Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

HHS Public Access

Author manuscript

Psychol Serv. Author manuscript; available in PMC 2016 July 21.

Published in final edited form as:

Psychol Serv. 2012 February ; 9(1): 64–73. doi:10.1037/a0026694.

Mental Health Experts' Perspectives on Barriers to Dissemination of Couples Treatment for Alcohol Use Disorders

Yael Chatav Schonbrun,
Butler Hospital, Providence, RI, and Warren Alpert Medical School of Brown University

Gregory L. Stuart,
University of Tennessee, Knoxville

Terrie Wetle,
Warren Alpert Medical School of Brown University

Tiffany R. Glynn,
Butler Hospital, Providence, RI

Elise N. Titelius, and
Butler Hospital, Providence, RI

David Strong
Butler Hospital, Providence, RI, and Warren Alpert Medical School of Brown University

Abstract

Despite evidence supporting the efficacy of couples-based approaches to treating alcohol problems, provision of such treatments has been limited. To better understand the limited use of this treatment, the current study explored barriers to the adoption of couples treatment for alcohol use disorders. Experts in alcohol treatment, couples treatment, and behavioral couples treatment for alcohol problems ($n = 12$) were interviewed on this topic; interview transcripts were analyzed using grounded theory qualitative procedures. All mental health experts endorsed the perspective that implementation and acceptance of couples treatment posed difficulties for providers. Four themes (logistical barriers at the provider level, logistical barriers at the system levels, provider treatment preferences, and lack of appropriate training) were identified. Results from the current study provide guidance in addressing barriers to the adoption of couples-based treatments.

Keywords

alcohol; barriers; couples treatment; dissemination; treatment seeking

Correspondence concerning this article should be addressed to Yael Chatav Schonbrun, Butler Hospital, Warren Alpert Medical School of Brown University, 345 Black-stone Boulevard, Providence, RI 02906. Yael_Chatav_Schonbrun@Brown.edu.
Yael Chatav Schonbrun and David Strong, Butler Hospital, Providence, RI, and Department of Psychiatry & Human Behavior, Warren Alpert Medical School of Brown University; Gregory L. Stuart, Department of Psychology, University of Tennessee, Knoxville; Terrie Wetle, Department of Community Health, Warren Alpert Medical School of Brown University; Tiffany R. Glynn and Elise N. Titelius, Butler Hospital, Providence, RI.

Portions of this article were presented at the 2009 annual conference for the Association of Behavioral and Cognitive Therapies.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

A long-standing central objective of clinical psychology research has been the development and testing of treatments for mental health and substance use disorders. As a result of decades of such research, there now exists a multitude of treatment packages with considerable scientific support that target mental health and substance use disorders across the spectrum (Nathan & Gorman, 2007). Nevertheless, a minority of individuals with disorders use treatment, particularly those with diagnosable substance use disorders (Wang et al., 2005), and even fewer access evidence-based practices (EBPs; Kazdin, 2008). As a consequence of the notable "chasm" between research and practice (Institute of Medicine, 2001), there has been a shift in emphasis from the development and testing of treatment to extending the reach of EBPs across public and private treatment settings (e.g., Kazdin & Blase, 2011).

Difficulties in dissemination of EBPs have been noted in a number of treatment settings with a high prevalence of substance use disorders, such as community mental health centers, the Department of Veterans Affairs, and criminal justice settings. For example, a survey conducted at six Veterans Affairs medical centers revealed inconsistent use of EBPs (Rosen et al., 2004). Implementation surveys of community mental health centers suggest that use of EBPs also represents a relatively small percentage of mental health and substance abuse treatments delivered (Jameson, Chambless, & Blank, 2009). A national survey of criminal justice and community-based programs offering substance abuse treatment to adult offenders across the United States reported that only 60% of programs use EBPs (Friedmann, Taxman, & Henderson, 2007). This evidence indicates that dissemination of EBPs into public health settings is limited. Investigations of what barriers exist in the adoption of EBPs in appropriate clinical settings would provide guidance in improving dissemination efforts.

