The Community Reinforcement Approach

A Guideline developed for the Behavioral Health Recovery Management project

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Overview

The Community Reinforcement Approach (CRA) is a comprehensive behavioral program for treating substance-abuse problems. It is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. Consequently, it utilizes social, recreational, familial, and vocational reinforcers to assist consumers in the recovery process. Its goal is to make a sober lifestyle more rewarding than the use of substances. Oddly enough, however, while virtually every review of alcohol and drug treatment outcome research lists CRA among approaches with the strongest scientific evidence of efficacy, very few clinicians who treat consumers with addictions are familiar with it.

The purpose of this guideline is to introduce clinicians to the use of the Community Reinforcement Approach with consumers who present for drug and/or alcohol treatment. Once you complete your review of this guideline, you can expect to be better prepared to work with consumers using CRA for several reasons. First, by gaining an introductory understanding of the principles underlying CRA, you will have a theoretical foundation by which to base your practice of this method. Second, by following the procedures outlined in the clinical guideline, you will have a number of treatment strategies by which to develop and structure an effective intervention with a variety of consumers presenting with a diversity of needs. When learning any new treatment modality, it is essential to bear in mind that mastery comes only as a result of both study and practice. To that end, we have also provided you with a resource section that we hope will serve as a useful starting point in your effort to become more knowledgeable of, and efficient with, the practice of the Community Reinforcement Approach.

Background for The Community Reinforcement Approach

The Community Reinforcement Approach (CRA) is a broad-spectrum behavioral program for treating substance abuse problems that has been empirically supported with inpatients (Azrin, 1976; Hunt & Azrin, 1973), outpatients (Azrin, Sisson, Meyers, & Godley, 1982; Mallams, Godley, Hall, & Meyers, 1982; Meyers & Miller, 2001), and homeless populations (Smith, Meyers, & Delaney, 1998). In addition, three recent meta-analytic reviews cited it as one of the most cost-effective alcohol treatment programs currently available (Finney & Monahan, 1996; Holder, Longbaugh, Miller, & Rubonis, 1991; Miller et al., 1995).

The first study to demonstrate the effectiveness of CRA was conducted more than 25 years ago (Hunt & Azrin, 1973). In this study, with 16 alcohol-dependent inpatients and matched controls, individuals were randomly assigned to either the CRA treatment or a traditional treatment program that focused on the 12 steps of Alcoholics Anonymous (AA). At the 6-month follow-up, participants in the CRA condition significantly outperformed the 12-step group with the former drinking an average of 14% of the follow-up days and the latter drinking 79% of the days. Significant differences in favor of CRA were also found for the number of days institutionalized and employed as well. A second related study of inpatients by Azrin (1976) again contrasted CRA with a 12 step program-this time with a larger sample. And, again, CRA proved to be superior at the 6-month follow-up, with the CRA group averaging 2% of their follow-up time drinking, as compared to 55% for the those participating in the 12-step program. As before, those treated with CRA were more likely also to report fewer days of institutionalization and more days employed. Importantly, the CRA condition's abstention rate at the 2-year follow-up continued to be very high at 90%.

Not only was the next study the first to be conducted with outpatients (n=43), but it also was the first to compare the effects of a disulfiram (Antabuse) compliance program within both CRA and 12-step programs (Azrin, Sisson, Meyers, & Godley, 1982). The disulfiram compliance component involved training a concerned family member or friend to administer the disulfiram to the drinker, and to provide verbal reinforcement. A third condition involved participation in a 12-step program (AA in this case) and a prescription for disulfiram, but it lacked the trained disulfiram monitor that was presumed to be an integral part of the disulfiram compliance protocol. As predicted, the two groups containing the additional disulfiram compliance component reported the most success during the sixth month of follow-up, with the CRA program averaging 97% and the 12-step condition reporting 74% of the days abstinent. It was noteworthy that couples assigned to the disulfiram condition within the 12-step group performed much better than the group's single subjects, even to the point of matching the CRA group's outcome on several variables. In contrast, the 12-step group that received only the disulfiram prescription had an abstinence rate of only 45% of the days.

