly important.

BCT with Female Patients with Drug Use Disorder

In a similarly designed study, Winters et al. (2002) conducted a randomized trial with married or cohabitating female patients with SUDs ($n = 60$) who were entering an outpatient treatment program. Participating couples were randomly assigned to one of two equally intensive treatment conditions: one treatment package consisted of IBT only, based on cognitive-behavioral therapy (CBT) for substance abuse; the other condition was BCT, consisting of individual- and CBT-based therapy plus BCT. Measures of drug use and dyadic functioning were collected pretreatment, during treatment, posttreatment, and at quarterly intervals thereafter for 1 year.

The couples in the BCT condition reported significantly greater marital satisfaction during treatment and through the 3-month posttreatment follow-up than the couples in which the female partner received IBT. The female patients in the BCT condition also reported lower frequency of substance use during treatment and throughout the 1-year posttreatment, when compared to the female patients in the IBT group.

In both our studies (Fals-Stewart et al., 2006; Winters et al., 2002), participants who received BCT had better within-treatment and posttreatment outcomes across several areas of substance use behavior and couple functioning. However, in the Winters et al. investigation of women in treatment primarily for drug abuse, differences in substance use and dyadic adjustment between the two treatments (i.e., BCT and IBT) diminished over the course of the 12-month follow-up period; in contrast, group differences in these domains of functioning increased during posttreatment follow-up for female patients with alcohol use disorder (Fals-Stewart et al., 2006). It is not clear why the effects of BCT were more robust with the female patients with the alcohol disorder, given the highly manualized treatment. However, differences in the sociodemographic and relationship characteristics of participants across the two studies suggest some plausible explanations. Females with SUDs from the Winters et al. study reported more formidable, multifaceted psychosocial problems (i.e., lower socioeconomic status, multiple current substance use diagnoses) and lower dyadic adjustment at baseline than the women entering alcohol treatment in the Fals-Stewart et al. study. These women appeared to spend more session time diffusing partner conflict and addressing substance-abuse-related crises than the female patients with alcohol problems, who appeared to use more session time on couple-based skills to enhance relationships and support for sobriety (Fals-Stewart et al., 2006).

BCT with “Double-Trouble” Couples

It is important to highlight that published studies of BCT have recruited couples in which only one partner met criteria for a current SUD. Couples in which both partners use drugs (i.e., double-trouble couples) have been far more difficult to treat, primarily because, in contrast to couples with one non-substance-abusing partner, there appears to be little support from within the dyadic system for sobriety. In fact, for dual-using couples, the more time partners reported spending together using substances, the stronger and more negative the association between length of time abstinent and dyadic adjustment; the inverse of this relationship is found for couples with only one partner with an SUD (Fals-Stewart, Birchler, & O’Farrell, 1999). Recently, a pilot study (Birchler & Fals-Stewart, 2007) examined the comparative efficacy of (1) a hybrid treatment of BCT plus contingency management (BCT + CM), (2) a standard BCT package without CM, (3) and treatment as usual (TAU). In this small-scale randomized clinical trial, participants were women with SUDs entering treatment for substance abuse ($n = 60$) who were married to, or in a stable relationship with, a male partner who met *DSM-IV* criteria for a current SUD. Couples were randomly assigned to one of the three conditions noted earlier. BCT + CM consisted of 32 sessions conducted over a 12-week period. Twelve sessions consisted of couple therapy, and the remaining sessions were 12-step facilitation sessions for the female partner only. Partners received vouchers contingent upon session attendance and providing clean urine and breath samples three times weekly. Standard BCT consisted of 12 BCT and 20 individual counseling sessions; vouchers were not provided in this condition. The TAU condition consisted of 32 individual counseling sessions for the female patients only; no CM procedures were used in this condition. Couples who received BCT + CM provided fewer positive urine samples during treatment, had a higher percentage of days abstinent during treatment and the year after treatment, and had higher levels of dyadic adjustment after treatment completion than couples in the other conditions. Although this was only a pilot study, the findings indicate that BCT + CM is a promising hybrid treatment for these very challenging couples in which both partners abuse substances.