One example of a treatment that has undergone substantial development and testing efforts is couples therapy for alcohol use disorders (AUDs). Over 30 years ago, a call to systematically evaluate couples therapy for AUDs sparked a series of studies testing such approaches. Since that time, couples treatment of AUDs, particularly behavioral couples therapy (BCT), have garnered extensive empirical support, with a recent meta-analysis demonstrating a greater effect of BCT on alcohol and relationship outcomes as compared with individual treatment (Powers, Vedel, & Emmelkamp, 2008). Recently, the American Psychological Association's Division 50 (Society of Addiction Psychology) committee on empirically supported treatments reviewed the outcome evidence and concluded that BCT met criteria for a well-established treatment, and BCT is currently listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (U.S. Department of Health and Human Services, 2011). Despite the extensive body of scientific research and its exemplary status as an efficacious treatment, the poor uptake of couples-based treatments for AUDs has persisted (Fals-Stewart & Birchler, 2001; McGovern, Fox, Xie, & Drake, 2004).

Although the general problem of limited uptake of EBPs in facilities providing treatment for substance use disorders has increasingly become a focus (e.g., Garner, 2009; Glasner-Edwards & Rawson, 2010; Lamb, Greenlick, & McCarty, 1998), much of the attention has been on treatments occurring on an individual basis, such as motivational interviewing, contingency management, and cognitive–behavioral therapy (Garner, 2009). In contrast,

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

barriers to dissemination of couples and family treatments for alcohol problems have received more modest attention. Three studies have explored the barriers to dissemination of this treatment approach. Results from these studies indicate that few providers offer such services, that many have never heard of BCT, and that few providers and administrators are likely to adopt such practices. These studies are described in greater detail below.

Two surveys have been conducted to better understand barriers to substance treatment dissemination. In a national survey of 398 outpatient substance abuse treatment programs in the United States, less than 5% of agencies reported use of any form of BCT (Fals-Stewart & Birchler, 2001). Based on interviews with program administrators, reported reasons why couples treatment was not provided included a lack of appropriate training for staff, the belief that couples treatment was not appropriate for patients, difficulties obtaining health insurance reimbursement, and the belief that a referral for couples treatment was more appropriate once substance abuse treatment had come to its completion. In a subsequent survey of readiness to adopt EBPs, directors and clinicians from 24 addiction treatment programs were evaluated, and results from this study revealed that 14% of clinical directors and 37% of clinicians were not familiar with BCT, and that BCT was among the least used EBPs (McGovern et al., 2004). Moreover, directors and clinicians reported that they saw many pros and cons to adopting BCT practices. Although these studies provide valuable information on barriers to the adoption of couples treatment for alcohol problems, reliance on researcher-generated questionnaires may prohibit the evaluation of barriers that might be spontaneously identified by practitioners.

Qualitative interviews with five community-based substance abuse treatment programs in which BCT efficacy trials had been completed were conducted to better understand why BCT has encountered obstacles in its dissemination (Fals-Stewart, Logsdon, & Birchler, 2004). Qualitative interviews were conducted 3 to 5 years following the completion of efficacy trials; at that time, four of the five programs involved in this study no longer offered BCT. Via interviews regarding barriers to retaining BCT as a service, many counselors reported that they had not ever heard of BCT, highlighting the issue of high counselor turnover rates at substance treatment facilities (McLellan, Carise, & Kleber, 2003). One supervisor at a treatment facility reported the belief that relationship work ought to be initiated only after a year of sobriety has been completed. Finally, at the administrative level, cost reimbursement was reported as a consideration to not retaining BCT services. The focus on providers at facilities where BCT clinical trials had been conducted limits the generalizability to providers at BCT-naïve facilities. Moreover, perspectives from experts in couples (vs. substance abuse) treatment may provide further insights into the barriers to dissemination of couples-based treatments.

Evidence-based BCT is a well-established treatment that has demonstrated some clear advantages over individual-based treatments for partnered individuals with an AUD. However, the dissemination of couples treatment, to date, has been limited, and there is a dearth of research examining the barriers to the adoption of couples treatment. Virtually no information has been gathered from mental health experts whose expertise in treatment barriers relates to various treatment settings, including the Department of Veterans Affairs and other community treatment settings. The collection of data from mental health

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

professionals with diverse experience and expertise may be instructive with regard to improving dissemination efforts across treatment settings. Use of qualitative methodology may be particularly informative for the understanding of barriers to dissemination efforts, as qualitative investigation permits greater understanding of why people take or do not take treatment-related action (e.g., Tsogia, Copello, & Orford, 2001).