In another study the effectiveness of CRA was examined within an alcohol-dependent population of homeless individuals (Smith, Meyers, & Delaney, 1998). During this 3-month program all participants were housed in grant-supported apartments. Individuals who were employed at the end of three months were allowed to remain in the apartments for an additional month. Housing privileges were suspended temporarily if random breathalyzer tests detected drinking. In contrast to those in the experimental group who were provided with housing, Standard Treatment group members had access to resources at a large day shelter, which primarily included basic meals, clothing, and showers. The shelter also

offered a job program, individual sessions with AA-oriented counselors, and on-site AA meetings.

Participants in the CRA condition were treated in a group therapy format, and two weekly prizes were awarded for good attendance. The focus of most groups was skills training, primarily in the areas of problem solving, communication, and drink-refusal. Additionally, a non-drinking social event was held on Friday evenings, which commonly entailed a group dinner at a local restaurant. Periodically, group sessions were supplemented with relationship counseling or case management meetings. The latter were particularly important for the individuals with dual diagnoses (major mental illness + alcohol dependence) within the sample. At the conclusion of treatment, follow-ups were conducted every 2-3 months for the next year. The results for this trial showed that compared with standard care at the shelter, those treated with CRA showed significantly better outcomes throughout a year of follow-up (Smith et al., 1998).

With respect to the use of CRA with substances other than alcohol, a series of studies have demonstrated that the combination of CRA and contingency management is an excellent program for treating cocaine and methadone-maintained heroin abusers. Contingency management for cocaine abusers entails monitoring cocaine use through frequent urine samples, and rewarding individuals who turned in clean urines with tokens that could be traded for prizes. Studies have ranged from a 2-case design (Budney, Higgins, Delaney, Kent, & Bickel, 1991) to a controlled but nonrandomized trial (Higgins, et al., 1991), and finally to a controlled and randomized experiment (Higgins, et al., 1993). In both controlled trials the CRA plus contingency management group participants decreased their cocaine use significantly more than those in the 12-step (AA philosophy) comparison condition. Figures for the third study showed that the CRA plus contingency management

group had fewer program dropouts than the control condition (5% versus 42%) and a greater number of continuous days of cocaine abstinence throughout. Continuous cocaine abstinence was still found 16 weeks into the trial for 42% of the CRA group and only 5% of the 12-step group. CRA has also been extended to the treatment of methadone-maintained heroin addicts, again with an advantage for the CRA-treated clients (Abbott, Weller, Delaney, & Moore, 1998).

CRA has also been integrated with unilateral family therapy into an approach called the Community Reinforcement Approach and Family Training (CRAFT), which showed promising results in a small initial evaluation by Sisson and Azrin (1986). In CRAFT, the person seeking help is usually the parent or spouse of a problem drinker who refuses to seek treatment. Without the drinker present, the CRAFT therapist works with the spouse or parent to change the drinker's social environment so as to remove any inadvertent reinforcement for drinking or drug using, and instead to reinforce any and all behaviors related to abstinence (Meyers & Smith, 1997). They also prepare for the next window of readiness, when the drinker may respond favorably to an offer of help and support.

In a recently completed clinical trial funded by NIAAA (Miller, Meyers & Tonigan, 1999), 64% of those given CRAFT counseling succeeded in getting their loved one into treatment following an average of 4-5 counseling sessions, while two other traditional methods for engaging unmotivated problem drinkers were significantly less successful: the Johnson Institute family intervention (30%) and counseling to engage in Al-Anon (13%). In a parallel NIDA study focusing on drug abuse (Meyers, Miller, Hill, & Tonigan, 1999), family members given CRAFT successfully engaged 74% of initially unmotivated drug users in treatment. Lending additional support to findings from the NIDA study, Meyers, Miller, Smith, and Tonigan (in press) compared CRAFT, CRAFT plus aftercare, and Al-Anon/Nar-

Anon facilitation therapy (AFT) for treatment-refusing drug users. CRAFT alone and CRAFT plus aftercare successfully engaged 59% and 77% (respectively) of initially unmotivated drug users into treatment, while AFT was successful in only 29% of cases.

