Couples Planning: A Treatment Plan Overview for Couples with Alcohol Problems

Spend at least one hour planning sample treatment plans that incorporate behavioral terms, long term goals, short term goals, and appropriate interventions or strategies for each goal selected.

Drinking and family functioning are linked (Roberts & Linney, 2000), although the relationship may be causal, reciprocal, iterative, or incidental to other causes. There are several family problems that are likely to co-occur with an individual's alcohol abuse, including intimate partner violence, conflict and low relationship satisfaction, economic and legal vulnerability, and child risks. Communication in family systems that involve members with substance problems may be characterized as highly critical, involving considerable amounts of nagging, judgments, blame, complaints, and guilt (Reilly, 1992). Families of individuals with alcohol use disorders are often characterized by conflict, chaos, communication problems, unpredictability, inconsistencies in messages to children, breakdown in rituals and traditional family rules, emotional and physical abuse (Connors, Donovan, & DiClemente, 2001).

Couples

Alcohol problems are common among couples that present for relationship/marital therapy (Halford & Osgarby, 1993), and marital problems are common among those who present for alcohol treatment (O'Farrell & Birchler, 1987). Alcohol abuse affects couples' relationships in a variety of negative ways, including communication problems, increased conflict, nagging, poor sexual relations, and domestic violence (Connors, Donovan, & DiClemente, 2001). Individuals married to persons with alcohol use disorders have higher rates of psychological, stress-related medical problems, and greater use of medical care systems, than other individuals (Connors, Donovan, & DiClemente, 2001; Holder, 1998). There is great controversy over the concept of co-dependency in couples' alcohol-involved relationships. On one hand, there exists some literature describing the characteristics of co-dependency. On the other hand, there are research studies indicating that these characteristics are present in the vast majority of the population (up to 95%), and that there is an absence of evidence supporting the validity of a "diagnosis" of co-dependency (Fisher & Harrison, 2000).

Families and Recovery

Family members and family process may play a direct role in relapse during recovery, as family conflict and/or strong negative affect (e.g., anger aroused during conflict) may
precipitate renewed drinking by abstinent alcoholics (Maisto, O'Farrell, Connors, McKay, & Pelcovits, 1988; Marlatt, 2004, oral presentation). On the other hand, the family may play an important role in facilitating alcohol treatment and recovery processes (Connors, Donovan, & CiClemente, 2001; McCrady, 1986, 1989). The integration of relapse prevention with couples counseling has been shown to be effective (Connors, Donovan, & DiClemente, 2001). Furthermore, family-based therapeutic interventions with adolescent substance abusers are proving more effective than individual or group therapy treatment approaches (Waldron & Slesnick, 1998).

Treatment of a substance abuser appears to have a preventive effect on the mental health and substance abuse risks among their children (O'Farrell & Feehan, 1999). Intervention goals with children of alcoholics are related to reducing their risk for developing alcohol problems of their own through identifying the dysfunctional behaviors that may be predisposing risks and assessing their risk (Fisher & Harrison, 2000). Social workers need to take into consideration the full gamut of vulnerability, risk, resilience, and protective factors expressed in a population in order to understand the heterogeneity in outcomes observed (Begun, 1993).

Family systems models hypothesize a series of homeostatic functions in families that have implications for the processes associated with an individual's recovery from alcohol problems. The underlying assumption is that an individual's maladaptive behavior (e.g., alcohol abuse) reflects dysfunction in the system as a whole (Van Wormer, 1995). As such, the alcohol abuse serves an "adaptive" function for the family system as a whole. For example, the family is allowed to divert its attention away from and to avoid even more threatening issues (e.g., a source of conflict that threatens the system's integrity as a whole) by attending to a member's drinking behavior. In this conceptualization, the drinking behavior transcends the individual and is relational, thus the relationships are a necessary focus of intervention (Waldron & Slesnick, 1998). These types of approaches are designed to address and restructure family interaction patterns that are associated with the alcohol abuse. As a result, the alcohol abuse is no longer "needed" by the family system for its survival.