The current study builds on previous work examining barriers to entry into couples treatment of alcohol problems by incorporating an in-depth analysis of barriers to the adoption of couples treatment at the provider and administrator levels. Use of qualitative analysis of semi-structured interviews permitted systematic investigation of barriers to the adoption of couples treatment generated by mental health experts. To build on previous studies, the current study incorporated perspectives of mental health experts from varied theoretical and training perspectives. Furthermore, rather than imposing researcher-generated notions of what barriers might exist, use of the open-ended interviews and qualitative analysis of interview data provided an opportunity to better understand the perspectives of mental health experts.

Method

Participants

Our sampling strategy involved both a criterion and a maximum variation approach (Crabtree & Miller, 1992), which seeks to include a wide range of perspectives within the sample. Therefore, in-depth qualitative interviews were conducted with experts in alcohol treatment ($n = 5$) and experts in couples treatment ($n = 5$); in addition, two experts in the specific modality of BCT for AUDs were interviewed; participants are referred to as mental health experts from here forward. Fifty-eight percent ($n = 7$) of mental health experts were men, and all were White. Experts averaged 24.45 years ($SD = 8.94$) of service. Mental health experts were either clinical practitioners or were prominent researchers in their respective areas of expertise. Experts were recruited from community mental health treatment centers, the Department of Veterans Affairs, and top-tier research universities. We made an effort to recruit providers with varied perspectives (i.e., theoretical orientations ranged from cognitive–behavioral to eclectic) and training backgrounds, which ranged from bachelor’s-level providers in community treatment facilities to doctorates in clinical psychology within academic institutions.

Qualitative Interviews

The first author conducted all interviews on an individual basis. Interviews ranged in length from 33 to 52 min. All interviews were recorded and transcribed. Questions asked were structured to elicit perspectives in the mental health experts’ own words and to allow respondents to elaborate on their perspectives:

1. What are barriers to the dissemination of couples treatment for alcohol problems?
2. What are barriers to providing couples treatment for alcohol problems?

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

3. Why do you think there is a deficit of clinicians trained in couples treatment for alcohol problems?

Follow-up questions (e.g., "Why do you think that is the case?") were asked to obtain further clarification regarding barriers to dissemination.

Qualitative Data Analysis

A grounded theory analysis was used to analyze qualitative data. The first author and two research assistants independently analyzed the interview transcripts and coded them using a line-by-line reading to identify barriers to the adoption of BCT. Open coding strategies (Strauss & Corbin, 1998) were used to generate a codebook of barriers to providing couples treatment for alcohol problems. Utterances that most clearly reflected an emerging specific concept (e.g., provider scheduling) were chosen from among text that had been marked. Subsequent to the independent coding of each transcript, the first author and two research assistants reviewed each transcript as a team to arrive at a consensus for marked text and the theme identification for each section of text. Axial coding was conducted through team consensus; specific concepts were grouped by broader themes (e.g., logistical barriers) and organized under broader organizational headings (i.e., provider-level and system-level barriers). After the first coding using the above-described procedures, selective coding was conducted by verifying the reliability of coding and data saturation with the aid of two new research assistants.

Results

The primary goal of the analysis of transcripts was to identify concepts and themes that represent important barriers to the adoption of BCT practices. A thematic analysis of the mental health expert interview transcripts identified four themes at two higher order levels (i.e., provider and system levels). All mental health experts endorsed the perspective that adoption of couples treatment practices posed difficulties, and emerging themes underscored the importance of specific barriers. The themes are described in the paragraphs that follow and are illustrated with sample quotations.

Provider Level

Several barriers were identified at the provider level.

Theme 1: Logistical barriers—Mental health experts across disciplines and areas of expertise described the importance of logistical barriers in the adoption of BCT practices by providers. Scheduling sessions with couples was viewed as an important barrier to adoption of BCT because the difficulty of scheduling therapy sessions with couples is greater than for individuals. One BCT expert stated, "If … clinicians have a limited number of evening hours, for example, and the couple could only come in the evening, then scheduling starts getting tricky." Mental health experts noted that scheduling issues may be relevant for individual therapy, but the salience is even greater for couples given the likelihood that at least one member of the couple is employed. Related to the issue of scheduling with the couple, other mental health experts noted the limited availability of appointment slots within

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

clinics and agencies: "I think that after-hours are really important and there are not enough of them."

