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Do outcomes after behavioral couples therapy differ based on the gender of the alcohol use disorder patient?

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HIGHLIGHTS

- We compared behavioral couples therapy (BCT) for female and male alcoholics.
- Few differences were found between female and male alcoholic patients.
- They did not differ on drinking or relationship outcomes after BCT.

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ABSTRACT

Objective: This naturalistic study (conducted from 1992 to 1998) of behavioral couples therapy (BCT) compared female and male alcohol use disorder (AUD) patients on improvement and on drinking and relationship outcomes after BCT. We also evaluated gender differences on presenting clinical problems and extent of BCT participation.
Method: Participants were 103 female and 303 male AUD patients (98.5% alcohol dependence, 1.5% alcohol abuse) and their heterosexual partners, mostly White in their forties. Couples received 20–22 BCT sessions over 5–6 months. Drinking outcomes were percentage days abstinent (PDA) and alcohol-related problems. Relationship outcome was Dyadic Adjustment Scale. Outcome data were examined at baseline, post-treatment, and 6- and 12-month follow-up. Presenting problems were demographics, alcohol problem severity, illicit drug use, emotional distress, and relationship adjustment. BCT participation was BCT attendance and BCT-targeted behaviors.
Results: We found few differences between female and male patients, who did not differ on improvement and outcomes after BCT. Both females and males showed significant large effect size improvements through 12-month follow-up on PDA and alcohol-related problems, and significant small to medium effect size improvements on relationship adjustment. Both females and males had high levels of BCT participation. Gender differences in presenting clinical problems (females being lower on age, years problem drinking, and baseline PDA, and higher on emotional distress) did not translate into gender differences in response to BCT.
Conclusion: Results showed no support for the suggestion that BCT might lead to greater improvement and better outcomes for female than male AUD patients on drinking or on relationship outcomes.

1. Introduction

Behavioral couples therapy (BCT) is a couple-based therapy for adults with alcohol use disorder (AUD) that aims to help the AUD patient and their partner build support for the patient's abstinence and improve relationship functioning. BCT has a strong research base establishing its efficacy, and it has been shown to be more effective than more typical individual-based treatment (IBT) for married or cohabiting AUD patients. Specifically, BCT produces better outcomes than IBT, consisting of greater abstinence, fewer substance-related problems, and better relationship functioning (for a review see Meis et al., 2013). However, the vast majority of the studies examining BCT have been conducted using couples where the male partner has an AUD and the female partner does not have any substance use disorder.

Three randomized controlled trials have evaluated the efficacy of BCT with female AUD patients (Fals-Stewart, Birchler, & Kelley, 2006; McCrady, Epstein, Cook, Jensen, & Hildebrant, 2009; Schumm, O'Farrell, Kahler, Murphy, & Muchowski, 2014). These studies showed better drinking outcomes over 12-month follow-up for BCT than

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individual counseling, similar to results obtained with male patients. Still, to date no studies have directly compared male and female AUD patients on BCT outcomes. However, broader studies that compared male and female patients may suggest possible gender differences to examine among patients undergoing BCT.

Studies directly comparing males and females reveal some apparent gender differences among patients entering substance use treatment. Females have lower rates of treatment entry than would be expected based on population prevalence estimates (Pelissier & Jones, 2005). Also, females enter treatment at a younger age with fewer years of substance use, yet some studies show they present with greater substance-related consequences than their male counterparts (Hernandez-Avila, Rounsaville, & Kranzler, 2004). Further, females have a higher prevalence of psychiatric disorders, such as depression, anxiety and PTSD (Greenfield et al., 2007).

Interestingly, many studies have found little to no difference in treatment outcome between males and females. However, when gender differences are present, results show a better treatment outcome for females (Greenfield et al., 2007). In terms of relapse, studies indicate that females have less severe and shorter relapses and seek help more quickly following a relapse (e.g., Project MATCH, 1997). A study of outpatient alcohol treatment found females had eliminated heavy drinking days at 6-month follow-up while males continued to report heavy drinking episodes (Satre, Mertens, Arean, & Weisner, 2004). Sanchez-Craig, Spivak, and Davila (1991) also found gender difference when evaluating brief alcohol treatments, with females showing greater drinking reduction across three different conditions.

The impact of interpersonal relationships on AUD may also represent an important gender difference. Relationship concerns appear to play a greater role in women's drinking and treatment seeking behaviors for AUD. Compared to males, females report less relationship satisfaction and increased likelihood of drinking in response to interpersonal stressors (Kelly, Halford, & Young, 2002). Similarly, Connors, Maisto, and Zywiak (1998) found women with AUD were more likely than men with AUD to attribute conflict with their partner as a primary relapse precipitant.