FUTURE DIRECTIONS

Much work remains to examine whether BCT effects significant and meaningful changes for women with SUDs through a research program of empirically based, randomized clinical trials that is comparable to that which has been established for men with SUDs. Gaps in BCT research exist for both males and females with SUDs. However, given the unique gender-specific contextual issues faced by many women who attempt sobriety, the effectiveness of BCT and other family-based treatments must be explored independently for women. In particular, investigations in the following areas seem most critical to address the issues facing women with SUDs and their intimate partners: (1) moving beyond whether BCT works to an examination of *how* it works; (2) exploration of whether adaptations of BCT might offer even stronger treatment options for unique women’s contexts (e.g., women who abuse drugs vs. alcohol, women who are a partner in a double-trouble couple, and lesbian couples); (3) addition of other intervention components to standard BCT specifically targeted to enhance important secondary outcomes, particularly enhancements of parenting and child functioning, decreases in IPV and HIV risk behaviors, and addressing issues specific to women with same-sex partners; and (4) dissemination of BCT to community-based programs to address treatment access and availability issues facing women with SUDs.

The “How” of BCT: Mechanisms of Action

Although the results of multiple randomized clinical trials indicate that BCT works, no studies, to date, have empirically established *how* it works. More precisely, the mechanisms of action that produce the observed outcomes have not been tested empirically. As described earlier, the general theoretical rationale for the effects of BCT on substance abuse has been that certain dyadic interactions serve as inadvertent reinforcement for continued substance use or relapse and that relationship distress in general is a trigger for substance use. In turn, the BCT intervention package that has evolved from this rationale involves (1) teaching and promoting methods to reinforce sobriety within the dyad (e.g., engaging in the Recovery Contract), (2) improving communication skills to address problems and conflict appropriately when it arises, and (3) encouraging participation in relationship enhancement exercises (e.g., Shared Rewarding Activities) to increase dyadic adjustment.

However, it is not clear if participation in any or all of these aspects of the BCT intervention results in the improvements observed. For example, although most BCT studies have found that participation in BCT results in improvements in relationship adjustment and reductions in substance use, none has conducted a formal test of mediation to determine if changes in relationship adjustment (i.e., either during treatment or after treatment completion) partially or fully mediate the relationship between type of treatment received (e.g., BCT, individual counseling, an attention control) and substance use outcomes. Indeed, it is important to highlight that most studies have generally failed to find strong relationships between theoretical mechanisms of action of different interventions and subsequent outcomes, both in general psychotherapy (e.g., Orlinski, Grawe, & Parks, 1994; Stiles & Shapiro, 1994), and in substance abuse treatment (e.g., Longabaugh & Wirtz, 2001). The apparently heightened sociodemographic and relationship complexities of females with SUDs seeking therapy may threaten the sustainability of effects and their recovery attempts. Thus, it is particularly important for future studies of women with SUDs to test formally the theoretical mechanisms thought to underlie the observed BCT effects.

BCT for Different Types of Couples and Partners

Although BCT has been the subject of multiple clinical trials in the last three decades, the vast majority of these studies has focused on heterosexual couples in which only one partner was an identified patient with an SUD. Moreover, the studies for alcohol and drug dependence have evolved on separate tracks. In nearly all cases, studies include either patients who report that their primary substance of abuse is alcohol *or* those who report that their primary drug of abuse is something other than alcohol. To increase the ecological validity of BCT research, participant inclusion must be broadened to capture the wide array of couples that typically enter clinical practice.

For example, the majority of BCT approaches have excluded patients whose partners met criteria for current alcohol or SUD. This exclusion criterion has particular salience for females with SUDs, whose non-substance-abusing male partners are most likely to leave the relationship before the couple enters treatment (Fals-Stewart et al., 1999). Thus, these couples may not be adequately represented in treatment-based investigations. Instead, studies have repeatedly found that the majority or significant minority of married or cohabitating females with alcohol or substance-abusing problems entering treatment are involved with partners who also abuse drugs (e.g., Fals-Stewart et al., 1999, 2006; Laudet, Magura, Furst, Kumar, & Whitney, 1999). The pilot study conducted by Gorman, Klostermann, Fals-Stewart, Birchler, and O’Farrell (2004) examining BCT with CM for dual-using couples, offers great promise for future efforts to reach these couples. A larger randomized trial is needed

to determine the effectiveness of this BCT + CM therapy for these dual-using couples. Such an approach would serve not only the needs of many female patients initially entering treatment, but would also have the effect of reaching patients' intimate male partners who might not otherwise seek help for alcohol or drug use problems.