Mental health experts also raised financial considerations as an important barrier to the adoption of couples treatment and to seeing substance abuse patients more generally. One substance treatment provider described the internal conflict of whether to continue providing treatment for patients who fail to show up for treatment sessions:

> I'd like to say, "Oh, well, we're just going to swing through here and carry on." But it has ramifications for me, because it's putting me on the line with the clients, it means, it's an ethical issue for me. Because, you know, do I eat, or do I [see patients]?

Several mental health experts noted that a potential limitation in insurance reimbursement might also be at the forefront of providers' minds. One BCT expert suggested that providers might wonder, "Will insurance reimburse it?" Another addictions researcher noted that reimbursement for couples versus individual work might also be a deterrent to providing BCT services: "[If] the reimbursement isn't [significantly] greater for seeing a couple than it is for an individual, there's no financial incentive to do it." Although many insurance providers reimburse couples therapy at a higher rate than individual therapy, providers may believe that the compensation for couples treatment is still insufficient relative to the higher level of work required by the treatment provider.

Theme 2: Provider treatment preferences—In contrast to standard individual treatment approaches for substance use disorders, couples treatment for alcohol problems incorporates a focus on both the individual and the contextual factors of the relationship of the patient with the AUD. Several mental health experts noted that this added complexity of couples approaches represents a disincentive to learning and providing this treatment. Indeed, one BCT researcher noted, "Our treatments are pretty complex." A couples researcher echoed this sentiment, stating that providers may perceive that "family therapy is just way too complicated. It's harder to learn [relative to individual therapy]." Indeed, substance treatment providers described similar perceptions, stating, "I think couples therapy is really hard to do. I think it's harder than individual. And, couples therapy, with someone that's an alcoholic and someone that isn't … that's harder." Therefore, mental health experts from varied backgrounds agreed that couples treatment represents a form of treatment with higher levels of complexity relative to individual treatment.

Several mental health experts also expressed the belief that incorporation of the partner into the identified patient's treatment might not be helpful in certain circumstances, and that partner participation in treatment was not necessarily "embraced" as a part of standard treatment. One substance treatment provider described a potential situation in which partner participation would be a detriment: "If a family doesn't want to get involved or they're negative, we don't want them to be part of the treatment process."

Discomfort of couples treatment providers with substance abuse treatment and discomfort of substance treatment providers with couples treatment also emerged as a barrier to the more widespread adoption of couples treatment. One BCT researcher noted that for "most

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

clinicians who are used to seeing people individually, the idea of having another [person] in the room and having to manage the dynamics of the other two, particularly around preventing excess conflict of some … Clinicians are afraid." A couples treatment provider further elaborated on the theme of how conducting couples treatments can be scary for providers: "And the transference with an individual is one thing, but when you've got two and they're playing out their bitterness and shame and upset, that's pretty scary." Moreover, one individual substance use treatment provider noted the additional concern about legal involvement with couples-oriented treatment: "So [if] there's just a lot of screaming and yelling and chaos … and this comes out and then, you're a clinician, you know there are kids in the house and overnight … That's the other thing, [potential Department of Social Services] involvement." In the particular case of disclosure of intimate partner violence, a mental health expert also noted that "providers are more concerned about the violence in couples treatment, because they don't know how to handle it, or they're concerned that they might not do the right thing, or something bad may happen …."

In contrast, a couples treatment provider described his discomfort in addressing substance use issues in the context of couples therapy: "You don't want to try to open up something with a substance user primarily because you're creating … the potential for harm really, because it's just not … they need external structures more. And I don't like that kind of work very much." In addition, the common belief that a substance treatment provider needs to be in recovery was also highlighted as a possible deterrent for couples treatment providers to treat substance use disorders:

> There's also historically been this notion that you kind of have to have had substance use problems to really be able to treat substance use … And so … couples therapists might think, well because of that, then I haven't been there, then I may not be the best, the most effective.

The lack of appeal of the underlying behavioral model guiding EBPs, including BCT, was also cited as a reason for reticence of providers to adopt evidence-based couples practices. One BCT researcher noted that "… The appeal of systems therapy is it's … really interesting. And … there are all these kind of exotic concepts, and the people, the kind of senior people in family systems approaches are, they've been really spectacular clinicians." In contrast, this BCT researcher noted that providers might find EBPs such as BCT less exotic or exciting.

System Level

In addition to barriers to adoption of couples treatment at the provider level, mental health experts also identified a number of system-level barriers to implementing couples treatment on a broader scale.