This greater salience of relationship factors for female patients, coupled with evidence in some studies of better treatment outcomes for female patients, suggest that BCT could lead to greater improvement and better outcomes for female than male AUD patients. The present naturalistic study of BCT compared female and male AUD patients on the extent of improvement and on drinking and relationship outcomes after BCT. Potential gender differences on presenting clinical problems and extent of participation in BCT also were evaluated.

2. Methods

Institutional review boards at Harvard Medical School and at VA Boston approved this study.[1]

2.1. Participants

These were 406 AUD patients (303 males and 103 females; 98.5% alcohol dependence, 1.5% alcohol abuse) and their heterosexual spouses or cohabiting partners who were recruited from four addiction treatment programs in Massachusetts to take part in a study designed to naturalistically examine factors that predict outcome following BCT. Study criteria included (a) patient and spouse were ages 21 to 65; (b) couple was married or living together for at least 1 year; (c) patient met current alcohol abuse or dependence diagnosis according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; American Psychiatric Association, 1987); (d) patient's alcohol problem diagnosis was at least as serious as any co-existing current drug problem diagnosis as shown by the patient having alcohol dependence with drug dependence, drug abuse or no drug problem or alcohol abuse with drug abuse or no drug problem; (e) patient accepted abstinence from alcohol and drugs at least for the duration of the BCT program and agreed to seriously consider taking Antabuse (if medically cleared); and (f) patient agreed to forego other AUD counseling (other than self-help such as Alcoholics Anonymous) during the BCT program. Also, patients generally were excluded if their partner also met criteria for current alcohol or drug abuse or dependence. An exception to this were 20 of the 103 female AUD patients whose male partners also had a current AUD problem, and both patient and partner agreed to use the BCT sessions to pursue abstinence.[2]

Study participants were drawn from 464 consecutive patients (347 males and 117 females) who signed informed consent from February, 1992 to June, 1998. Fifty-eight patients dropped out early before completing the baseline assessment and were not followed further. The percentage of these early dropouts did not differ by gender (44 [13%] males and 14 [12%] females). This left 406 study patients (303 males and 103 females) who began BCT and were included in the present study sample. When compared on demographics to the study sample, the early pre-assessment dropouts, on average, were significantly younger ($M = 37.7$ vs. 42.5 years respectively; $t\,(455) = 3.36$, $p = .001$) and more likely to be in a non-marital, cohabiting relationship (31% vs. 12% cohabiting respectively; $\chi^2\,(1, 464) = 14.78$, $p < .001$), with a trend toward being in relationships of briefer duration ($M = 9.6$ vs. 12.6 years respectively; $t\,(448) = 1.88$, $p = .06$); but they did not differ in years of education ($M = 13.1$ vs. 13.4 years respectively; $t\,(453) = 0.76$, $p = .450$). The early dropouts did not provide other information (e.g., alcohol or relationship severity) on which comparisons with the study sample could be made.

Of the 406 study cases, 199 (49%) entered the study immediately after completing inpatient AUD treatment (typically 3–10 days in length), 172 (42%) came from persons requesting outpatient AUD treatment, and the remaining 35 (9%) came from media announcements or from other referral sources.

2.2. Procedures

2.2.1. BCT treatment program

This program is described by O'Farrell (1993). It consisted of 20–22 weekly couple sessions over a 5–6 month period — 10–12 weekly 1-hour conjoint sessions with each couple followed by 10 weekly 2-hour couples group sessions. The program included a daily recovery contract to promote abstinence, instigation of positive couple activities, and training in communication skills. The recovery contract included Alcoholics Anonymous (AA) meetings and daily spouse observed Antabuse for most patients. For patients who did not take Antabuse, the recovery contract involved a daily discussion in which the patient stated their intent not to drink that day, and the spouse expressed support for the patient's efforts to stay abstinent. Ratings of videotaped BCT sessions showed therapists adhered to the BCT manual and did so in a competent manner (see O'Farrell et al., 2004 for more details).

2.2.2. Data collection

Demographics and alcohol problem severity measures were collected before BCT. Drinking and relationship outcome measures were

[1] Some data from this sample were included in earlier articles on reductions in IPV among male (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004) and female (Schumm, O'Farrell, Murphy, & Fals-Stewart, 2009) AUD patients. However, the data presented in this article examining possible gender differences on demographics, treatment participation, and drinking and relationship outcomes have not appeared elsewhere. More details about study methods are in O'Farrell et al. (2004) and in Schumm et al. (2009).

[2] Another paper (Schumm, O'Farrell, & Andreas, 2012) that also used the present sample showed that these 20 couples in which both partners had a current AUD did not differ from the rest of the sample on extent of improvement in days abstinent in the year following BCT.