A criticism of BCT is that there has been a nearly exclusive application to heterosexual couples. It is widely recognized that partners in gay and lesbian couples have unique individual and relationship needs, and that findings from research with heterosexual couples may not generalize to same-sex couples (e.g., Mohr & Fassinger, 2006). A recent small-scale randomized clinical trial comparing BCT versus individual-based treatment for substance dependence with gay and lesbian couples found that BCT was more effective in reducing substance use frequency and relationship satisfaction than individual-based treatment (Fals-Stewart, O'Farrell, & Birchler, 2007). Although these findings are promising, they are far from definitive and highlight the need for further research on the use of BCT with these couples.

Lastly, it is also not clear if the demarcation between alcohol dependence and drug dependence of female patients, which is standard in BCT studies, continues to be necessary or useful. Although the distinctions between these patient populations may very well have been more defined 30 years ago, when BCT research began in earnest, the boundaries between these patient groups have become increasingly blurred over time. In most instances, female patients now entering treatment for an SUD meet criteria for multiple SUDs. It is plausible that the sociocultural differences between women with drug- versus alcohol dependence continue to be important and clinically relevant and, as such, warrant separation of these groups. It is a question that deserves greater empirical scrutiny.

Additions to Standard BCT Targeted to Enhance Secondary Outcomes

Although participation in BCT appears to have a positive impact on important secondary outcomes, the next phase of research needs to examine if these effects can be enhanced if the BCT intervention were modified to specifically target these outcome domains (in addition to substance use and relationship satisfaction). Some preliminary research is now underway with males with SUDs and their female partners to examine the effect of adding such circumscribed interventions to the standard BCT intervention package to determine if such outcomes can be further improved. Parallel investigations for women with SUDs and their male partners will be especially important to address the psychosocial contexts that are highly relevant to them.

For example, we completed a study exploring the impact of adding parent skills training to BCT to ascertain the effect on school-age children living with participating parents (Fals-Stewart, Fincham, Vendetti, & Kelley, 2003). In this study 72 couples who were raising a school-age child and in which the male partners abused drugs were randomly assigned to one of four conditions: (1) a 24-session manualized BCT condition, consisting of 12-sessions of BCT plus 12 sessions of 12-step group drug counseling (Daley, Mercer, & Carpenter, 1998); (2) a 24-session manualized Parent Skills plus BCT (PSBCT) condition, consisting of 6 sessions of BCT, 6 sessions of parent skills training, and 12 sessions of 12-step group drug counseling; (3) a manualized 24-session parent skills (PS) training condition, consisting of 12 sessions of parent skills training and 12 sessions of group drug counseling; or (4) a manualized 24-session group drug counseling condition for the male partner only. Parents and children were assessed at baseline, posttreatment, and quarterly thereafter for 12 months. Substance use frequency, dyadic adjustment, and children's emotional and behavioral adjustment were measured at each assessment point. Although participants who received BCT and PSBCT

had equivalent substance use frequency and relationship outcomes during the posttreatment follow-up period, with participants having superior outcomes in these areas to those who received PS or group counseling, children whose parents received PSBCT had higher levels of psychosocial functioning (i.e., reductions in internalizing and externalizing symptoms) during and after treatment completion than children whose parents were assigned to BCT, PS, or group counseling.

These findings suggest that the positive effects of standard BCT on children's emotional and behavioral adjustment can be enhanced with the addition of parent skills training. These findings have particular relevance for women with SUDs, who often maintain primary caregiving responsibilities for custodial children. In addition, the results of the study have implications for similarly designed investigations intended to explore the effects of adding other components to standard BCT to enhance secondary outcomes of interest. Pilot studies are also underway to determine if components added to BCT intended to reduce HIV risk behaviors, IPV, and issues facing lesbians with SUDs will also enhance the effects of standard BCT on these secondary outcomes.

Dissemination to Community-Based Settings

Although it has strong research support for its efficacy, BCT is not yet widely used in community-based alcoholism and drug abuse treatment settings. A national survey was conducted of 398 randomly selected U.S. substance abuse treatment programs that treated adults to determine the proportion of settings that use different family- and couple-based therapies (Fals-Stewart & Birchler, 2001). Based on responses from program administrators, 27% of the facilities provided some type of couple-based service mostly confined to assessment, that included couples. Less than 5% of the agencies used behaviorally oriented couple therapy, and none used BCT specifically.