Theme 1: Logistical barriers—Several logistical barriers were identified at the system level. One BCT expert noted that when conducting couples treatment, there are complexities in record keeping that do not arise in individual treatment. One mental health expert wondered, "Do they have to open a medical record … for the intimate partner? [If they don't, then] they're seeing somebody without a record." Therefore, confidentiality

Author Manuscript

concerns and record keeping practices carry additional burden for providers, and there are few guidelines available to direct practices for maintaining confidentiality when conducting couples treatment.

In addition, lack of funding for public awareness campaigns was also noted as a cause for the limited dissemination of couples treatment. One addictions researcher noted that "… there's a [public relations] issue of getting the word out that it's more effective than treating an individual." A couples treatment provider further noted that "… there's not much advertisement for … couples [treatment]." Several researchers and clinicians surmised that the method to overcome this barrier would be to implement far-reaching public health campaigns educating providers and treatment administrators about the efficacy of BCT.

Theme 2: Lack of appropriate training—Indications of the lack of a broader orientation of the field toward supporting training in individual versus couples treatments also emerged as an important barrier to the dissemination of evidence-based couples treatment. First, a number of mental health experts commented on the lack of cross-training for substance abuse treatment and couples treatment. One couples therapist noted that "… new people coming into the field aren't getting the training both in the alcoholism, alcohol treatment and the couple treatment." Describing the training divergence in individual versus couples approaches, one couples researcher stated,

> I think probably … for the training of master's-level people who do a lot of the couples and family therapy, that there probably isn't a major focus on training and recognizing psychopathology, and they similarly [may] not be as familiar with the literature showing couples therapy has been effective for a variety of mental health problems.

This couples researcher described that as a result of this training system, "there's couples therapy providers who are used to doing couples therapy, and there's mental health professionals who are used to kind of doing individual treatment for psychiatric disorders. And then there's not much overlap."

A number of mental health experts further described the difficulty in obtaining training in evidence-based couples treatments. One couples researcher (and director of a clinical training program) noted that this trend begins early in the education of psychologists:

> In terms of what psychologists are getting in terms of their training, most programs would probably not include a major focus on couples issues as a contributing factor for mental health problems. And, they probably don't include couples therapies as major treatment modalities. And I think it starts at the undergraduate level, as well. The popular undergraduate psychology texts on abnormal psychology probably don't have a major focus on couples issues or couples therapy.

This deficit in training applied to numerous evidence-based treatment approaches, but was more salient for couples treatments: "I think … there's a lot of problems with [the] training of therapists and nonadoption of evidence-based practice … And then, couples training, at least for psychologists, is kind of specialty training." Therefore, training in evidence-based

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

couples treatments, such as BCT, is largely absent from the training programs that give rise to providers that serve in substance treatment facilities across the country.

For established clinicians in the field, funding for training remains an important barrier to adopting treatments. Several frontline clinicians noted that funding within community treatment facilities has decreased considerably over recent years, with resulting declines in opportunities to obtain further training. One couples therapist described the current circumstances: "I think the training in all of the entire field is decreasing. In agencies, there's no longer talks, there's no longer money, there's no longer even supervision for people who have been certified." Therefore, training in couples treatment for alcohol problems might be difficult to obtain. Indeed, although some substance treatment providers reported that they felt capable of providing couples treatment for AUDs, none of them endorsed having received any formal training in BCT.

Discussion

The current study represents one of few efforts to better understand barriers to disseminating couples-based treatments to treatment providers and among various treatment facilities. Given the evidence for the utility of evidence-based couples approaches to treating alcohol problems, and given the poor uptake of couples-based EBPs in treatment facilities providing substance abuse treatment, it is important to obtain a better understanding of what barriers exist to dissemination. With this understanding, researchers, clinicians, and policymakers can take informed steps to improving the dissemination of couples-based EBPs, including BCT. Furthermore, the current study is informative in understanding the general barriers to uptake of couples-based treatments for various mental health disorders.