In sum, thus far CRA has been found in at least ten clinical trials to be effective in treating alcohol and other drug problems, and in helping relatives get their unmotivated loved ones into substance abuse treatment. In most but not all cases, it has also been found to be more effective than traditional approaches with which it has been compared, or to which it has been added.

Clinical Guidelines

A successful CRA therapist must have sound, fundamental counseling skills. Supportiveness, empathy, and a genuinely caring attitude are key to establishing the consumer-therapist relationship. However, CRA also requires that the therapist be directive, energetic, and engaging. Indeed, CRA-therapist trainees are often encouraged to consider themselves cheerleaders as well as therapists! It is their enthusiasm and motivation that facilitates the same in the consumer. As a behavioral program, CRA makes extensive use of modeling, role-playing, and shaping. Such an action-oriented approach implies that the CRA therapist does not submissively wait for the therapy session to move on its own. Rather, the therapist engages the consumer and works with him or her to solve problems. In line with this, problems are always defined as the property of both the consumer and the therapist. For instance, whereas another therapist might point out to the consumer, “Communication skills training could really benefit you,” the CRA therapist says, “It looks like *we* really need to do more work in the area of communication skills. Where do you think *we* should start?”

Rooted in operant principles, CRA uses positive reinforcement for each step, no matter how small. Consequently, a CRA therapist must be willing to look continually for opportunities to reinforce consumers. For example, if a consumer arrives 20 minutes late for a session, the CRA therapist might say something along the lines of, “I’m glad you made it today. I’m sorry we don’t have the whole 60 minutes to work together, but I’m just glad you’re here and we have 40 minutes together. Thanks for coming.” In addition to reinforcing a consumer’s attempts at change, a CRA therapist must be committed to helping the consumer identify potential positive reinforcements in the community. By helping the consumer find “payoffs” for learning new skills and trying new behaviors, the consumer creates his or her own motivation for change. Common examples are found in the willingness of consumers to modify their communication styles to minimize interpersonal conflict with significant others in their lives. Other examples include situations in which individuals learn assertiveness to bolster their self-esteem, or practice interviewing skills in order to eventually enjoy the pleasures of a job and a paycheck.

Finally, substance abuse is not viewed as an isolated behavior independent of the rest of the individual’s life. Instead, it is seen as intertwined with many aspects of the consumer’s life, and attention must be given to the context in which the substance abuse occurs. As a result, the CRA therapist must also possess the skills to work with couples, or in some cases, act as a case manager. Knowing community resources and being willing to actively help consumers address problems other than those that are purely substance abuse related is essential.

Although several randomized clinical trials have shown CRA to be effective within a relatively short 3-month period, it is structured in an open-ended format. Given the objective of helping consumers master a specific set of skills necessary to achieve their

goals, therapy is not complete until those skills are mastered and a reasonable degree of progress has been made toward obtaining their goals. With this in mind, the amount of time that is required varies from individual to individual.

In addition to consumer variables affecting the length of therapy, the therapist's ability to structure successes early in treatment is also a factor. By carefully selecting initial treatment goals well within the consumer's capability (e.g., showing up for the next session), self-efficacy is enhanced, the therapeutic relationship is strengthened, and the consumer continues to attend. In turn, the therapist has the opportunity to help the consumer learn to identify his or her behavioral contingencies and to begin to increase the number of pro-social behaviors in his or her repertoire, while decreasing drinking or drug using activities.

Treatment frequency is dictated by the consumer's motivation and progress. Although a CRA therapist normally would have sessions once weekly, the decision may be made to hold several sessions within the first week or two of treatment if the consumer is ambivalent or if there is concern about an impending relapse. During this period it would be important to apply proper positive reinforcement so as to make attendance and compliance with homework as rewarding as possible. As already noted, by structuring early successes, the therapist increases the likelihood that the consumer will be around for later ones! As therapy progresses and both therapist and consumer agree that the consumer is ready to become more independent, a "weaning" process is introduced. Essentially, sessions are scheduled every two weeks, then once a month, and so on. In this fashion the consumer-therapist relationship remains strong, and the consumer feels welcome to resume the regular sessions if difficulties arise.