In addition, some family systems authors have postulated that the family system adopts a host of "adaptive" responses to an individual's alcoholism-emotional repression, emotional walls and barriers, and other survival mechanisms. When the alcoholic family member stops drinking and attempts to re-engage with the family system, the system risks losing its hard-won sense of balance (equilibrium) that was established around the drinking and drinking individual (Brown & Lewis, 1999; Wegscheider, 1981). It is argued that these "adaptive" behaviors may become functionally maladaptive, and that the family system may fight to regain its equilibrium by encouraging a return to drinking or by refusing acceptance of the changed individual who attempts to re-engage or redefine his or her old roles. Interventions based on this model emphasize interactional elements among family members and family structures-redefining roles, explicating rules that direct family behavior, and redefining boundaries (O'Farrell & Fals-Stewart, 1999).

Behavioral Family Models are founded on the principles of social learning theory. The underlying assumption is that alcohol use disorders are acquired and maintained through interactions with the social environment. This includes observational learning (e.g., imitation of role models), operant learning (e.g., behaviors are enhanced or suppressed through reinforcing or punishing consequences), and the presence or absence of opportunities provided by the environment. In this framework, family is important in the development and maintenance of alcohol use disorders for several reasons (McCrady, 1989; Waldron & Slesnick, 1998):
Their behaviors can act as stimulus cues that trigger drinking responses; 
Family members act as models for specific alcohol-related behaviors, as well as for more general coping strategies (e.g., observation of drinking to relieve stress); 
The family may influence an individual's emotional and physical reactions which are associated with vulnerability to alcohol abuse; 
Their responses can act to reinforce or punish efforts at sobriety, abstinence, or reduction of alcohol use 
Family members may interfere with the individual experiencing the negative consequences of drinking, and this shielding encourages perpetuation of the drinking. Models of behavioral family treatment (including Behavioral Marital Therapy, BMT) encourage family members to address the ways in which they can facilitate recovery by providing positively reinforcing responses for behaviors that are incompatible with drinking, removing responses that might be encouraging drinking behavior, and attending to features in the environmental context that encourage drinking. There may be additional components to specific approaches, such as behavioral family therapy to encourage the alcohol abusing family member to enter into treatment or to comply with treatment regimens (e.g., taking medication). BMT addresses the many ways in which an individual's substance abuse affects family process and marital relationships (e.g., communication, conflict, poor sexual relations, violence).

The Family Disease Model suggests that alcohol use disorders are not only diseases affecting an individual, they affect other family members, as well. The model indicates that the disease is manifested in other family members in terms of phenomena such as anxiety, enmeshment and other dysfunctional relationships, low self-esteem, and "co-dependence" (O'Farrell & Fals-Stewart, 1999). Co-dependence, according to this model, is a complementary or parallel disease to alcoholism, exhibited by the alcoholic's significant others. The codependent person presumably exhibits a number of symptoms associated with the disease (e.g., issues about control, perfectionism, "frozen" feelings/emotional blunting, and external referencing), and engages in "enabling" behaviors. Enabling is described as behaviors that perpetuate another person's substance use-for example, protecting the person from experiencing the natural consequences of substance use that might have led to deterrence in the future; making access easier; covering up for the other person's drinking. Treatment approaches formulated around this model do not address the individual's substance use directly, but encourage the significant others to heal themselves from their own disease and recover from the impact that the drinking has had on their lives. The family members are encouraged to detach themselves from the other's drinking, reduce their own emotional distress, and improve their own coping and functioning. There exists little in the way of empirical support for this model (O'Farrell & Fals-Stewart, 1999) that underlies the Al-Anon program.

