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Review Article

Behavioral Couples Therapy for Substance Use Disorders: Recommendations for Implementation

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Abstract

In Behavioral Couples Therapy (BCT) is a theoretically-based, manualized, and an empirically supported treatment based on social learning theory which posits that distressed couples engage in interaction patterns characterized by punishment rather than mutual positive reinforcement behaviors. BCT was originally designed for a marital family model of general psychotherapy; however, in the past 4 decades, BCT has proven to be effective for the treatment of conjoint alcoholism and substance abuse. Despite empirical data demonstrating positive outcomes with this population, BCT has not been widely accepted in community-based alcoholism and drug abuse treatment. Implementation of new treatments, like BCT, often fail due to a lack of careful consideration as to whether the necessary resources, timing, and commitment of staff and management are present to launch the treatment process into action for full operational execution. A successful implementation process requires a cultural shift within and throughout the agency. Recommendations for implementation of BCT for community-based agencies are presented along with several reasons why implementation often fails.

Keywords: Behavioral couples therapy; Dissemination; Implementation

Introduction

Behavioral Couples Therapy (BCT) is a theoretically-based, manualized, and empirically supported treatment based on social learning theory, which posits that distressed couples engage in interaction patterns characterized by punishment rather than mutual positive reinforcement of relationship benefitting behaviors [1,2]. While initially developed as a marital therapy model for use in general psychotherapy, in the past 4 decades, BCT has also been shown to be an effective conjoint treatment for alcoholism and drug abuse [3,4].

O'Farrell, et al. [5] conducted a study on couples affected by alcoholism. The authors randomly assigned male alcoholics and their female partners to either one of the following treatment options: 1) alcoholism counseling, 2) alcoholism counseling and couples group therapy, or 3) alcoholism counseling and BCT. Overall, the authors found BCT to be effective and successful at the time of two-years follow-up, in addition all men assigned to each condition improved as demonstrated by the number of their nondrinking days [5]. Moreover, Emmelkamp et al. [6] study on 64 alcohol disordered patients and their partners similarly supports BCT as an effective treatment modality with this population. Here, subjects were assigned to BCT or cognitive-behavioral treatment (CBT). Despite drinking outcomes being relatively alike at posttreatment, subjects in the BCT condition reported higher relationship satisfaction [6]. Notwithstanding this evidence, BCT has not been widely used in community-based alcoholism and drug abuse treatment. This may be attributed to the fact that BCT was initially established for use in general psychotherapy, though it has been shown to be an effective conjoint treatment with individuals battling a substance use disorder [4]. Still, BCT has been demonstrated through meta-analysis to improve relationship functioning in couples engaged in this type of therapy; these improvements can improve one's interpersonal relationship(s) and support, which could theoretically lead to positive outcomes in terms of one's alcohol and drug use [7].

McGovern, et al. [8] investigated community addiction providers' (i.e., directors [n = 21] and clinicians [n = 89]) experiences, beliefs, and readiness to implement a variety of evidence-based practices. Results were mixed; providers reported higher rates of readiness

for the adoption of twelve-step facilitation, cognitive behavioral therapy, motivational interviewing, and relapse prevention, while being less inclined to implement contingency management, BCT, and pharmacotherapies. McGovern et al. [8] concluded that in order for treatments to be successfully disseminated, investigators must explicitly communicate the relevance of the treatment to clinicians and staff, even if empirical support has already established. Other factors to consider include degree of difficulty in implementation, how closely (or not) the treatment is aligned with the therapist's preferred theoretical orientation, current agency counseling approaches, cost of providing the new treatment, and whether the treatment fills a perceived area of need for the clinic. As will be discussed later, each of these areas may serve as a potential barrier to successful dissemination of the treatment.