As for session duration, an hour is usually adequate for an individual treatment session. If CRA is offered in a group format, duration runs easily to 1½ hours per session. Typically, only the first individual session runs as long as 1½ – 2 hours. During this time, assessment material is obtained, the program is explained, and strategies for maintaining sobriety until the next session are planned.

The specific components of the CRA program will now be addressed. While the assessment and treatment planning techniques are utilized with everyone, only those skills training procedures needed to address a consumer's specific deficits would be introduced in actual therapy.

CRA Functional Analysis

This structured interview outlines both the antecedents (triggers) for the drinking behavior and the consequences. Antecedents are broken down first into external triggers: people and places that typically precede drinking episodes. Internal triggers include common thoughts, physical sensations, and emotions. This information allows the therapist to point out high-risk situations for the problem drinker or drug user that set the stage for the introduction of alternative behaviors. Next a description of the type and amount of alcohol or other substance typically consumed is outlined so that progress can be monitored. Finally, the consequences for an individual's use are examined. The highly reinforcing but short-lived immediate consequences are identified first, such as the reported ability to relax and socialize more easily when drinking or using drugs. Eventually the therapist would assist in finding non-using ways for the individual to obtain these same feelings. Then the negative, long-term consequences of the using behavior are highlighted, including problems in interpersonal relationships, health, job, legal issues, and

finances. Improvements in these areas typically accompany abstinence, and reminders of this can motivate the individual throughout treatment.

Although traditional functional analyses stop here, the CRA Functional Analysis examines the antecedents and consequences of several types of pleasurable, *non-drinking* behaviors as well. Strategies for increasing the frequency of these behaviors can be introduced, and any obstacles to their implementation can be tackled through problem-solving efforts (For a complete description see Meyers & Smith, 1995, pp. 20-41).

Sobriety Sampling

Upon first entering treatment, most consumers are resistant to the message that they can never drink or use drugs again. So even in cases in which abstinence may clearly be the best option, the notion of "sampling" sobriety for a limited period of time is much less threatening. The therapist proceeds by reviewing some of the naturally occurring benefits of a period of abstinence, including renewed support from family members and the motivation to address other related problems. Once the consumer has agreed to a period of abstinence, the therapist usually asks for a 90-day commitment. Most individuals resist this, and consequently the negotiation process begins. Regardless of whether 60 or 6 days is settled upon, the therapist assists with a plan for accomplishing this. Since the necessary skills have not yet been taught, the therapist returns to the high-risk triggers outlined on the functional analysis and helps identify temporary competing behaviors for those times (For a complete description see Meyers & Smith, 1995, pp. 42-56).

Disulfiram Use with a Monitor

Frequently, the use of disulfiram (Antabuse) can provide an added benefit to many consumers who are seeking behavioral treatment for alcohol abuse. Since disulfiram is a medication that makes individuals very sick if they drink alcohol while taking it, it can be a

useful deterrent for impulsive drinking-especially with those consumers who have a history of chronic alcohol dependence. In describing the disulfiram option to a consumer it is important to outline the many advantages of its use, such as reductions in "slips", family worry, and agonizing daily decisions about whether or not to drink. If a consumer agrees to try disulfiram, the therapist explains that a supportive monitor (for taking the medication daily) is critical for ensuring success. The therapist would then meet with the consumer and monitor jointly so that role-plays of the administration procedure could be rehearsed (For a complete description see Meyers & Smith, 1995, pp. 72-77).

CRA Treatment Plan

The Happiness Scale is the first of two instruments that form the foundation of the treatment plan. It asks the consumer to rate current happiness for each of 10 life categories: drinking (or drug use), job, money management, social life, personal habits, family relationships, legal issues, emotional life, communication, and general happiness. This provides a quick overview of the severity of problems in a variety of areas. The Goals of Counseling chart follows readily, as the same 10 categories are listed again. This time the therapist assists in defining specific goals and strategies for achieving them in these areas, while adhering to behavioral guidelines and keeping in mind that the overall goal is to increase satisfaction in non-drinking areas, so that the role of alcohol and/or drugs as the major determinant of an individual's happiness is diminished.