Readiness to Change within a family system may proceed in a manner that closely parallels the change process for an individual (Connors, Donovan, & DiClemente, 2001). Families that minimize the drinking problem of an individual member are reflecting a process parallel to the individual who is in the precontemplation phase in stages of change concerning an alcohol use disorder. The tendency is to deny that the problem exists, or to acknowledge that drinking is a problem, but to minimize its significance and severity. This precontemplation phase is also generally characterized by a sense of helplessness to change the situation-poor self-efficacy.

As the family becomes increasingly exposed to and aware of the negative consequences associated with the drinking, family members or the family as a whole may shift into the next stage in the process of change: contemplation. Families in this stage evaluate the situation, considering the ways in which the drinking makes the family vulnerable-children and
adolescents may be experiencing difficulties with behavior and school, the partner or spouse finds relationship problems with the alcohol abuser to be less and less tolerable. At this point, the family becomes convinced that something must change in the system, but they have not yet made a concrete commitment to specific change actions. In preparation for change, the family has begun to take some small steps toward change of the situation, and has a “near future” timeline for implementing change. This is a point in which the family is likely to be seeking help alternatives and information about treatment options, and may also be considering the pros and cons of other alternatives to life with an alcohol abuser.

One or more of the family members may become increasingly concerned and may begin to explore popular or professional literature, the local phone directories, Internet websites, substance abuse help-lines, as well as consulting friends, clergy, or health care professionals in an attempt to gain information to help them better understand substance use and dependence and to direct them toward possible treatment options. (Thomas et al, 1987, p. 151)

When a family takes specific, notable steps to change the situation, it is said to have entered into the action phase of the change process. Different families settle on different action plans, and a single family may adopt multiple strategies. During this phase of the change process, it is important that action steps be reinforced and supported if change is to proceed. Otherwise, the family may fall back to its earlier ways of thinking, believing, and behaving about the alcohol abuse, in response to the pain, difficulty, and resistance associate with the change process. Thus, whether or not the individual with the alcohol use disorder seeks help, the family system needs support. When the alcohol abuser does seek help, the family needs assistance in seeking and achieving stable, abstinent relationships, and ultimately, in maintaining long-term recovery and relapse prevention.

Behavioral Descriptors for Alcohol Problems in Couples:

1. Frequent use of alcohol by one or both spouse or partners, in large amounts that meet the diagnosis of alcohol abuse or dependency. This abuse interferes with major social obligations.
2. Many arguments over the issue of alcohol abuse by one or both spouse or partners.
3. Failure of spouse or partner with drinking problem to stop drinking or reduce amount of drinking.
4. History of episodes of violence or threats to do harm by the spouse or partner with drinking problem.
5. Deterioration of the relationship due to alcohol abuse problems.
6. Little or no communication, sexual intercourse or recreation due to alcohol abuse problems.
7. Spouse or partner without the drinking problem enables drinking spouse or partner by denying the seriousness of the drinking problem, and making excuses for the drinking problem.
8. High financial pressures such indebtedness, poor money management due to alcohol abuse problems.
9. Social isolation by drinking spouse or partner, having only contact with drinking spouse or partners.
10. User or partner with drinking problem becomes socially isolated due to shame, or threats.

Long Term Goals for Alcohol Problems in Couples:

1. Spouse or partner with alcohol abuse accepts or agrees to the need to stop drinking and initiate abstinence by participating in an alcohol recovery program.
2. Spouse or partner with alcohol abuse agrees to greatly reduce the amount of alcohol consumption.
3. Sobriety improves the quality of relationship with support from better communication and more frequent interactions between spouse or partners.
4. Spouse or partner without drinking problem learns to be more supportive by becoming more assertive and independent.
5. Spouse or partner without drinking problem learns to be free from denial of drinking problem.
6. Both spouse or partners agree to re-establish a relationship free from violence.
7. Both partners agree to establish a sense of mutual trust and respect and learn to seek each other when needed.
8. Spouse or partners address how drinking has affected their relationship, and learn to develop problem solving skills to address new aspects of the relationship without drinking.
9. Spouse or partner without the drinking problem learns to reduce his or her argumentativeness about the drinking problem.
10. Spouse or partner with drinking problem learns to address his or her drinking problem.