In this survey program administrators were also queried about significant barriers to adoption of BCT; two primary concerns were raised. BCT was viewed as too costly to deliver, requiring too many sessions in its standard form. In addition, most BCT studies used master's-level therapists as treatment providers, but most community-based treatment programs employ counselors with less formal education or clinical training. Thus, the concern was that counselors who typically work in substance abuse treatment programs, most of whom have undergraduate degrees or less and have little formal clinical training, could not deliver BCT as effectively as master's-level therapists.

Two recently completed studies addressed each of these concerns regarding the use of BCT with men who abused substances. First, we evaluated the effectiveness of a briefer version of BCT. Brief BCT (six couple sessions and six individual sessions) and standard BCT were significantly more effective than IBT or PACT in terms of male partners' percentage of days abstinent and other outcome indicators during the year after treatment (Fals-Stewart, O'Farrell, & Birchler, 2001). Furthermore, brief BCT and standard BCT produced equivalent posttreatment outcomes. A second parallel study with male patients who were drug dependent produced similar findings as with the male patients who were alcohol dependent (Fals-Stewart, Klostermann, Yates, O'Farrell, & Birchler, 2005).

We also examined the differential effect of BCT based on counselors' educational background, comparing outcomes of couples randomly assigned to be treated by either bachelor's- or master's-level counselors in delivering BCT (Fals-Stewart & Birchler, 2002). Results for 48 men with alcohol dependence and their female partners showed that, in comparison to master's-level counselors, bachelor's-level counselors were equivalent in terms of adherence ratings to a BCT treatment manual, but were rated lower in terms of quality of treatment

delivery. However, couples who received BCT from the bachelor's- and master's-level counselors reported equivalent (1) levels of satisfaction with treatment, (2) relationship happiness during treatment, (3) levels of relationship adjustment, and (4) percentage of days abstinent (for patients with alcohol dependence) at posttreatment, 3-, 6-, 9-, and 12-month follow-up.

The findings of these investigations suggest that the primary identified barriers to BCT implementation in community-based settings (i.e., concerns about counselors with limited educational backgrounds and that BCT required too many sessions) either were not found when tested (i.e., no differential effectiveness of BCT based on counselors' educational background) or could be effectively overcome (i.e., use of an abbreviated version of BCT). Taken together, the results of these studies suggest that BCT could potentially be delivered effectively in the context of community-based substance abuse treatment programs, with one caveat: These studies targeted male patients; comparable investigations are needed for women with SUDs.

KEY POINTS

- Among female patients diagnosed with SUDs, dyadic and familial factors play a particularly salient role in etiology and maintenance of drinking and drug use behavior, as well as in relapse among patients who achieve stable periods of abstinence.
- Addressing these relationship and family factors may be a critical aspect of effective treatment efforts with married or cohabiting female patients diagnosed with SUDs.
- Three decades of research indicate that BCT is more effective, in terms of substance use, relationship quality, and family adjustment, than individual-based treatments for married or cohabiting males with SUDs and their non-substance-abusing female partners.
- Consistent with the findings of BCT with male patients, the results of two randomized clinical trials with married or cohabiting female patients with SUDs and their non-substance-abusing male partners revealed that BCT was more efficacious than individual-based treatments across multiple domains of functioning.
- More trials are needed to examine not only whether or not BCT is effective for married or cohabiting females with SUDs, but also to explore how it works (i.e., its mechanisms of action) and how it might be modified to meet the unique needs of different couple types (lesbian couples, dual-substance-using partners).

REFERENCES

Asterisks denote recommended readings.

- Allan, C. A., & Cooke, D. J. (1985). Stressful life events and alcohol misuse in women: A critical review. *Journal of Studies on Alcohol*, 46, 147-152.
- Annis, H. M., & Graham, J. M. (1995). Profile types on the Inventory of Drinking Situations: Implications for relapse prevention counseling. *Psychology of Addictive Behaviors*, 9, 176-182.
- Becker, J. V., & Miller, P. M. (1976). Verbal and nonverbal marital interaction patterns of alcoholics and nonalcoholics. *Journal of Studies on Alcohol*, 37, 1616-1624.
- Bendtsen, P., Dahlström, M., & Lejman, B. P. (2002). Sociodemographic gender differences in patients attending a community-based alcohol treatment center. *Addictive Behaviors*, 27, 21-33.
- Birchler, G. R., & Fals-Stewart, W. (2007, June). *Learning sobriety together*. Workshop presented at the Smart Marriages Conference, Denver, CO.