In formulating these goals, three basic rules are taught: keep them brief, specific (measurable), and use positive terms (stating what the consumer <u>will</u> do, as opposed to what he or she will <u>not</u> do anymore). In the process of identifying strategies for achieving the goals, it often becomes clear that the consumer does not yet possess some of the necessary skills. These interventions are typically marked with an asterisk (*) to serve as

a reminder to the therapist that the skills need to be taught. Sample items from the Goals of Counseling form are presented below. These represent the goals that a given consumer might begin working on immediately (For a complete description see Meyers & Smith, 1995, pp. 80-101).

Goals of Counseling

Goals	Strategies	Time Frame
1. *In the area of drinking or drugs I would like:*		
(a.) To stay clean and sober.	Take disulfiram daily w/ a monitor	Next 30 days
	Attend therapy 1x/wk	
	Attend AA daily.	
	Use functional analysis to identify drinking/drug triggers.*	Next week
	Practice problem -solving to control urges.*	
	Practice drink-refusal.*	
2. *In the area of job progress I would like:*		
(a.) To attend work sober every scheduled day.	(see above strategies) Attend even if I have a hangover.	Next 30 days

(b.) To remain calm & in control of my anger at work.	Practice problem-solving & communication skills to control anger.*	
3. *In the area of marriage/ family relationships I would like:*		
(a.) To remain calm & in control of anger when speaking w/ ex-wife (no violence).	Practice problem-solving to control anger.* Invite ex-wife to a session to work on communication w/ each other.	Next 2 weeks
4. *In the area of social life I would like:*		
(a.) To add 1 new alcohol-free social activity.	Make a list of possible social activities. Select 1 & try it 1x.	Next week

Behavioral Skills Training

Much of CRA is devoted to teaching new skills in areas of deficits, such as communication, problem-solving, and drink refusal. Communication skills training focuses on three components of a good conversation: 1) giving an understanding statement, 2) accepting partial responsibility for problems, and 3) offering to help. The therapist models the use of these across a variety of situations, and the consumer then rehearses through role-plays. Problem-solving training is a step-by-step procedure for addressing specific

problems, such as combating urges to drink, developing non-drinking friendships, or developing new ways to relax. It begins with defining the problem precisely and brainstorming until a number of possible solutions are generated. Next the consumer selects one potential solution, outlines the manner in which it will be executed, and addresses anticipated obstacles. Finally the consumer commits to attempting the solution during the week, and the therapist reviews the outcome at the next session. The third major skill area, drink refusal, essentially involves assertiveness training that is also role-played (For a complete description see Meyers & Smith, 1995, pp. 102-120).

Job Skills

In the interest of finding multiple ways to increase the reinforcers in a consumer's life, it is very important to examine the individual's job satisfaction. A good job is often the source of many reinforcers, such as positive self-esteem, pleasant social interactions with coworkers, and obvious financial incentives. The CRA job program teaches the necessary skills for obtaining a job (See Azrin & Besalel, 1980, for a complete description) and keeping it, or for simply improving satisfaction with a current position. The latter two issues are, again, addressed primarily through problem solving (For a complete description see Meyers & Smith, 1995, pp. 121-126).

Social and Recreational Counseling

Typically a new consumer's friendships and social activities revolve around drinking. Given the importance of having satisfying social activities that compete with alcohol use and support sobriety, this issue must be addressed. The CRA therapist spends considerable time helping the individual identify new sources of non-drinking recreation, and using problem solving to overcome obstacles to participation (For a complete description see Meyers & Smith, 1995, pp. 138-146).

CRA's Marital Therapy

Although many relationships improve with the elimination of excessive drinking, interpersonal difficulties will often persist. The CRA therapist attempts to involve the partner of the drinker in treatment, so that relationship problems can be addressed and the partner's support for the drinker can be enlisted or, in some cases, re-enlisted. These joint sessions begin with a couples' version of the CRA assessment and treatment planning instruments. These provide information about designated problem areas in the relationship, reasonable goals, and viable strategies for initiating the necessary changes. Throughout this process the couple is taught basic communication skills, as well as techniques for gradually increasing the number of pleasant interactions they have with each other on a daily basis (For a complete description see Meyers & Smith, 1995, pp. 147-179).