A number of barriers to couples treatment uptake that emerged in the current study resemble those identified in prior studies (Fals-Stewart & Birchler, 2001; McGovern et al., 2004). The current study builds on previous findings by providing an in-depth analysis of barriers using qualitative data analysis, and by including the perspectives of both couples and substance treatment experts. Consistent with literature demonstrating the efficacy of couples treatment (Powers et al., 2008), many mental health experts highlighted the importance of bridging the gap between research and practice by disseminating couples approaches to treating AUDs: "We really need to be able to offer people really good, competent approaches to care that incorporate family members and right now, I think that's a big gap out there." This disconnect was reflected in the Institute of Medicine's (2001) report on shaping the future of health care, which states that "between the health care that we now have and the health care that we could have lies not just a gap, but a chasm" (p. 1).

A model of dissemination developed from work on a behavioral family intervention for children with mental health problems proposes a system-contextual approach (Sanders & Turner, 2005; Turner & Sanders, 2006) that accounts for both contextual variables and organizational barriers. Such an approach is relevant for a variety of treatment settings, including publicly and privately funded treatment centers. Indeed, results from the current study underscore the significance of both provider-level and system-level barriers as obstacles to the uptake of couples treatment for alcohol problems. Sanders and Turner

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

(2005) also highlight a number of areas in which dissemination failures can occur, including ineffective communication with providers about the treatment, insufficient organizational supports, and theoretical clashes between the existing and new treatment model. Current study results point to dissemination barriers specific to these areas, as well. It also should be noted that dissemination failures may be especially relevant in public sector settings, given the limited resources and inherent difficulties enacting systemic changes in larger organizations.

At a contextual (i.e., provider) level, a number of logistical barriers to the uptake of couples treatment for alcohol problems emerged. Scheduling and financial constraints were perceived to be greater for couples compared with individual treatment for AUDs. To address these issues, mental health experts suggested the need for the provision of after-hour sessions. In addition, treatment protocols that can incorporate biweekly and even monthly sessions may be practical. Increased financial incentives for providers to offer couples, versus individual, sessions would likely facilitate motivation to receive training and to provide couples treatments. Finally, collaboration with policymakers and third-party reimbursement organizations is clearly necessary to effect changes in reimbursement schedules and training support.

In addition to basic logistical barriers, mental health experts also identified some important preference, fears, and information deficits that contribute to difficulty in adoption of BCT services. Concern about the greater level of complexity of couples versus individual treatment was discussed as an important reason for providers opting out of providing couples services. A similar theme emerged from the national survey of substance treatment facilities (Fals-Stewart & Birchler, 2001). It is clear that providers with limited time and funding support for additional training require treatment approaches and treatment manuals that are simple and straightforward. These findings appear to be relevant for treatment settings across public and private sectors. Therefore, adapting EBP manuals to formats that are simpler, require less training, and reduce complicated protocols to their basic active ingredients will be essential for enhancing the uptake of couples approaches to treating AUDs. Inclusion of simple guidelines for handling feared situations, including legal issues, would also be an important component for adapted treatment manuals. Such guidelines might also provide simple decision trees for determining couples that are not good candidates for couples treatment.

At the system level, many treatment facilities were described as not having adequate structures in place to be able to provide couples treatment. For example, record keeping for couples must be conducted differently for couples versus individual treatment. Whereas it is clear who the patient is in individual treatment, such a distinction may be more ambiguous in couples treatment. Similarly, there are no clear guidelines for obtaining reimbursement for couples treatment in which an AUD is the target problem (vs. marital distress). As noted previously, clear guidelines or recommendations for addressing such issues and clear communication between agencies and third-party payers are required to address these barriers. Guidelines may need to be modified depending on the organization. For example, procedures for obtaining reimbursement for services differ in the Department of Veterans Affairs as compared with community-based substance treatment facilities. An additional

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

issue of lack of awareness of the existence of couples treatments for AUDs speaks to the importance of improving communication between researchers and clinicians (Miller, Sorensen, Selzer, & Brigham, 2006).

In addition to organizational limitations, current and well-established training paradigms that separate out training in treatments for “individual disorders” and “marriage and family counseling” were highlighted as an important impediment to dissemination of couples treatment for alcohol problems. As a consequence of training programs that exclusively provide training in family or in disorder-specific treatment, family counselors are likely to feel ill equipped to treat substance use disorders, and substance treatment counselors may feel similarly unprepared to treat a maritally distressed dyad with co-occurring alcohol problems. Although it is unlikely that training paradigms will undergo an immediate overhaul, the concerns raised in the current study highlight the importance of providing training in skill sets that permit providers to engage the support of a patient’s partner.