- Blum, L. N., Nielsen, N. H., & Riggs, J. A. (1998). Alcoholism and alcohol abuse among women: Report of the Council on Scientific Affairs. *Journal of Women's Health, 7*, 861-871.
- Brady, K. T., & Randall, C. L. (1999). Gender differences in substance use disorders. *Psychiatric Clinics of North America, 22*, 241-252.
- Connors, G. J., Maisto, S. A., & Zywiak, W. H. (1998). Male and female alcoholics' attributions regarding the onset and termination of relapses and the maintenance of abstinence. *Journal of Substance Abuse, 10*, 27-42.
- Daley, D., Mercer, D., & Carpenter, G. (1998). *Group drug counseling manual*. Holmes Beach, FL: Learning Publications.
- Dunn, N. J., Jacob, T., Hummon, N., & Seilhamer, R. A. (1987). Marital stability in alcoholic-spouse relationships as a function of drinking pattern and location. *Journal of Abnormal Psychology, 96*, 99-107.
- Edwards, M. E., & Steinglass, P. (1995). Family therapy treatment outcomes for alcoholism. *Journal of Marital and Family Therapy, 21*, 475-490.
- Epstein, E. E., McCrady, B. S., & Morgan, T. J. (2007). Couples treatment for drug-dependent males: Preliminary efficacy of a stand alone outpatient model. *Addictive Disorders and Their Treatment, 6*, 21-37.
- Fals-Stewart, W., & Birchler, G. R. (1994). *Marital functioning among substance-abusing patients in outpatient treatment*. Poster presented at the Annual Meeting of the Association for Advancement of Behavior Therapy, San Diego, CA.
- Fals-Stewart, W., & Birchler, G. R. (2001). A national survey of the use of couples therapy in substance abuse treatment. *Journal of Substance Abuse Treatment, 20*, 277-283.
- Fals-Stewart, W., & Birchler, G. R. (2002). Behavioral couples therapy for alcoholic men and their intimate partners: The comparative effectiveness of master's- and bachelor's-level counselors. *Behavior Therapy, 33*, 123-147.
- Fals-Stewart, W., Birchler, G. R., & Kelley, M. L. (2006). Learning Sobriety Together: A randomized clinical trial examining behavioral couples therapy with alcoholic female patients. *Journal of Consulting and Clinical Psychology, 74*, 579-591. (*)
- Fals-Stewart, W., Birchler, G. R., & O'Farrell, T. J. (1999). Drug-abusing patients and their intimate partners: Dyadic adjustment, relationship stability, and substance use. *Journal of Abnormal Psychology, 108*, 11-23. (*)
- Fals-Stewart, W., Birchler, G. R., & O'Farrell, T. J. (2001, July). Use of abbreviated couples therapy in substance abuse treatment. In J. V. Cordova (Chair), *Approaches to brief couples therapy: Application and efficacy*. Symposium conducted at the World Congress of Behavioral and Cognitive Therapies, Vancouver, BC.
- Fals-Stewart, W., Fincham, F., Vendetti, K., & Kelley, M. L. (2003, August). *The effect of adding parent skills training to behavioral couples therapy*. Poster presented at the 110th annual convention of the American Psychological Association, Toronto, ON.
- Fals-Stewart, W., Kashdan, T. B., O'Farrell, T. J., & Birchler, G. R. (2002). Behavioral couples therapy for drug-abusing patients: Effects on partner violence. *Journal of Substance Abuse Treatment, 22*, 87-96.
- Fals-Stewart, W., Klostermann, K., Yates, B. T., O'Farrell, T. J., & Birchler, G. R. (2005). Brief relationship therapy for alcoholism: A randomized clinical trial examining clinical efficacy and cost-effectiveness. *Psychology of Addictive Behaviors, 19*, 363-371.
- Fals-Stewart, W., O'Farrell, T. J., & Birchler, G. R. (2001, June). Both brief and extended behavioral couples therapy produce better outcomes than individual treatment for alcoholic patients. In T. J. O'Farrell (Chair), *Behavioral couples therapy for alcohol and drug problems: Recent advances*. Symposium conducted at the 24th annual scientific meeting of the Research Society on Alcoholism, Montreal, QU.
- Fals-Stewart, W., O'Farrell, T. J., & Birchler, G. R. (2007, November). Behavioral couples therapy for gay and lesbian couples. In T. J. O'Farrell (Chair), *Behavioral couples therapy for addictive disorders: New applications*. Symposium conducted at the annual meeting of the Association for the Advancement of Behavioral and Cognitive Therapies, Philadelphia, PA.
- Fals-Stewart, W., O'Farrell, T. J., Birchler, G. R., Cordova, J., & Kelley, M. L. (2005). Behavioral cou-