Short Term Goals for Alcohol Problems in Couples:

1. Describe the effects of alcohol abuse on self esteem, social relationships, family, and work.
2. Spouse or partner with drinking problem agrees to sign a contract as a means to assess his or her ability to limit alcohol drinking.
3. Spouse or partner with drinking problem agrees to read material on alcohol abuse and controlled drinking.
4. Both partners agree to attend therapy sessions alcohol free.
5. Spouse or partners sign a non-violence contract.
6. Spouse or partner without the alcohol abuse problem develops a safety plan.
7. Spouse or partners agree to attend conjoint and individual psychotherapy sessions.
8. Identify with couple the perceived benefits of alcohol intoxication.
9. Identify non drinking behaviors that result after alcohol abuse or drinking.
10. Learn stress reduction skills that may help couple substitute drinking as a way to reduce stress.
11. Spouse or partner with alcohol abuse practices anger management techniques and methods.
12. Help couple understand social and biological causes for alcohol abuse.
13. Couple agrees to develop a list of recreational activities that can bring joy and substitute need for alcohol drinking.
14. Couple lists how each may interfere with open communication.
15. Couple learns listening and empathy skills in a communication exercise.
16. Each spouse or partner identifies an example when she or he was listened and understood by the other spouse or partner.
17. Couple learn problem solving skills.
18. Couple learns cooperative problem skills during session and apply them during session.
19. Spouse or partner with alcohol abuse apologizes to each family member for distress he or she has caused.
20. Identify triggers to episodes of drinking and develops non drinking alternatives to cope with situation.
21. Non drinking spouse or partner learns how she or he may be an enabler of alcohol drinking behavior.
22. The spouse or partner without drinking problem learns how to confront abusive behavior from drinking spouse or partner.
23. Couple learns to discuss how drinking impacts their budget and develop a plan to attack
it.
24. Couple develops a plan to make social contact with non drinking couples and develop a network to initiate contact for non drinking activities.

Interventions for Alcohol Problems in Couples:

1. Both spouse or partners describe the negative effects of alcohol abuse.
2. Spouse or partner with drinking problem signs a contract that specifies frequency and amounts of consumption allowed.
3. Spouse or partner with alcohol abuse problem reads pamphlet that specifies how to control drinking.
4. Require that all therapy session will be alcohol free periods.
5. Both partners sign a non violence contract.
6. Individual treatment to address anger issues, and provide supportive counseling.
7. Probe the benefits the spouse or partner with drinking problem gains from drinking, such as reduce anxiety, altered moods, etc.
8. Assist couple in planning constructive non-drinking alternatives to produce similar effect sought when drinking.
9. Teach drinking spouse or partner anxiety or stress reduction techniques,(exercise, verbalizing concerns or stress, relaxation, etc.).
10. Teach couple anger management techniques.
11. Teach couple assertiveness as healthy substitution to aggression.
12. Educate couple in physical and psychological factors in alcohol abuse.
13. Provide a referral to physician for medical alternatives and evaluation.
14. Teach couple to learn to be kind to one another and do small favors for each other.
15. Encourage a well develop plan to increase recreational actives.
16. Have each spouse or partner express how she or he may interfere with communication.
17. Help couple explore their own communication styles and how they interfere with problem.
18. Teach couple to attack a conflict topic and assess communication styles.
19. Reinforce positive communication during and after sessions.
20. Couple learns to describe problem in non blaming manner.
21. Couple models and role play problem solving following steps: Define Problem, List Solutions, Evaluate Solutions.
22. Encourage use of learned problem solving techniques at home.
23. Assist spouse or partner with drinking problem to identify situations that may trigger drinking behavior.
24. Confront couple with behaviors that support the continuation of drinking behaviors.

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