Indeed, in a recent review of EBPs in addiction treatment, we recommend a shift in training strategies from specific manualized treatments (i.e., BCT) to broadly applicable skills sets (i.e., engaging the support of substance abusers’ family members; Glasner-Edwards & Rawson, 2010). In addition, another review of research on training of therapists in EBPs (Beidas & Kendall, 2010) concludes that changes in uptake of EBPs will occur only if barriers at various levels (i.e., provider and system) are addressed. Taken together, dissemination may be improved if the current focus of manual-based treatments shifts toward a focus on specific skill sets that can be more broadly applied and learned with minimal training (Glasner-Edwards & Rawson, 2010). Such an approach is supported by results from the present study, which indicate that mental health experts are overwhelmed by couples-based treatments and the associated complex issues, including record keeping and legal concerns. Efforts to repackage couples-based approaches to emphasize a perspective in which the partner aids in the treatment of the identified patient, and in which clear guidelines are provided for common situations, may address this issue. Such a strategy is likely to benefit providers across diverse treatment setting types. However, it will be important to empirically investigate whether these simplified approaches maintain the significant treatment outcome advantages that full BCT has shown over individual therapy. Moreover, it will be important to ascertain whether different strategies to repackage couples-based approaches are required for different treatment settings, or whether a one-size-fits-all strategy is sufficient.

The current study highlights important barriers to adopting couples-based practices. Such barriers include provider barriers, such as scheduling and financial limitations encountered by providers, and concerns of providers of the added complexity of couples treatment, as well as beliefs that couples treatment is not helpful or would be outside of the bounds of a providers’ competency or comfort level. In addition, systemic barriers to adoption of couples treatment included organizational barriers and informational barriers, as well as significant limitations in current training models and resources. Despite the importance of these findings, there are a number of limitations that should be noted. First, this study relied on a small, convenience sample of mental health experts. Results may therefore not be representative of mental health experts across the United States and may not be

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

generalizable across the multitude of possible treatment settings where BCT and other EBPs might be delivered, including criminal justice settings and other community mental health settings. Therefore, it is important to note that conclusions are tentative and require follow-up with larger representative samples that are recruited from diverse treatment settings. Despite this concern, many barriers to providing BCT services reflect those identified in previous larger surveys of providers (McGovern et al., 2004), including a national survey (Fals-Stewart & Birchler, 2001). This study is also limited insofar as the focus was on mental health experts' perspectives on barriers to treatment uptake and utilization, rather than evaluating the occurrence of adopting couples treatment for alcohol problems, and the associated barriers, over time. Future trials evaluating methods to enhance dissemination of couples-based EBPs for alcohol problems are clearly necessary to identify effective means to promote the integration of couples-based approaches into routine alcohol treatment.

These limitations notwithstanding, this study provides a valuable examination of barriers to dissemination of couples treatment for AUDs. Given the dearth of research in this area, as well as the considerable body of research supporting the value of couples-based treatments for AUDs, attention to factors limiting uptake of such approaches is needed. Findings from this study highlight important barriers at the provider and system levels, and suggest some feasible future directions that may enhance the dissemination of evidence-based couples treatment for AUDs. Findings from this study may also more broadly apply to improving dissemination of couples-based EBPs for other mental health disorders.

Acknowledgments

This work was supported by National Institutes of Health Grant AA 17815. We acknowledge the contributions of Ayla Durst, Autumn Froias, Tara Ruggieri, and Chloe Troia in the collection and analysis of data.

References

Beidas RS, Kendall PC. Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. Clinical Psychology: Science and Practice. 2010; 17:1–30. DOI: 10.1111/j.1468-2850.2009.01187.x [PubMed: 20877441]

Crabtree, BF.; Miller, WL. Doing qualitative research. Thousand Oaks, CA: Sage; 1992.