- ples therapy for alcoholism and drug abuse: Where we've been, Where we are, and where we're going. *Journal of Cognitive Psychotherapy*, 30, 1479–1495. (*)
- Gerolamo, A. M. (2004). State of the science: Women and the nonpharmacological treatment of substance abuse. *Journal of the American Psychiatric Nurses Association*, 10, 181–189.
- Gorman, C., Klostermann, K., Fals-Stewart, W., Birchler, G. R., & O'Farrell, T. J. (2004). *Treatment for dual drug-abusing couples: The effectiveness of contingency management plus couples therapy*. Poster presented at the 38th Annual Meeting of the Association for the Advancement of Behavior Therapy, New Orleans.
- Greenfield, S. F., Brooks, A. J., Gordon, S. M., Green, C. A., Kropp, F., McHugh, K., et al., (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and Alcohol Dependence*, 86, 1–21.
- Grella, C. E., Scott, C. K., Foss, M. A., Joshi, V., & Hser, Y. I. (2003). Gender differences in drug treatment outcomes among participants in the Chicago Target Cities Study. *Evaluation and Program Planning*, 26, 297–310.
- Hernandez-Avila, C. A., Rounsaville, B. J., & Kranzler, H. R. (2004). Opioid-, cannabis- and alcohol-dependent women show more rapid progression to substance abuse treatment. *Drug and Alcohol Dependence*, 74, 265–272.
- Hser, Y., Evans, E., & Huang, Y. (2005). Treatment outcomes among women and men methamphetamine abusers in California. *Journal of Substance Abuse Treatment*, 28, 77–85.
- Hser, Y., Huang, D., Teruya, C., & Anglin, M. D. (2004). Diversity of drug abuse treatment utilization patterns and outcomes. *Evaluation and Program Planning*, 27, 309–319.
- Jellinek, E. M. (1952). Phases of alcohol addiction. *Quarterly Journal of Studies on Alcohol*, 13, 673–684.
- Kail, B. L., & Elberth, M. (2002). Moving the Latina substance abuser toward treatment: The role of gender and culture. *Journal of Ethnicity in Substance Abuse*, 1, 3–16.
- Kelley, M. L., & Fals-Stewart, W. (2002). Couples versus individual-based therapy for alcoholism and drug abuse: Effects on children's psychosocial adjustment. *Journal of Consulting and Clinical Psychology*, 70, 417–427. (*)
- Kelley, M. L., & Fals-Stewart, W. (2007). Treating paternal alcoholism with Learning Sobriety Together: Effects on adolescents versus preadolescents. *Journal of Family Psychology*, 21, 435–444. (*)
- Kidorf, M., Disney, E. R., King, V. L., Neufeld, K., Beilenson, P. L., & Bronner, R. K. (2004). Prevalence of psychiatric and substance use disorders in opioid abusers in a community syringe exchange program. *Drug and Alcohol Dependence*, 74, 115–122.
- Laudet, A., Magura, S., Furst, R. T., Kumar, N., & Whitney, S. (1999). Male partners of substance-abusing women in treatment: An exploratory study. *American Journal of Drug and Alcohol Abuse*, 25, 607–627.
- Lemke, S., Brennan, P. L., & Schutte, K. K. (2007). Upward pressures on drinking: Exposure and reactivity in adulthood. *Journal of Studies on Alcohol and Drugs*, 68, 437–445.
- Longabaugh, R., & Wirtz, P. W. (Eds.). (2001). *Project MATCH hypothesis: Results and causal chain analyses*. Project MATCH Monograph Series, Vol. 8 (NIH Publication No. 01-4238). Washington, DC: U.S. Department of Health and Human Services.
- Longabaugh, R., Wirtz, P. W., Beattie, M., Noel, N., & Stout, R. (1995). Matching treatment focus to patient social investment and support: 18-month follow-up results. *Journal of Consulting and Clinical Psychology*, 63, 296–307.
- Maisto, S. A., O'Farrell, T. J., McKay, J., Connors, G. J., & Pelcovitz, M. A. (1988). Alcoholics' attributions of factors affecting their relapse to drinking and reasons for terminating relapse events. *Addictive Behaviors*, 13, 79–82.
- McCrary, B. S., Hayaki, J., Epstein, E. E., & Hirsch, L. S. (2002). Testing hypothesized predictors of change in conjoint behavioral alcoholism treatment for men. *Alcoholism: Clinical and Experimental Research*, 26, 463–470.
- Mohr, J. J., & Fassinger, R. E. (2006). Sexual orientation identity and romantic relationship quality in same-sex couples. *Personality and Social Psychology Bulletin*, 8, 1085–1099.
- Moos, R. H., Finney, J. W., & Cronkite, R. C. (1990). *Alcoholism treatment, context, process, and outcome*. New York: Oxford University Press.