Any discussion of the introduction of a new technology must start with a basic question: "Why should we do this?" Previous research on implementation of evidence-based treatments has found that only 5-30% of implementation attempts are successful [9]. These findings may be a function of the planning fallacy-more specifically, the idea that if you train someone in the confines of a particular treatment approach, they will return to their place of employment and do it well. The purpose of this commentary is to describe why new implementation efforts often fail and to provide recommendations for disseminating treatments into clinical practice.

Why do Most Implementation Efforts Fail?

The decision to adopt a new intervention must be based upon careful assessment as to whether the necessary resources, timing, and commitment of staff and management are present to even begin the implementation process. Thus, thorough and honest consideration must be given to the resources needed to adopt the new treatment – both in the short- and long-term – for each unit within the agency. Implementation efforts fail when emphasis is solely placed on the intervention itself and the clinician disseminating it, rather than organizational change as a whole [9]. Historically, the implementation model used in most settings involved sending a clinician or two to a training to watch demonstrations, with the goal of returning to their site to lead implementation efforts. More recently, Miller and colleagues [10] argued for a paradigm shift from an off-site, isolated training experience to a more practice oriented, feedback-driven process with continuous on-the-job coaching. Implementation efforts fail for a myriad of reasons including, poor timing, inadequate supervision and oversight, a lack of necessary skill set(s) to offer the new treatment, deficiencies in communication, a shortage or absence of buy-in from staff or administration, an unwillingness to tolerate failure(s), and/or poor investment [11].

Successful implementation efforts require a culture change in which the new treatment is embedded within the organization; thus, all staff must be clear on the rationale behind the new approach [12]. This type of shift is cultivated over time through an iterative process of collecting constructive criticism and incorporating it back into the system to refine and improve practice. In other words, it is not an acute event but an ongoing process of installation, and feedback on successes and failures, which are then used to further integrate the treatment into the agency. Implementation efforts are best conceptualized in terms of years (rather than months) of successful agency-wide implementation and organizational culture change [13,14]. Moreover, a systematic plan for installation of the new treatment is also critical with careful consideration of the necessary procedural and structural changes to support the new intervention [15,16].

Factors Affecting Implementation

According to the implementation machinery developed for Feedback Informed Treatment (FIT), Miller and his colleagues [10] at the International Center for Clinical Excellence (ICCE) argued that installation of any new approach is a complex and multi-layered endeavor which must be evaluated and reviewed from three perspectives: 1) the practitioner (e.g., the individual therapist), 2) the agency, and 3) the system of care (e.g., funders, payers, etc.). Although adoption of a new technology may impact each of these areas in unique and specific ways, these three perspectives are not mutually exclusive; they reciprocally interact with one another leading to ubiquitous implications for the system [10]. Accordingly, Miller et al. [10] describe five factors that must be considered before deciding to implement a new treatment: 1) the relative advantages, 2) the compatibility of the treatment, 3) the complexity or simplicity of the new treatment model, 4) the ability to pilot the treatment, and 5) the treatment's observability. Simply stated, "relative advantages" refers to whether the new treatment is better than what is currently being offered. In terms of compatibility, how does the new treatment fit within the agencies current service delivery model, methods, and priorities? In general, the greater the difference between the new treatment and what is currently offered, the longer the installation process required. Complexity or simplicity denotes the balance between adopting the new treatment in its truest form, yet not overwhelming staff with too much information too soon. Along these lines, it is sometimes helpful to think of the implementation process in terms of an "installation," with specific pieces to be implemented at different times. In the pilot stage, the agency begins to try the new intervention to identify barriers that must be addressed prior to widespread implementation. Finally, observability refers to the importance of others being aware of the new treatment and its corresponding progress (or lack thereof); this may take the form of video review, group supervision around challenging cases using data collected as part of FIT, and regular internal communication about the status of the project. Moreover, in an effort to increase observability, some agencies will offer "lunch and learns," where each month a staff member will informally discuss one of the core FIT principles as a refresher for staff.