CRA Relapse Prevention

Relapse prevention actually begins when high-risk situations and triggers are first identified on the initial functional analysis. CRA also trains partners in an Early Warning System, whereby old precursors to drinking are recognized, and a preplanned strategy is set into motion if they surface. In the event that a client does have a relapse, a relapse version of the CRA Functional Analysis is completed. Effective coping strategies for dealing with the triggers in the future are also devised (For a complete description see Meyers & Smith, 1995, pp. 180-195).

Frequently Asked Questions

Once aware of the primary components of CRA, there are some specific questions that should guide the clinician's development of an overall CRA treatment plan. Listed below are 15 general considerations with brief descriptions that the therapist might find helpful

when engaged in the process of formulating and carrying out an effective CRA treatment plan.

1. What are the therapeutic goals for the consumer? Which are primary, and which are secondary goals?

These aspects are best accomplished via the Happiness Scale and Goals of Counseling form discussed above.

2. What further information would you want to have to assist you in structuring the consumer's treatment? Are there specific assessment tools you would use (i.e. data to be collected)? What would be the rationale for using those tools?

The main assessment instruments for the CRA program are the two functional analyses. The first one examines drinking behavior, so that the antecedents and consequences for alcohol and drug use can be outlined, while the CRA functional analysis for pleasurable non-drinking behaviors demonstrates that the client already is engaging in enjoyable activities that do not involve alcohol. Other assessment instruments that the therapist finds routinely helpful in his or her clinical work (e.g. MMPI-II, NEO-PI-R, SCL-90, BDI, etc.) may also be used in an effort to obtain a thorough assessment of overall functioning. Having such information is useful with regard to the next question.

3. What is your conceptualization of the consumer's personality, behavior, affective state, and cognitions?

A consumer's developmental history, pattern of substance abuse, treatment, and relapse, as well as the results of psychological testing all point to consistent patterns that suggest a certain cognitive style. CRA is particularly appropriate for individuals whose testing indicates an overall cognitive style that reflects poor problem solving or planning capacity. Fortunately, these are the skills explicitly trained in the comprehensive format of CRA.

4. What potential pitfalls would you envision in this therapy? What would the difficulties be and what would you envision to be the source(s) of the difficulties?

Problems associated with the successful implementation of CRA come from two possible sources: the consumer or the therapist. Consumer difficulties arise when he or she is uncomfortable with CRA's action-oriented style. Particularly passive consumers who look outside themselves for answers and are incapable of joining the therapist in active problem solving may feel overwhelmed. Therapist-centered difficulties tend to arise when therapists become overly focused on the CRA "techniques" to the exclusion of other important issues. First and foremost is the problem that occurs when a poorly trained therapist confuses the behavioral component of the therapy for the whole therapy. Specifically, an over-emphasis on implementing operant principles without equal emphasis on the human aspects of counseling (i.e., warmth, empathy, unconditional positive regard) relegates the therapy to just another skills-training program. It is the combination of compassion and skill that makes the CRA therapist effective.

5. To what level of coping, adaptation, or function would you see a consumer reaching as an immediate result of therapy? What result would be long-term subsequent to the ending of therapy (i.e. prognosis for adaptive change)?

While other approaches to substance abuse treatment may view consumer's previous "failed" attempts as a poor prognostic indicator, CRA does not. Given the CRA emphasis on harm reduction, more prolonged periods of abstinence and abbreviated relapses can be reframed as evidence that the consumer has the capacity to attain sobriety and that the focus needs to be shifted to maintaining that goal.

6. What would be your time line (duration) for therapy? What would be your frequency and duration of the sessions?

Aspects of the time frame and duration of therapy are discussed at length at the beginning of the clinical guideline section.

7. Are there specific or special techniques that you would implement in the therapy? What would they be?

Two of CRA's key techniques have already been explained in some detail: CRA Functional Analyses and Sobriety Sampling. The remaining techniques that would be most useful for these consumers fall into the behavioral skills training category: Problem-solving, communication skills, and drink/drug-refusal. Problem solving is a step-by-step method for defining a problem, generating potential solutions, and devising a specific plan for implementing the desired solution. The procedure can be applied to virtually any type of problem by following these 7 steps: 1) Define the problem, 2) Brainstorm potential solutions (therapist does not criticize any), 3) Eliminate any undesired solutions (ones that the consumer cannot picture themselves trying in the upcoming week), 4) Select 1-2 potential solutions and determine if feasible, 5) Identify any obstacles to implementing the solutions, 6) Address each obstacle, and 7) Check on the outcome at the next session.