- O'Farrell, T. J., Cutter, H. S. G., Choquette, K. A., Floyd, F. J., & Bayog, R. D. (1992). Behavioral marital therapy for male alcoholics: Marital and drinking adjustment during two years after treatment. *Behavior Therapy, 23*, 529-549.
- O'Farrell, T. J., Murphy, C. M., & Stephan, S. H. (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology, 72*, 202-217.
- Oggin, J., Guydish, J., & Delucchi, K. (2001). Gender differences in income after substance abuse treatment. *Journal of Substance Abuse Treatment, 20*, 215-224.
- Orlinski, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 270-283). New York: Wiley.
- Project MATCH Research Group. (1998a). Matching alcoholism treatments to client heterogeneity: Treatment main effects and matching effects on drinking during treatment. *Journal of Studies on Alcohol, 59*, 631-639.
- Project MATCH Research Group. (1998b). Matching alcoholism treatment to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: Clinical and Experimental Research, 22*, 1300-1311.
- Randall, C. L., Roberts, J. S., DelBoca, F. K., Carroll, K. M., Connors, G. J., & Matson, M. E. (1999). Telescoping of landmark events associated with drinking: A gender comparison. *Journal of Studies on Alcohol, 60*, 252-260.
- Sanchez-Craig, M., Leigh, G., Spivak, K., & Lei, H. (1989). Superior outcomes of females over males after a brief treatment for reduction of heavy drinking. *British Journal of Addiction, 84*, 395-404.
- Sonne, S. C., Back, S. E., Zuniga, C. D., Randall, C. L., & Brady, K. T. (2003). Gender differences in individuals with comorbid alcohol dependence and post-traumatic stress disorder. *American Journal on Addictions, 12*, 412-423.
- Stewart, D., Gossop, M., & Trakada, K. (2007). Drug dependent parents: Childcare responsibilities, involvement with treatment services, and treatment outcomes. *Addictive Behaviors, 32*, 1657-1668.
- Stiles, W. B., & Shapiro, D. A. (1994). Disabuse of the drug metaphor: Psychotherapy process-outcome correlation. *Journal of Consulting and Clinical Psychology, 62*, 942-948.
- Straussner, S. L. A., & Zelvin, E. (Eds.). (1997). *Gender and addiction: Men and women in treatment*. Northvale, NJ: Jason Aronson.
- Sun, A. (2007). Relapse among substance-abusing women: Components and processes. *Substance Use and Misuse, 42*, 1-21.
- Vaillant, G. E. (1995). *The natural history of alcoholism revisited*. Cambridge, MA: Harvard University Press.
- Webster, J. M., Rosen, P. J., & McDonald, H. S. (2007). Mental health as a mediator of gender differences in employment barriers among drug abusers. *American Journal of Drug and Alcohol Abuse, 33*, 259-265.
- Winters, J., Fals-Stewart, W., O'Farrell, T. J., Birchler, G. R., & Kelley, M. L. (2002). Behavioral couples therapy for female substance-abusing patients: Effects on substance use and relationship adjustment. *Journal of Consulting and Clinical Psychology, 70*, 344-355. (*)