The five factors identified above must be considered from all three perspectives (the practitioner, the agency, and the system of care). All these factors are interconnected and jointly interacting. A common mistake made by eager clinicians, supervisors, and/or administrators is that the overall scope of the implementation process, a project in and of itself, is not well-contemplated and overlooked leading to decreases in enthusiasm and passion as the group runs into roadblock after roadblock. Successful

implementation requires a team effort and involves more than just one person. Although one staff member may be the most enthusiastic and passionate about the new treatment (i.e., "the champion"), it is critical that the choice to implement is a team decision, rather than perceived by staff as the one person's project. There must be open lines of communication to elicit conversation (both up and down, as well as sideways) so as to encourage dialogue about the treatment, and to determine (at least initially) if the treatment fits within the agency and is a service worth adopting given the amount of effort required to change the culture of the clinic.

Barriers to Successful Implementation

Even the most well-thought out plans are likely to encounter obstacles during the early stages of implementation. Thus, it is important to consider a small-scale adoption to identify any problem areas and consistently use the data gleaned from this preliminary implementation to revise and refine the process-clinically, administratively, and so forth. The key is to start small and fail in a survivable way as opposed to jumping into an agency-wide implementation before the necessary structures are in place and failing catastrophically (which is likely frustrating, costly, and decreases the likelihood of future implementations). Consequently, it is imperative to identify barriers and develop solutions prior to pervasive adoption. There must be a commitment to continuous monitoring and assessing progress throughout the implementation process. Ultimately, the goal is for a change in culture in which the new treatment is completely embedded within the agency.

Common obstacles to introducing a new treatment include lack of communication and information sharing among staff about the intervention and implementation progress [10]. Staff must be aware of the rationale and justification for the introduction of a new service, as well as any associated reverberations for the agency and its patients. Another common obstacle is the lack of commitment and involvement from management and administration. Although many administrators/supervisors initially agree to adopting the new treatment, their support and commitment is not always overt. This results in staff not viewing the new treatment, as well as any changes in policy and procedures, as important or an agency priority; perception matters. Another common barrier occurs when management does not scale down caseloads for those involved in the piloting phase of the intervention so as to accommodate for any increased demands which may occur from participating in the project. If staff begin to feel that the new intervention is simply another administrative burden, fatigue and burnout will set in and implementation efforts are likely to fail. Finally, many implementation efforts simply fail because the management and staff do not accurately consider the amount of time necessary to change the culture of the organization to include the new treatment. Relatedly, many agencies struggle with implementation as a result of lack of planning and underestimating the scope of this type of endeavor.

Recommendations for Implementation

Given the high rate of implementation failure, it is critical that management, administration, and staff carefully consider the benefits of adopting a new treatment methodology/approach, as well as not overlook the obstacles and barriers that this may create. As noted earlier, a 2-day intensive workshop on any given model is not sufficient to return home and implement in practice; a shift is needed at the cultural level of an organization. Extensive planning among key personnel who are representative of the 3 organizational levels is critical-everyone must have input into the decision to implement a new treatment. In addition, after the decision is made to proceed with introducing a new treatment, agencies are strongly encouraged to start with a small and slow installation rather than an elaborate agency-wide project. Successful implementation efforts struggle and 'fail small' often, and use the knowledge gleaned from these experiences to continually revise and strengthen efforts. Furthermore, it is also worth noting that it may be better to risk failure on a small scale, rather than continue trying to implement in a manner which does not work.

Conclusion

Behavioral Couples Therapy (BCT) has shown promise for treating addictive disorders, yet its implementation for community-based alcoholism and drug abuse treatment has lagged. Efforts to more widely adapt this promising treatment often fail for reasons to do with the ability of clinic administrators to effectively embed and implement the new treatment, rather than the efficacy of the treatment itself. Patients and clinicians could benefit from a more disciplined and targeted approach to change management; this includes mindful adaptation of new procedures in a manner that results in a cultural change within the agency itself, creating and encouraging lasting improvements.

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