Fals-Stewart W, Birchler GR. A national survey of the use of couples therapy in substance abuse treatment. Journal of Substance Abuse Treatment. 2001; 20:277–283. DOI: 10.1016/S0740-5472(01)00165-9 [PubMed: 11672643]

Fals-Stewart W, Logsdon T, Birchler GR. Diffusion of an empirically supported treatment for substance abuse: An organizational autopsy of technology transfer success and failure. Clinical Psychology: Science and Practice. 2004; 11:177–182. DOI: 10.1093/clipsy.bph068

Friedmann PD, Taxman FS, Henderson CE. Evidence-based treatment practices for drug-involved adults in the criminal justice system. Journal of Substance Abuse Treatment. 2007; 32:267–277. DOI: 10.1016/j.jsat.2006.12.020 [PubMed: 17383551]

Garner BR. Research on the diffusion of evidence-based treatments within substance abuse treatment: A systematic review. Journal of Substance Abuse Treatment. 2009; 36:376–399. DOI: 10.1016/j.jsat.2008.08.004 [PubMed: 19008068]

Glasner-Edwards S, Rawson R. Evidence-based practices in addiction treatment: Review and recommendations for public policy. Health Policy. 2010; 97:93–104. DOI: 10.1016/j.healthpol.2010.05.013 [PubMed: 20557970]

Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: Author; 2001.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Jameson JP, Chambless DL, Blank MB. Empirically supported treatments in rural community mental health centers: A preliminary report on current utilization and attitudes toward adoption. Community Mental Health Journal. 2009; 45:463–467. DOI: 10.1007/s10597-009-9230-7 [PubMed: 19636705]

Kazdin AE. Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. American Psychologist. 2008; 63:146–159. DOI: 10.1037/0003-066X.63.3.146 [PubMed: 18377105]

Kazdin AE, Blase SL. Rebooting psychotherapy research and practice to reduce the burden of mental illness. Perspectives on Psychological Science. 2011; 6:21–37. DOI: 10.1177/1745691610393527 [PubMed: 26162113]

Lamb, S.; Greenlick, MR.; McCarty, D. Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment. Washington, DC: National Academies Press; 1998.

McGovern MP, Fox TS, Xie H, Drake RE. A survey of clinical practices and readiness to adopt evidence-based practices: Dissemination research in an addiction treatment system. Journal of Substance Abuse Treatment. 2004; 26:305–312. DOI: 10.1016/j.jsat.2004.03.003 [PubMed: 15182895]

McLellan AT, Carise D, Kleber HD. Can the national addiction treatment infrastructure support the public's demand for quality care? Journal of Substance Abuse Treatment. 2003; 25:117–121. DOI: 10.1016/S0740-5472(03)00156-9 [PubMed: 14680015]

Miller WR, Sorensen JL, Selzer JA, Brigham GS. Disseminating evidence-based practices in substance abuse treatment: A review with suggestions. Journal of Substance Abuse Treatment. 2006; 31:25–39. DOI: 10.1016/j.jsat.2006.03.005 [PubMed: 16814008]

Nathan, PE.; Gorman, JM. A guide to treatments that work. 3. New York, NY: Oxford University Press; 2007.

Powers MB, Vedel E, Emmelkamp PMG. Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. Clinical Psychology Review. 2008; 28:952–962. DOI: 10.1016/j.cpr.2008.02.002 [PubMed: 18374464]

Rosen CS, Chow HC, Finney JF, Greenbaum MA, Moos RH, Sheikh JI, Yesavage JA. VA practice patterns and practice guidelines for treating posttraumatic stress disorder. Journal of Traumatic Stress. 2004; 17:213–222. DOI: 10.1023/B:JOTS.0000029264.23878.53 [PubMed: 15253093]

Sanders MR, Turner KMT. Reflections on the challenges of effective dissemination of behavioural family intervention: Our experience with the triple P–Positive Parenting Program. Child and Adolescent Mental Health. 2005; 10:158–169. DOI: 10.1111/j.1475-3588.2005.00367.x

Strauss, A.; Corbin, J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2. Thousand Oaks, CA: Sage; 1998.

Tsogia D, Copello A, Orford J. Entering treatment for substance misuse: A review of the literature. Journal of Mental Health. 2001; 10:481–499. DOI: 10.1080/09638230120041254

Turner KMT, Sanders MR. Dissemination of evidence-based parenting and family support strategies: Learning from the Triple P–Positive Parenting Program system approach. Aggression and Violent Behavior. 2006; 11:176–193. DOI: 10.1016/j.avb.2005.07.005

U.S. Department of Health and Human Services. SAMHSA's national registry of evidence-based programs and practices. 2011. Retrieved from http://www.nrepp.samhsa.gov/ViewAll.aspx

Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelvemonth use of mental health services in the United States: Results from the National Comorbidity Survey Replication. Archives of General Psychiatry. 2005; 62:629–640. DOI: 10.1001/archpsyc.62.6.629 [PubMed: 15939840]