8. Are there special cautions to be observed in working with this consumer (e.g. danger to self or others, transference, counter-transference)? Are there any particular resistances you would expect and how would you deal with them?

Aspects related to safety concerns would be identical to other types of clinical treatment and should be addressed in a manner appropriate to standard ethical codes and considerations. With regard to resistance, the fact that CRA will represent a very new, and hopefully refreshing, approach to treatment, it is common for consumers to respond with less resistance than may typically be present in other types of treatment. However, even where resistance is encountered, CRA does not attack such behavior "head-on." There is ample evidence to suggest that a confrontational style does little but to increase resistance on the part of consumers (Miller & Rollnick, 1991; in press). Instead, CRA focuses on

looking at the meaning of the resistance as it relates to the functional analysis of the substance use behavior.

9. Are there any areas that you would choose to avoid or not address with the consumer? Why?

Although CRA is designed to handle virtually any problem area, certain issues may temporarily be avoided until some basic skills are taught. For example, if an individual decides that they want to try a new social activity, but the therapist is convinced that communication and drink-refusal skills need to be taught first, the consumer could be advised to put this plan on hold temporarily.

10. Is medication warranted for the consumer? What effect would you hope to expect the medication to have?

The use of medication to address withdrawal symptomatology during alcohol detoxification for all but the most severe cases is controversial. In a comprehensive review of both the psychiatric and psychological literature on the effectiveness of medication versus cognitive-behavioral therapy, which would include CRA, (Antonuccio, Danton, & De Nelsky, 1995), it was determined that medication should not be the first line treatment approach. As already discussed, one medication that might be considered, however, would be disulfiram (Antabuse). Another medication to consider at the point of aftercare is Naltrexone, since this opioid antagonist has shown some promise in reducing binges if an individual starts to drink again (O'Malley, et al., 1992; Volpicelli, Alterman, Hayashida, & O'Brien, 1992). To date, it has not been utilized in a controlled trial with CRA.

11. What are the strengths of the consumer that can be used in the therapy?

Let's say, for example, that a given consumer's major strength is the pride they take in their work, and the fact that they have been viewed by co-workers as fair, hard working, and conscientious. Since the individual experiences a sense of dignity and self-esteem

associated with work, their job would be considered a powerful reinforcer for them. Consequently, a CRA therapist would link the consumer's efforts toward sobriety with doing well at work. Similarly, the consumer could be reminded that they stood to lose something of great value to them (their job) if they continued to drink.

12. How would you address limits, boundaries, and limit setting with the consumer?

In terms of setting limits and boundaries within the therapeutic relationship, CRA operates in accordance with most standard clinical treatments. This includes establishing clear expectations for starting and ending sessions on time, and for paying in a timely fashion. The professional nature of the therapeutic relationship is also discussed. If a consumer violates any of these boundaries, the CRA therapist would raise the issue, discuss it with the individual in an effort to understand his or her feelings and motives, and then move toward a positive solution of the problem.

13. Would you want to involve significant others in the treatment? Would you use out-of-session work (homework) with this consumer? What homework would you use?

CRA always has viewed problem users' significant others as important collaborators in the treatment of substance abuse, and has included them successfully as disulfiram monitors, partners in marital counseling, active agents in re-socialization and reinforcement programs, and relapse or problem detectors (Azrin, et al., 1982; Meyers, Dominguez, & Smith, 1996; Meyers & Smith, 1995; 1997). At some point during treatment the therapist should try to work on relationship issues between the consumer and his or her significant others. There are three CRA tools that may be useful for such work. They include the Marriage/Relationship Happiness Scale (see UNM CASAA website or Meyers & Smith, 1995; page 171 for entire form), the Perfect Marriage/Relationship form (which allows for specification of behavioral goals and strategies) (see Meyers & Smith, 1995; pp.

174-176 for entire form), and the Daily Reminder To Be Nice chart (see Meyers & Smith, 1995; p. 179 for entire form).

Out-of-session homework is essential to CRA, since only 1–2 hours of therapy a week will not change a pattern that has taken years to develop. Assignments are often written onto the Goals of Counseling form in the strategies column (example of partial form given on pp. 14-15 of this guideline; see Meyers and Smith, 1995; pp. 98-99 for entire form). A basic consideration when assigning homework is to make sure that the consumer has the skills to be successful. In the event that he or she did not complete an assignment, the CRA therapist would explore the reason, as opposed to questioning commitment. Next, problem solving may be utilized, or the assignment might be tackled during the session instead.

14. What would be the issues to be addressed in termination? How would termination and relapse prevention be structured?

Relapse prevention work is critical in any case, as the period after acute care is problematic for most people. The integration of relapse prevention throughout all CRA interventions is implicit. In general, it will be important to see that the consumer has been trained in the necessary behavioral skill areas, and that he or she utilizes these new skills appropriately in the community (job, home). Since continued use of those skills is dependent upon being reinforced for doing so, the CRA therapist must check on this regularly.

An additional issue in the termination process is the importance of establishing positive expectations for treatment success, with a clear understanding of what this would mean specifically for the consumer. CRA strongly emphasizes that recovery is an ongoing process, and that while slips are not desired, they can be used as a source of valuable information in the determination of unforeseen high-risk situations.

15. What do you see as the hoped-for mechanisms of change for the consumer, in order of importance?

The most important mechanism of change for any consumer being treated with CRA is the individual's own set of reinforcers, most of which are inaccessible as a result of his or her use of substances. The second mechanism of change is inherent to CRA's non-confrontational format. At no time should the consumer be told that they are required to quit drinking or using drugs. The choice to change is always up to the individual. In essence, the most powerful mechanism of change; whether accessed through CRA or another approach; is the set of natural consequences of positive behavior. This is true across a wide range of behaviors, across persons of different personalities and cognitive styles, and regardless of previous failed attempts to change. It is at the foundation of any change strategy such as CRA that is based on a thorough understanding of behavioral science and principles.

Summary

CRA is a comprehensive, individualized treatment approach designed to initiate changes in lifestyle and the social environment that will support a client’s long-term sobriety. It has a strong track record of effectiveness in clinical trials that span geographic regions, inpatient and outpatient treatment, individual and family approaches, alcohol and other drug problems, homelessness, and cultural-ethnic differences. CRA teaches the therapist how to find and use the consumer's own intrinsic reinforcers. This is a unique and necessary part of CRA therapy process. Its flexibility of approach and philosophy of positive reinforcement are likely to be applicable, with modification, across a broad range of populations.

Resources

Recommended Reading

Azrin, N. (1976). Improvements in the community-reinforcement approach to alcoholism. Behaviour Research and Therapy, 14, 339–348.

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Wolfe, B. L., & Meyers, R. J. (1999). Cost-effective alcohol treatment: The community reinforcement approach. Cognitive and Behavioral Practice. 6, 105-109.

Recommended Assessment and Treatment Manuals

Budney, A. J. & Higgins, S. T. (1998). National Institute on Drug Abuse therapy Manuals for drug addiction: Manual 2. A Community Reinforcement Approach: treating cocaine addiction. (NIH Publication No. 98–4309). Rockville, MD: U.S. Department of Health and Human Services.

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National Institute on Alcohol Abuse and Alcoholism. *Assessing Alcohol Problems*. Treatment Handbook Series 4. J.P. Allen, & M.Columbus (eds.). NIH Pub. No. 95-3745. Rockville MD: National Institute on Alcohol Abuse and Alcoholism, 1995.

Trainers

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Internet-Based Resources

If you are looking for assessment instruments, or information on a variety of other related topics, you can find them on the University of New Mexico Center on Alcoholism, Substance Abuse, and Addictions (CASAA) website at http://casaa.unm.edu.

Also listed below are two other websites containing helpful information about the Community Reinforcement Approach.

http://www.nida.nih.gov/TXManuals/CRA/CRA1.htmlCRA1.html
http://www.healthyplace.com/Communities/Addictions/stanton_peele/faq/cra.html

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